OSSINING CHILDREN'S CENTER

Where Children Learn to Love Learning

APPLICATION FOR INFANTS & TODDLERS

SPECIAL DISABILITIES (PHYSICAL, LEARNING, SPEECH, ETC.), ALLERGIES OR OTHER PROBLEMS:

_____

_____

THIS APPLICATION MUST BE ACCOMPANIED BY YOUR CHILD'S BIRTH CERTIFICATE

APPLICATION FOR ENROLLMENT

Today's Date: _____ Date $25.00 Non- Refundable Application Fee Paid *: _____
Requested Starting Date: _____CHECK/CASH/CC RECEIPT #_____ Received by: _____
(*PAYMENT OF APPLICATION FEE PLACES APPLICANT ON WAIT LIST AND DOES NOT GUARANTEE FUTURE ENROLLMENT)
DEPOSITS ARE NONREFUNDABLE: Deposit amount paid_____ Date received_____

Child's Name:_____ Circle: Male / Female

Child's Nickname:_____ Date of Birth:_____ Age:_____
Child's Address:_____

Guardian #1 Name: _____ Cell: _____
Relation to Child: _____ Home Phone: _____
Address: _____
Email: _____
Occupation: _____ Present Position: _____
Name and Address of Employer:_____
_____ Work # :_____

Guardian #2 Name: _____ Cell: _____
Relation to Child: _____ Home Phone: _____
Address: _____
Email: _____
Occupation: _____ Present Position: _____
Name and Address of Employer:_____
_____ Work # :_____

Limitations on Visitation Rights: _____
DSS case worker:_____ DSS case #_____ Phone #_____

How many people live in your household? _____

Please list all household members not described above:

Name	Relationship	Age	Health	Employed	Home	School	Grade

OSSINING CHILDREN'S CENTER

Where Children Learn to Love Learning

How did you learn about the Ossining Children's Center? Please check all that apply:

____ from a friend or family member
____ Google Search
____ Ad on a Grocery Cart
____ Other (please specify) _____
____ Sign in front of 32 State Street
____ Facebook group
____ Welcome Wagon

What language(s) are spoken in your home? _____

Has your child ever been in the care (even for brief periods) of anyone other than yourself? _____. If so, when, with whom, and for what periods of time?

_____

Please give us information about your child's habits and need:

Allergies _____

Special Health Conditions _____

Special Interests and Abilities _____

Ways your child communicates his/her needs _____

Comforting Needs _____

Naptime Habits _____

Toileting Habits _____

Eating Habits _____

Diet: Type of formula _____
Ounces per serving: _____ Times per day: _____

Type of Food	Amount per Serving	Times per Day
Cereal		
Fruit		
Meat/ Protein		
Vegetables		
Fluids (juice, water, etc.)		
Other foods		

I give the Ossining Children's Center permission to use wet wipes and over-the-counter diaper rash ointments on my child as I direct.

_____ _____
Parent / Guardian signature Date

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CHILD DEVELOPMENT (INFANTS AND TODDLERS):

1. Was your child's birth normal? _____ Any problems?_____
   _____
   _____
2. At what age did your child:
   Walk?_____ Talk?_____ Toilet Trained?_____
   Does your child have any special routines or words about toileting? _____
   _____
3. Describe your child's sleeping habits? _____
   _____ Nap? _____
4. Has your child been identified by a professional as having any type of learning disabilities or other developmental delay? _____
   _____

MEDICAL:

DOES YOUR CHILD HAVE ANY SPECIAL DISABILITIES, ALLERGIES, OR OTHER MEDICAL PROBLEMS WE SHOULD KNOW ABOUT? _____
_____
_____

Pediatrician _____

Address _____ Telephone_____

Last Physical Examination on (Date) _____

Summary _____
_____

Growth Rate: Normal _____ Slow _____ Rapid _____

Has your child had:

Spasms _____	Frequent Colds _____
Convulsions _____	Nosebleeds _____
Injuries _____	Speech Difficulties _____
Surgery _____	Dental Problems _____

ANY unusual experiences regarding health?_____

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ENROLLMENT STATEMENT

_____, age _____ is enrolled at the Ossining Children's Center, 32 State Street, Ossining, NY 10562, commencing on _____

Signatures: _____

Parent/ Guardian Date

_____

Children withdrawn from enrollment on _____ .

