

Appendix L – Day Care Registration (Blue Card)

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? <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	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;">RELATIONSHIP</th> <th style="width: 25%;">CONTACT NAME</th> <th style="width: 25%;">TELEPHONE NUMBER DURING CHILD CARE</th> <th style="width: 35%;">OTHER TELEPHONE NUMBER (Check type)</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> <input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> <input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> <input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> <input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other </td> </tr> </tbody> </table>	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				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
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Front View ↑

Back View ↓

Provider/Day Care Facility Name and Address:	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: _____
	ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S): _____		DAYTIME TELEPHONE NUMBER: _____
	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: _____	