CHILD REGISTRATION FORM

CHILD'S INFORMATION:

Last Name_____ First Name_____ Gender: M/F

Date of Birth_____ Age_____ Enrollment Date_____ Start Date_____

Assigned Classroom_____ Days Attending *(please circle)* M T W Th F

School Meal Plan: Yes/No __Non-Vegetarian __Vegetarian *Pizza Fridays*: Yes/No *Parent View*: Yes/No

Allergies or other important information:_____

I give permission for my child's photo to be sent via the Tadpoles system. Initials _____

For security purposes, please provide both parent/guardian information

PARENT/LEGAL GUARDIAN 1 INFORMATION:

Last Name_____ First Name_____ Gender: M/F

Home Address_____ City_____ State_____ Zip Code_____

Social Security Number ___-___-___

Employer _____

Address_____

City_____ State____ Zip Code_____

Home Phone _____

Cell Phone _____

Work Phone_____

Email Address_____

PARENT/LEGAL GUARDIAN 2 INFORMATION:

Last Name_____ First Name_____ Gender: M/F

Home Address_____ City_____ State_____ Zip Code_____

Social Security Number ___-___-___

Employer _____

Address_____

City_____ State____ Zip Code_____

Home Phone _____

Cell Phone _____

Work Phone_____

Email Address_____

CUSTODIAL ACKNOWLEDGEMENT:

I understand that providing both parents/guardians information gives both parties the right to visit/pick up the above mentioned child at any time. If custody circumstances change for any reason, Lightbridge Academy must be notified in writing and we may request documentation by the proper authority.

Parent 1 Signature _____ Parent 2 Signature _____

CUSTODIAL INFORMATION:

If a non-custodial parent is not among those persons authorized to pick up the child or if a court order pertains to your custodial agreement, a court order must be provided. Please check the appropriate box below.

_____Yes, this situation applies. A court order is attached. _____Not Applicable

EMERGENCY CARE AUTHORIZATION:

In the event that a medical emergency occurs, I authorize Lightbridge Academy to seek emergency care for my child as deemed necessary by the Director and I authorize such medical provider to carry out required emergency treatment.

Signature: _____ Date: _____

MARKETING INFORMATION:

How did you hear about Lightbridge Academy?

___ Personal Referral (If so, who?) _____ ____Drive-By

___ Internet (what search engine?) _____ ___Advertisement (which one)_____

I understand and agree to the policies and requirements outlined in the Lightbridge Academy Parent Handbook and the Financial Agreement. Specifically, I understand that full tuition is due regardless of holidays, snow days, short-term illnesses, or vacations. All returned transactions will be assessed a penalty to cover banking fees. In addition, I understand the Expulsion Policy and Parent Code of Conduct (included in the Parent Handbook).

Parent/Legal Guardian 1 Signature:_____Date:_____

Parent/Legal Guardian 2 Signature:_____Date:_____

OFFICE USE ONLY:

_____

_____

_____

_____

Lightbridge Academy℠

OCFS-LDSS-4433 (Rev. 5/2014) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

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

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

Immunizations required for entry into day care ☐ Yes ☐ No

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).

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)

Lightbridge Academy℠

OCFS-LDSS-4433 (Rev.5/2014) REVERSE

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 _____

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

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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:

OCFS-LDSS-0792 (1/2005) REVERSE

EMERGENCY CONTACT INFORMATION FORM

(Please attach to the blue card. Must be included in the Office & Classroom Emergency Binders)

Child's Name: _____

In the event of a minor injury (cut, scrape, etc) would you like to be notified? _____

Which parent should we contact first in case of an emergency? _____

Emergency Care Authorization:

In the event that a medical emergency occurs, I authorize Lightbridge Academy to seek emergency care for my child as deemed necessary by the director and I authorize such medical service provider to carry out required emergency treatment.

Parent Signature: _____ Date: _____

Parent Signature:_____Date:_____

****

Dietary preferences_____

_____

If cakes, cookies, or other treats are given as a snack in the event of a Birthday or other special occasion, do you object to your child consuming them? _____

Is a language other than English spoken at home? _____
If so, what language? _____

What Holidays do you and your family celebrate?