Date

Comments:

_____

_____

_____

Signatures: _____

Parent/ Guardian Date

OSSINING CHILDREN'S CENTER

Where Children Learn to Love Learning

Child's Name_____ Telephone _____

1. I hereby give my permission to the OSSINING CHILDREN'S CENTER to seek EMERGENCY MEDICAL TREATMENT for my child in case I am unavailable when such treatment is required. I will bear all medical expenses for this treatment.

_____

Signature Date

2. In case of emergency, the following persons (more, if possible) will be called and are authorized to pick up my child:

Name Relationship To Child Address (7AM-6PM) Telephone (CELL/ WORK)

1. _____

2. _____

_____

Signature Date

3. I assume responsibility for my child from the time he/she leaves home until arrival at the Center and from the time he/she leaves the Center at the end of the day.

_____

Signature Date

4. _____ will pick up my child from the Center at approximately_____ each day. I hereby agree to notify the Center office each time any other person will pick up my child from the Center.

_____

Signature Date

5. I hereby give my permission for my child to go on educational trips under the jurisdiction of the Ossining Children's Center with ample and mature supervision.

_____

Signature Date

6. I hereby give my permission for my child to appear in the photographs taken by the Center and to allow any pictures of my child to be released for publication, electronic or print, for the purpose of fundraising or public relations.

_____

Signature Date

7. I hereby give my permission for my child to appear on OCC's Facebook and Instagram pages.

_____

Signature Date

8. I hereby give my permission for my child to be seen by the OCC psycho- educational consultant for initial and follow-up assessment screenings.

_____

Signature Date

OSSINING CHILDREN'S CENTER

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Income Statement

Child's Name _____ Date of Birth _____

Number of Family/Household Members _____
Number of Children in day Care:
Full time: _____ Part time: _____ **Total**: _____

One (1) month's payroll stubs for all income sources submitted _____
- For example: If you get paid once a week, you must submit four (4) paystubs.

Gross Income Source(s):	**Amount/How Often:**
Salary (Guardian #1)	
Salary (Guardian #2)	
Support Payments	
Social Security	
DSS/ADC	
Alimony	
Other (Specify_____):	

Total: _____

Falsification of the above information shall result in the termination of your child's participation in our program. Four payroll stubs for each wage earner in the household **must** accompany this form.

The office is to be notified immediately if there is any change in gross income. **Income verification may be required twice yearly.**

_____ _____
Parent/Guardian Signature **Date**

Rebecca and Arthur Samberg Building · 32 State Street · Ossining, NY 10562 · 914-941-0230
www.ossiningchildrenscenter.org

OSSINING CHILDREN'S CENTER

Where Children Learn to Love Learning

FEE SCHEDULE

(For Office Use Only)

Child(ren) name(s):_____

Program	First Child		Second Child		Third Child	
A) Infants – Young 3's	_____		_____		_____	
B) Pre-School – UPK	_____		_____		_____	
C) School-Age (K-7)	_____PT	_____FT	_____PT	_____FT	_____PT	_____FT
D) Bus & Breakfast	_____PT	_____FT	_____PT	_____FT	_____PT	_____FT
E) Summer Camp	_____		_____		_____	
Total Monthly Family Fee:			_____PT		_____FT	

I hereby agree to pay $ _____F/T and/or $_____P/T monthly to the Ossining Children's Center for the care of my child(ren):

_____ beginning on _____.

_____ _____

Parent/Guardian Signature **Date**

OSSINING CHILDREN'S CENTER

Where Children Learn to Love Learning

Policy Statement

The Ossining Children's Center is open to all children regardless of race, creed or ethnic origin.

For a child to be admitted to the Center, the parent/guardian(s) must complete and sign the forms presented by the Center, including:

A: Application for Enrollment
B: Permission Forms
C: Income statement and Fee schedule
D: CACFP Form
E: Title XX Form (when applicable)
F: Policy Statement
G: Health Form (completed by a physician) required annually

Income Verification

- Income verification may be required twice a year for all parents whose children attend the Center.

