PRESCHOOL ADMISSION APPLICATION

CHILD'S NAME:	
SEX:	
DATE OF BIRTH:	
TOILET TRAINED:	Please circle: YES NO

SCHEDULED START DATE:	
DEPOSIT AMOUNT:	
FORM OF DEPOSIT:	Please circle: CASH CHECK #: _____ CREDIT CARD

	Parent	Parent
Name:		
Home Address:		
City, State, Zip code:		
Phone #:		
Cell #:		
***Email:		
*Emergency pick up Name/Information: Phone #:		

*In case of emergency, the above individual is authorized by the parent(s) to pick up child. The authorized individual MUST show I.D. prior to child being released.

Medical / Allergy Information:

List all Allergies below:	List any pertinent medical condition(s):

Does your child have any specific needs that we need to know about?

How did you learn about Steps To Success?

As a cooperative day care center, Steps To Success relies and respects parent involvement. How do you see yourself involved in our school?

Please list the 3 most important qualities you look for in a day care center:

1.
2.
3.

Parent's signature	Date

Steps To Success Program Agreement Form

I, _____, parent/guardian of _____, agree to pay $_____ for my child's attendance at Steps To Success Daycare facility. *** *I also understand that any deposits given to secure my child(ren)'s seat is non-refundable unless a 3 month notice prior to the start date is provided to Steps To Success. Furthermore, should I decide to postpone my child's start date, I understand and acknowledge that a onetime allowance is permitted for a postponement and should we decide not to attend after the postponement is granted, our deposit is relinquished immediately as the 3 month notice policy will NOT apply (the 3 month refund policy ONLY applies to the initial start date selected).-*

Payment is due by the 5th of each month or I am liable for $30.00 late fee. I understand that my child is permitted ONE (1) Vacation Week Credit (vacation time is considered 5 consecutive days and *MAY* include when Steps to Success is closed and non-operational for holidays or emergency closures) per year at no charge to me. In furtherance, I understand that my child is entitled to TWO (2) Sick Week Credits (5 consecutive school/OPERATIONAL days) per year for which I will be responsible for 50% of the tuition for that week ONLY. My year commences from the date that my child begins attending Steps to Success and will be construed as my official enrollment. I am aware that I may NOT rollover any unused sick / vacation days/credits into the following attending year. I am also aware that any credit for vacation or sick time is limited to ONLY ONE (1) week maximum per month. I am also aware that any credit for vacation or sick time is limited to ONLY ONE (1) week maximum per month. Please note, if you are vacationing in a "high risk COVID country," you MUST quarantine for 2 weeks upon your return. However, you will only receive a ONE (1) week credit as per this agreement providing that you still have a credit owed to you. No additional vacation credits will be applied. ****Please note these credits DO NOT APPLY to the 3PK/UPK programs.*

Furthermore, if we are closed due to weather related conditions or events that are out of our control (i.e.: no electricity/heat, storm related disasters, floods) we are not liable and full tuition will be applied for that particular month ONLY. If we are closed due to any of the following unforeseen events below, in the first 5 days of closure, there will be no credit applied towards that month's tuition payment. In addition, we will *ONLY* provide credit for 50% of the remaining tuition paid for said month beyond the first 5 days. *If we are closed beyond that month, you will not be required to pay tuition until our centers re-open*:

1. Government forced shutdown
2. Department of Health Mandated Quarantine due to COVID cases
3. Pandemics
4. Force Majeure

In addition, it is our policy that if you remove your child for a given month(s) you are responsible for half of the month's tuition in order to hold your child's seat. The maximum amount of days your child is permitted to attend within the month that you have notified management of non-attendance is five (5). If you go beyond the five permissible days, you will be responsible for the entire month's tuition less any applicable vacation/sick credits that you may have available and have not exhausted in the last 12 months. If your child is out for 2 consecutive weeks and we are unable to reach you and/or you have not contacted us, your child's seat is subject to being forfeited.

Finally, Steps To Success LLC, and its agents reserve the right to terminate admission into said Day Care Facility if instances arise that can potentially be harmful or threatening to children attending the facility and/or staff/management performing their duties. Moreover, should a parent/guardian of an attending child constitute a threat, either mental or physical to any of the employees, management, or a child attending said Day Care Facility, management reserves the right to preclude admission. Additionally, in the event that your child requires special needs care that we will unfortunately be unable and/or qualified to provide and once we have exhausted alloptions at our Center, for the betterment of your child's care and development, we will terminate services and assist in any way possible in finding alternate care.