_____New year's	_____Valentine's day	_____St Patrick's Day
_____Easter	_____Cinco de Mayo	_____Independence Day
_____Rosh Hashanah	_____Ramadan	_____Halloween
_____Thanksgiving	_____Chanukah	_____Christmas
_____Kwanzaa	_____Diwali	

Other(s):

_____

_____

AUTOMATED ELECTRONIC FUNDS TRANSFER AUTHORIZATION FORM

Center: _____Center's Employer Identification Number: _____

Child's Name: _____

TAPE VOIDED CHECK HERE

I/We _____ hereby authorize Lightbridge Academy® Child Care Centers to initiate debit entries (and if necessary, credit adjustments for any debit entries in error due) to my/our __checking __savings account (select one) from the depository listed below. I understand that the amount of the funds transferred from my account to Lightbridge Academy® will occur on the 27th of the month proceeding the month services are rendered or if the 27th falls on a holiday or weekend the EFT will occur the last Lightbridge Academy® business day preceding the 27th. I understand that the amount withdrawn each month from my account will equal the amount of the outstanding balance owed on my account. I also understand that a $40.00 fee will be charged to me on all electronic payments dishonored.
Depository Name:_____Branch:_____
City: _____State:_____Zip:_____
Transit /ABA#:_____Account #: _____
This authority is to remain in full force and effect until Lightbridge Academy® has received written notification from me/us of its termination in such a manner as to afford Lightbridge Academy® a reasonable opportunity to act on it (minimum of seven business days).
Name (s) on account:_____

Signature: _____ Date: _____

Signature: _____ Date: _____

FINANCIAL AGREEMENT

This agreement is made and entered into between Lightbridge Academy® Child Care Centers and (Parent(s) Name) _____. The Center hereby accepts (Child's Name)_____for enrollment beginning _____, 20__. I/We the parent(s), agree to pay the applicable tuition and fees for the services which we subscribe per month under the following terms:

1. Yearly tuition is divided into equal monthly payments. Adjustments or pro-rated tuitions are not applicable for illness, vacations, and closings due to holidays, inclement weather or as a result of the end of the programs cycle. All monies, once paid are non-refundable. Once you have paid your child's tuition for the month, you are committed for the entire month. There is no exception to this policy. Any change in tuition becomes effective as of the 1st of the next month. This refers to a child moving from one program to the next or a shift in the number of days a child is scheduled to attend in the program in which they currently participate.

2. Any child registered who does not start at the Center on the agreed upon date will forfeit all deposits and fees paid (unless previously agreed to with the Center Director).

3. An annual registration fee (non-refundable) and a one-time only security deposit are due at the time of enrollment to guarantee space for your child. The security deposit will be held in a noninterest bearing account and will be applied to delinquent tuition payments if necessary. If in the event this security deposit is used for the above stated purpose it must be replaced before your child can return to school. The security deposit will be applied to the last month's tuition as a credit when your child leaves Lightbridge Academy®. Security deposits will not be credited unless Lightbridge Academy® is notified (in writing) at least 45 days prior to terminating services. The security deposit will be credited to the final two weeks of the last months services provided.

4. It is the responsibility of the parent to maintain tuition payments throughout any intermission in attendance, regardless of the length of time, to continue your account in good standing. Interruption of payments resulting from temporary withdrawal from the center will result in the forfeiture of the Registration Fee and Security Deposit and risk losing the child's space. If space is available upon return, a new Registration Fee and Security Deposit will be required prior to reinstatement and is subject to all previous conditions.

5. Monthly tuition payments are due on the 27th of the month preceding the month of service and will be automatically deducted using the automatic EFT (Electronic Funds Transfer) system. If this date falls on a weekend or a holiday, payments will be due the last Lightbridge Academy® business day prior to the due date. Payments received after the due date will be subject to a $40.00 "Late Fee" for each day they are late. Payments not received by the 1st of the month will result in the interruption of the child's attendance until all financial obligations including late fees are up to date.

6. If you terminate services and have an outstanding balance due on your account, you will be held responsible for paying your bill. If it is necessary that we must seek legal action against you in order to obtain payments due, you will be responsible for all of our collection and legal costs including attorney and court fees.

7. There will be a $40.00 fee charged for any returned checks or accounts accessed which do not have sufficient funds to cover tuition payments.

8. A late pick-up fee will be imposed for children held after their scheduled pick-up time. This charge will be assessed at a rate of $10.00 for each ten-minute period, or portion thereof beyond the scheduled pick-up time. This fee will be charged even if you have notified us that you will be late. The late pick-up fee will be billed to you on the following day and must be paid within two business days. We will use the clock located in the office to determine if a parent is late. Please set your watch to this time. Try to make alternate arrangements if you cannot be at the Center in time to pick up your child. This will save you a late fee and ensure our staff a timely departure. Chronic lateness is not acceptable, regardless of fees and could result in termination of services and forfeiture of your Security Deposit.

9. In the event your child has not been picked up by 7:30 p.m. and we have not been in contact with you or the emergency contact, we will by law call DCF (Division of Children and Families). See Policy on the Release of Children.

I/We have read the above terms and understand the financial commitment to Lightbridge Academy®. I/We recognize that this is a legal agreement. I/We sign it with the full knowledge and consent of its meaning and importance.