Tuition

- Accounts will be billed monthly on or the third Friday of the month for the upcoming month. Payment in full must be received by the 15th of the month that the bill is for, or your child's enrollment may be jeopardized.
- Fees may be based on a sliding scale and are adjusted whenever there is a change in income. Fee increases for parents who fail to provide income verification are retroactive to the last verification date. Fee decreases are not retroactive.
- Part-time school-age students' tuition will be charged at the full day tuition rate for full weeks (i.e. school vacation weeks).
- Parents who are eligible for government funding but who refuse to accept funding or who fail to submit the required documents in an accurate and timely manner will be required to pay a fee equal to the amount of the funding they refuse.
- If a parent falls ***two weeks*** behind in payment of tuition fees, the child will ***not*** be allowed to attend the Ossining Children's Center until such time as payments are brought up-to-date.
- Credit balances will be refunded upon termination of your child's enrollment from our program.

Past Due Accounts

- Past due accounts of children who have left the Center with an outstanding balance will be transferred to an attorney and the cost of collection will be added to the overdue account.

Hours

- The hours of the Ossining Children's Center are from 7:00a.m. to 5:55p.m.
- Arrival should be between 7:00a.m. and 10:00a.m.
  - PLEASE NOTE: UPK class only **and** Summer hours – arrival time by 9:00 a.m.
- CHILDREN MUST BE SIGNED IN AND OUT ON THE CLIPBOARD. PARENTS ARE TO SIGN THEIR FULL NAME ON THE ATTENDANCE SHEET.
- If students are being dropped off or picked up from school, parents are responsible to notify the teacher and main office. A fee will be charged when the Center is not notified.
- The Center closes promptly at 5:55p.m. each day. If a child is not picked up by 6:00p.m. a late fee of $10.00 for every 15 minutes or part thereof will be charged. The parent will be asked to record in the late fees book the time arrival, the child's name and the parent's signature. The fee will be due with regular tuition fees.
- Parents who arrive late consistently (more than four times in six months) will be requested to find childcare which better suits their individual needs.
- If a child is not picked up by 7:00p.m. and a call has not been received from the parents or the Center has been unable to contact any of the family's designated emergency numbers, the child will be taken to the Ossining Police Station.

OSSINING CHILDREN'S CENTER

Where Children Learn to Love Learning

FOOD

- All Center menus, consisting of breakfast, lunch, and snack each full day, are approved by a nutritionist.
- With the exception of infant formula, the Center will provide each full-time child with at least two-thirds of his daily food requirement. Children attending a part-time program without lunch will receive at least one nutritious snack. Other part-time children will receive snack and lunch.
- Menus will be dated and posted on the bulletin board in the entrance hall.

HEALTH

- The Center has arranged for group accident insurance coverage for all children for accidents occurring while children are under the Center's care. All parents are required to pay the insurance fee with the first week's tuition and each September thereafter.
- Children are required to have physical examinations once a year as preschoolers and once every two years as school-agers. Children will not be admitted to the Center without an up-to-date medical examination and a health form on file.
- The children are given a routine check every day upon arrival. Any child who shows symptoms of infection will have to be returned home.

Exclusion Guidelines

- The following symptoms, but not limited to, could represent communicable disease and are reasons for excluding children:
  - Diarrhea: two or more loose stools (with increased stool water and/or decreased form) or if stools contain blood or mucous.
  - Rash: any unexplained rash must be diagnosed by a physician. A doctor's note is required stating that your child is not contagious and is able to return to daycare.
  - Conjunctivitis: child may return to the Center 24 hours after medication has begun and a doctor's note is required stating that the child is not contagious.
  - Vomiting: two or more times in previous twenty-four hours unless physician determines vomiting is not due to communicable condition and child is not in danger of dehydration.
  - Fever: 100.4°F or higher.

Any child with these symptoms should remain at home for 24 hours after the symptoms are gone. **Please note: all Exclusion Guidelines are subject change/update in accordance with our Health Consultant.**

MEDICATION

- The Center may not administer any medication or special diet without written instructions from a physician.