**PRICES ARE SUBJECT TO CHANGE*

_____
Parent/Guardian Signature

_____
Staff Signature

_____
Date

OCFS-LDSS-0792 (1/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE REGISTRATION

PHOTO OF CHILD
(Optional)

Child's Full Name:

Does your child have any allergies? ☐ Yes ☐ No
If Yes, what is your child allergic to?

Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs please discuss these with your child-care provider.

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus? ☐ Yes ☐ No

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other

Provider/Day Care Facility Name and Address:

CHILD'S FULL NAME:

SEX: ☐ Male ☐ Female

CHILD'S HOME ADDRESS:

DATE OF BIRTH:

HOME TELEPHONE NUMBER:

DATE OF ACCEPTANCE:

DATE OF DISCHARGE:

NAME OF PERSON APPLYING FOR CHILD:

☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other _____

HOME TELEPHONE NUMBER:

DAYTIME TELEPHONE NUMBER:

ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision. ☐ Yes ☐ No

In case of accident or injury, I authorize any and all emergency medical, dental, and /or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. ☐ Yes ☐ No

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and /or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. ☐ Yes ☐ No

I agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE

DATE:

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly Press Hard

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) ___/___/____

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other

City/Borough | State | Zip Code | School/Center/Camp Name | District ___ Number ____ | Phone Numbers: Home / Cell / Work

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER

If "yes" to any item, please explain (attach addendum, if needed)

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Other *(specify)* _____

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)*

☐ None ☐ Yes *(list below)*

_____

_____

Dietary Restrictions

☐ None ☐ Yes *(list below)*

_____

PHYSICAL EXAMINATION

Height _____ cm (____%ile)

Weight _____ kg (____%ile)

BMI _____ kg/m² (____%ile)

Head Circumference *(age ≤2 yrs)* _____ cm (____%ile)

Blood Pressure *(age ≥3 yrs)* _____ / _____

General Appearance:

	NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl		NI	Abnl
HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development	☐	☐
Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language	☐	☐
Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* _____

☐ Communication/Language _____

☐ Social/Emotional _____

☐ Adaptive/Self-Help _____

☐ Motor _____

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/____ ___/___/____	_____ µg/dL _____ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/____	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	___/___/____	☐ Normal ☐ Abnormal
— Head Start Only —		
Hemoglobin or Hematocrit *(age 9-12 mo)*	___/___/____	_____ g/dL _____ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	___/___/____	Induration _____mm
PPD/Mantoux *read*	___/___/____	☐ Neg ☐ Pos
Interferon Test	___/___/____	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	___/___/____	☐ NI ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4-7 yrs)*	___/___/____ ☐ with glasses	Acuity *Right* ___/___ *Left* ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	___/___/____	___/___/____	___/___/____
Rotavirus	___/___/____	___/___/____	___/___/____
DTP/DTaP/DT	___/___/____	___/___/____	___/___/____
	___/___/____	___/___/____	___/___/____
Hib	___/___/____	___/___/____	___/___/____
PCV	___/___/____	___/___/____	___/___/____
Polio	___/___/____	___/___/____	___/___/____

Influenza	___/___/____	___/___/____	___/___/____
MMR	___/___/____	___/___/____	___/___/____
Varicella	___/___/____	___/___/____	
Td	___/___/____	___/___/____	___/___/____
Tdap ___/___/____	Hep A	___/___/____	___/___/____
Meningococcal	___/___/____	___/___/____	
HPV	___/___/____	___/___/____	___/___/____
Other, *Specify:* _____	___/___/____;	_____	___/___/____

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/____

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other _____

ASSESSMENT ☐ Well Child (V20.2) ☐ Diagnoses/Problems *(list)* — ICD-9 Code

_____ _____

_____ _____

_____ _____

Health Care Provider Signature | Date ___/___/____

DOHMH ONLY PROVIDER I.D.

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___)___-____ | Fax (___)___-____

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: ___/___/____ I.D. NUMBER

REVIEWER:

Copies: White School/Child Care/Early Intervention/Camp, Canary Health Care Provider, Pink Parent/Guardian