



Parma Kids
Preschool & Child Care Center
 39 Hovey Street
 PO Box 57 ~ Hilton, NY 14468
 (585) 392-5792

For Office Use Only: Non-Refundable Registration Fee \$ ____ Check # ____ Date Paid ____ Medical Form Rec'd ____
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2018-2019 School Year Registration Form

Child's Full Name _____
First Middle Last

Home Address _____
Street City State Zip

Home Phone _____ Cell _____ Date of Birth ___/___/___ Gender: M F

Parents' Marital Status: ___ Married ___ Divorced ___ Separated ___ Other

Parent's Email Address _____ Church You Attend _____

Mother's Name _____ Phone _____ Occupation _____ Hours _____

Father's Name _____ Phone _____ Occupation _____ Hours _____

Names and ages of other children in your family _____

Allergies or any medical conditions we should be aware of: _____

Frequent ear infections? ___ Tubes in ears? ___ Tubes in ears now

Is your child toilet trained? ___ yes ___ no ___ needs assistance

Is your child ___ right handed ___ left handed ___ undetermined

Does your child have any unusual habits? _____

Unusual words _____ Fears _____ Dislikes _____

Explain any emotional or learning problems your child might have _____

PHOTO AUTHORIZATION: I give permission for my child to be photographed and put on the school website or in newspaper. ___ YES ___ NO

SCHOOL DIRECTORY: I give permission for my child's address, parent's names, phone #, and email to be put in our school directory (Not our website). This is to stay connected with other parents and for staff usage.
 ___ YES ___ NO Please only list my: _____

Please circle day(s) & write the time(s) you need: Child's Age _____

Daycare:	Mon Tues Wed Thurs Fri Start Time: _____ Pick-Up Time: _____
Start Date:	Preschool Only 9:15am-11:45am <small>Mon Tue Wed Thurs Fri</small>
	Preschool Class (circle one) 2's 3's 4's
Suggest other options, comments and/ or second choices: _____	

Statement of Understanding

Please note that payment is due by the first of every month. No refunds will be given for missed days due to but not limited to; a sick child, personal vacations, or school vacations. Exceptions for refunds will be made at the discretion of the Board of Directors with the advisement of the School Director. Additional activities, meals, and days require advanced permission from the School Director and payment in full before the starting date of attendance. Failure to make payments on time will result in the assessment of late fees and possible dismissal from the program. Your signature confirms your understanding of the above stated conditions and agreement to fulfill your financial obligations to Parma Kids Preschool & Child Care Center around program.

Print name: _____ **Signature:** _____ **Date** ___/___/___

OCFS-LDSS-0792 (1/2005) FRONT

PHOTO OF CHILD (Optional)	NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES DAY CARE REGISTRATION			
	Child's Full Name: _____			
	Does your child have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other

The emergency contact(s) is allowed to pick up my child in the event of an emergency. Yes _____ No _____

Parent/ Guardian Signature: _____

Parma Kids Preschool and Child Care Center PO Box 57 Hilton, NY 14468	CHILD'S FULL NAME: _____		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
	CHILD'S HOME ADDRESS: _____		DATE OF BIRTH: _____
			HOME TELEPHONE NUMBER: _____
	DATE OF ACCEPTANCE: _____	DATE OF DISCHARGE: _____	
	NAME OF PERSON APPLYING FOR CHILD: _____	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No			
I agree to review and update this information whenever a change occurs and at least once every six months. <input type="checkbox"/> Yes <input type="checkbox"/> No			
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE		DATE: _____	

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