PERSONAL BELONGINGS

- The Ossining Children's Center cannot be held responsible for lost items. Please label all of your child's belongings with his or her name: clothing, blankets, naptime stuffed animals, etc.

I have read the above statements and will abide by the policies of the OSSINING CHILDREN'S CENTER.

_____ _____

Parent/Guardian Date

Rebecca and Arthur Samberg Building · 32 State Street · Ossining, NY 10562 · 914-941-0230
www.ossiningchildrenscenter.org

OSSINING CHILDREN'S CENTER

Where Children Learn to Love Learning

CONFERENCES

- Conferences are scheduled with teachers in February and June. Parents may request a teacher conference at any time.

TERMINATION

- The Center reserves the right to terminate a child from the Center if it is determined that our program does not meet the needs for a child.

I have read the above statements and will abide by the policies of the OSSINING CHILDREN'S CENTER.

_____ _____

Parent/Guardian Date

Rebecca and Arthur Samberg Building · 32 State Street · Ossining, NY 10562 · 914-941-0230
www.ossiningchildrenscenter.org

CACFP Agreement #_____

NEW YORK STATE | Department of Health | Child and Adult Care Food Program

INFANT FEEDING STATEMENT

Baby's Name _____ Date of Birth _____

Dear Parent/Guardian:

This center participates in the Child and Adult Care Food Program and we will give your baby Enfamil and solid food. If you want to bring breast milk or your own formula or food, you can do that instead. Also, we encourage moms to come to the center to nurse their babies.

NAME OF FORMULA

Please indicate your choice below.

BREAST MILK/FORMULA (CHECK ONE)	FOOD (CHECK ONE)
_____The center can give my baby the formula they buy. ____I will bring breast milk or formula for my baby.	_____The center can give my baby solid foods when I tell them the baby is ready. _____I will bring solid foods for my baby.

Parent's Signature _____ Date _____

This institution is an equal opportunity provider.

In accordance with OCFS Regulations for Child Care Centers, this is our napping agreement/policy for each child in care (418.15(16).

- If a child is unable to sleep during nap time, the child will be provided with a supervised place for quiet play. No child will be confined to a sleeping surface, if they are unable to sleep.
- When sleeping your child will be placed in a crib/cot (*circle one).*
- Sleeping arrangements for infants require that the infant be placed flat on his or her back to sleep, unless medical information from the child's health care provider is presented to the program by the parent that shows that arrangement is inappropriate for the child.
- Cribs and other sleeping areas for infants must not have bumpers, toys, large stuffed animals, heavy blankets, pillows unless medical information from the child's health care provider is presented indicating otherwise.
- The resting/napping places must: be at least two feet apart from each other.
- Bedding must not be shared between children.
- Sleeping surfaces, including bedding, will not come in contact with the sleeping surfaces of another child's rest equipment during storage. Mats/cots must be stored so that the sleeping surfaces do not touch when stacked.
- No cot or crib will be occupied by more than one child.
- Individual clean bed coverings will be available for each child requiring a rest period.
- Children may not sleep or nap in car seats, baby swings, infant seats, strollers or bouncy seats unless otherwise prescribed by a health care provider. Should a child fall asleep in one of these devices, he or she must be moved to a crib/cot.
- Except while sleeping, awaking or going to sleep, an infant must not be left in a crib, or other confined space for more than 30 minutes at any one time. Other than at meals or snack time, a child must not be left in a high chair for longer than 15 minutes.

I have read this napping agreement.

Parent's Signature Date Child's Name

PLEASE COMPLETE

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

POR FAVOR COMPLETE

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME OSSINING CHILDREN'S CENTER

Print the name of the child(ren) enrolled in this child care center

1. 2. 3.