Signature of Parent / Legal Guardian	Relationship	Date

Signature of Parent / Legal Guardian	Relationship	Date

IDENTIFICATION FORM

Child's Name:_____
Parent's Signature:_____

Please bring in copies of identification (i.e. drivers license) on or before your child's first day at Lightbridge Academy®.

Please attach:
Parent / Legal Guardian 1's License:

Parent / Legal Guardian 2's License:

MEDICATION ADMINISTRATION PACKET

Dear Parents,

This packet contains a Medication Administration Policy as well as other policies to help us provide the best possible care for your child. They include: Medication Consent Form and Non-Medication Consent Form. These policies are in accordance with the most up to date state and federal regulations.

Please take the time to read through below on the guidelines of these forms.

1. Medication Administration Policy. Please read through, sign and return to the center.
2. Medication Consent Form. Our suggestion is to keep this in the glove box of your car so that any time you are taking your child to the doctor you will have it on hand. **No medication will be administered without this form completed by both a parent and health care provider.**
3. Non-Medication Consent Form. This form may be used when a parent consents to having over the counter products administered. These products can include diaper creams, lotions and creams, sunscreen and insect repellant.
4. Care Plan for Children with Special Health Needs. This form needs to be completed by the health care provider in the event a child has any special health needs including asthma or allergies. This form should be updated in the event of a change of how the health need will be treated or every August, whichever comes first. Please see your Director if your child requires this form.
5. Food Allergy and Anaphylaxis Emergency Care Plan & Asthma Action Plan. These should be completed if applicable to your child. The forms must be completed by both the health care provider and a parent/guardian. These should be updated when there is a change in treatment or every August. Please see your Director if your child requires this form.

What to do now:

- Carefully read through the Medication Administration Policy.
- Discuss any questions with the center Director.
- Sign and return the Medication Administration Policy.
- If your child suffers from any food allergies or asthma, have your health care provider complete the appropriate action plans and promptly return them to the center.
- If your child is currently in need of prescription diaper rash cream or other topical lotions, have your health care provider complete the Medication Consent Form and promptly return to the center.
- If your child is currently in need of over the counter diaper rash cream or other topical lotions, complete the Non-Medication Consent Form and promptly return to the center.

What to prepare for:

- Keep copies of Medication Consent Form in your car. It will be on hand for when you visit your child's health care provider. This form must be completed by a health care provider before any medication is administered at the Center.
- We are required to maintain yearly updates to these records. These forms will be updated every August.

All forms must be returned to the office upon registration. As always, please feel free to stop in the office if you have any questions.

MEDICATION ADMINISTRATION POLICY

PURPOSE: This policy was written to encourage communication between the parent, the child's health care provider and the child care provider to assure maximum safety in the giving of medication to the child who requires medication to be provided during the time in child care.

INTENT: Assuring the health and safety of all children in our Center is a team effort by the child care provider, family, and health care provider. This is particularly true when medication is necessary to the child's participation in child care.

GUIDING PRINCIPLES AND PROCEDURES:

1. Whenever possible, it is best that medication be given at home. Dosing of medication can frequently be done so that the child receives medication prior to going to child care, and again when returning home and/or at bedtime. The parent/guardian is encouraged to discuss this possibility with the child's health care provider.
2. The first dose of any medication should always be given at home and with sufficient time before the child returns to child care to observe the child's response to the medication given. When a child is ill due to a communicable disease that requires medicine as a treatment, the child must have been on the prescribed medication for 24 hours before returning to child care. This is for the protection of the child who is ill as well as the other children in child care.
3. Medication will only be given when ordered by a child's health care provider and with written consent of the child's parent/legal guardian. A Medication Consent Form is attached to this policy. All information on the Medication Consent Form must be completed before the medication can be given. Copies of this form can be duplicated or requested from the child care provider.
4. "As needed" medications may only be given when the child's health care provider completes a Medication Consent form that lists specific reasons and times when such medication can be given.
5. Medications given in the Center will be administered by a staff member designated by the Center Director and will have been informed of the child's health needs related to the medication and will have had training in the safe administration of medication.
6. Any prescription or over-the-counter medication brought to the child care center must be specific to the child who is to receive the medication, in its original container, have a child-resistant safety cap, and be labeled with the appropriate information as follows:
    a. Prescription medication must have the original pharmacist label that includes the pharmacists phone number, the child's full name, name of the health care provider prescribing the medication, name and expiration date of the medication, the date it was prescribed or updated, and dosage, route, frequency, and any specific instructions for its administration and/or storage. **It is suggested that the parent/guardian ask the pharmacist to provide the medication in two containers, one for home and one for use in child care.**
    b. Over the COUNTER (OTC) medication must have the child's full name on the container, and the manufacturer's original label with dosage, route, frequency, and any special instructions for administration and storage, and expiration date must be clearly visible. **The prescription for all over the counter medications must expire within 30 days.**
    c. ANY OTC medication must have a completed Medication Consent Form from the health care provider.
        i. Examples of over-the-counter medications that may be given include:
            1. Topical or oral antihistamines
            2. Decongestants
            3. Non-aspirin fever reducers/pain relievers
            4. Cough Suppressants
            5. Teething medication such as Orajel
            6. Topical itch or rash relief cream such as hydrocortisone
            7. Gas relief drops or gripe water
        ii. Exceptions of OTC items that do not require a Medication Consent Form include non-prescription diaper cream, sunscreen and insect repellant. These items require a Non-Medication Consent form completed by the child's parents.
    d. All medications will be stored:
        i. Inaccessible to children
        ii. Separate from staff medications