DIRECTIONS

Complete SECTION A if anyone in your household

1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case #

TANF #

FDPIR #

Names of
Foster Children

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature

Date

FOR SPONSOR USE ONLY

CACFP Agreement # 3086

Total Number of Household Members
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $

Free Reduced Paid

Date of Determination

Signature of
Center Staff

Complete SECTION B if no one in your household participates in SNAP, receives TANF participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature

Print Name

LAST FOUR 4) DIGITS OF SOCIAL SECURITY NUMBER

DATE

Privacy Act Statement: The Richard B. Russell National School Lunch Act requires the information on this form. You do not have to give the information, but if you do not, we cannot approve the participant for free or reduced-price meals. You must include the last four digits of the Social Security Number of the adult household member who signs the form. The Social Security Number is not required when you: apply on behalf of a foster child; provide a SNAP, TANF or FDPIR number; or when you indicate that the adult household member signing the form does not have a Social Security Number. We will use your information to determine if the center is eligible for free or reduced-price meal reimbursement and for administration and enforcement of the Program.

INSTRUCTIONS FOR COMPLETING DOH-3688

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) Social Security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) unemployment compensation; (7) government civilian employee or military retirement, or pensions or veteran's payments; (8) private pensions or annuities; (9) alimony or child support payments; (10) regular contributions from persons not living in the household; (11) net royalties; (12) military benefits received in cash, such as housing allowance except if you are in the Military Housing Privatization Initiative; and (13) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR PARENTS OR GUARDIANS

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household participates in the Supplemental Nutrition Assistance Program (SNAP), receives Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the SNAP, TANF or FDPIR number (do not use your ACS or DSS child care subsidy number). Then sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, write in the names of the foster children.

Section B: Complete this section if you did not complete Section A. Write in your name and the names of all other adults and children living in the household, including unrelated people, even if they do not have any income. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income.

The last four digits of the Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*. The form must be signed by an adult member of the household.

INSTRUCTIONS FOR CENTERS AND SPONSORS

The *For Sponsor Use Only* section is to be completed, signed and dated by center or sponsor staff. The sponsor/center representative must review the income eligibility form and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The CACFP Agreement Number.

Total Number of Household Members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care and the number of foster children, if applicable.

Total Household Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the form must be categorized as *paid*.

Number of Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced** or **Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete forms (missing signatures, income information, last four digits of Social Security Number or SNAP, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility form is valid until the last day of the month one calendar year from the date it is signed by the household member. For example, a form signed on May 12, 2014 is valid until May 31, 2015.

NEW YORK STATE | Department of Health | Child and Adult Care Food Program

LETTER TO HOUSEHOLDS

Dear Parent, Guardian or CACFP Participant,

This center participates in the Child and Adult Care Food Program (CACFP) and provides healthy meals at no cost to all children and adults enrolled in the daycare center. By completing and returning the attached Income Eligibility Form, you will help your center receive money from CACFP for the meals that are served. If your household's income is equal to or less than the amounts indicated for your household size on the chart below, the center will receive a higher rate of funding for the meals served. The Income Eligibility Form needs to be completed every year. Your center and CACFP will keep all information private.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2024 until June 30, 2025)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	27,861	2,322	536
2	37,814	3,152	728
3	47,767	3,981	919
4	57,720	4,810	1,110
5	67,673	5,640	1,302
6	77,626	6,469	1,493
7	87,579	7,299	1,685
8	97,532	8,128	1,876
FOR EACH ADDITIONAL FAMILY MEMBER	+9,953	+830	+192

HOWARD MILBERT
SPONSOR/CENTER OFFICIAL

OSSINING CHILDREN'S CTR
SPONSORING ORGANIZATION

7/1/2024
DATE

This institution is an equal opportunity provider.

Good nutrition today means a stronger tomorrow!

Building for the Future with CACFP

This day care receives support from the Child and Adult Care Food Program to serve healthy meals to your children.

Meals served here must meet USDA's nutrition standards.

Questions? Concerns?

[Here is space for the State agency and sponsoring organization to add contact information]

Learn more about CACFP at USDA's website:

https://www.fns.usda.gov/

United States Department of Agriculture
Food and Nutrition Service FNS-317
November 2019

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child	Date of Birth: / /	Date of Examination / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date OR 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization	Date / /	Type of Immunization:	Date / /
Type of Immunization	Date. / /	Type of Immunization:	Date / /
Type of Immunization.	Date / /	Type of Immunization:	Date / /

Tests

Tuberculin Test Date: / / Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: / /

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years / / Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

/ / Result _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date