iii. Under proper temperature control
iv. A box will be used in the kitchen to hold medications requiring refrigeration
v. All medications not requiring refrigeration will be stored in the office
vi. Life-saving medication will be stored in the child's classroom

e. Single dose medication or sample doses from the physician's office will not be administered.

f. For safety reasons, medications or procedures that are considered invasive will not be administered or carried out.
   i. Examples of invasive medications and procedures include:
      1. Eye drops
      2. Ear drops
      3. Nose drops
      4. Taking temperature orally or rectally

g. For safety reasons, procedures that are considered unsafe will not be carried out.
   i. Examples of unsafe procedures include:
      1. Splinter removal
      2. Bee sting removal
      3. Tick removal
      4. Nail cutting

7. For the child who receives a particular mediation on a long-term daily basis, the staff will advise the parent/guardian one week prior to the medication needing to be refilled so that needed doses of medication will not be missed.
8. Unused or expired medication will be returned to the parent/guardian when it is no longer needed or able to be used by the child.
9. Records of all medication given to a child are completed in ink and are signed by the staff designated to give the medication. These records are maintained in the Center.
10. Information exchange between the parent/guardian and child care provider about medication that a child is receiving should be shared when the child is brought to and picked-up from the Center. Parents/guardians should share with staff any problems, observations, or suggestions that they may have in giving medication to their child at home, and likewise with staff from the center to the parent/ guardian.
11. Confidentiality related to medications and their administration will be safeguarded by the Center Director and staff. Parents/Guardians may request to see/review their child's medication records maintained at the Center at any time.
12. Parent/guardian will sign all necessary medication related forms that require their signature.
13. Parent/guardian will update emergency contact information as necessary to safeguard the health and safety of their child.
14. Parent/guardian will authorize the director to contact the pharmacist or health care provider for more information about the medication the child is receiving, and will also authorize the health care provider to speak with the Center Director in the event that a situation arises that requires immediate attention to the child's health and safety particularly if the parent/guardian cannot be reached.
15. Parent/guardian will read and have the opportunity to discuss the content of this policy with the Director. The parent signature on this policy is an indication that the parent accepts the guidelines and procedures listed in this policy, and will follow them to safeguard the health and safety of their child. Parent/guardian will receive a copy of the signed policy including single copies of the records referenced in this policy upon request.

Parent/legal guardian signature (s):

_____ Date_____

_____ Date_____

References: Information for the Medication Administration in Child Care policy was derived from the current **Manual of requirements from the Office of Children and Family Services** in New York and **Caring for Our Children**-The National Health and Safety Performance Standards for Out-of-Home Child Care Programs, second edition.

Lightbridge Academy℠

OCFS-LDSS-7002 (5/2015) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth:	3. Child's Known Allergies:
4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: _____

8A. Possible side effects: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe):* _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized:	15. Date to be Discontinued or Length of Time in Days to be Given:
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

Lightbridge Academy℠

OCFS-LDSS-7002 (5/2015) REVERSE

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized:

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent:

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on _____
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X

Lightbridge Academy℠

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: _____

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent _____

Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

AND/OR

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law): _____

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number:	17. Program telephone number:

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:

21. Staff's signature:

X

Child Image Usage Consent Form

This parental consent form serves to both inform you and to request permission for your child's photo/image and personally identifiable information to be published online, including our public website, social media sites, other Internet sites and to be used for Lightbridge Academy publicity purposes.

If you, as the parent or guardian, wish to rescind this agreement, you may do so at any time in writing by sending a letter to the director of your child's center and such rescission will take effect upon receipt.

Check one of the following choices: _____I/We GRANT or _____DO NOT GRANT permission for my child's photo/image to be used.

Child's Name:_____

Classroom: _____

Parent Name (Print): _____

Parent Signature: _____ Date: _____

CHILD'S FILE CHECKLIST

(FOR OFFICE USE ONLY)

Child's Name_____

Birth date_____ Enrollment Date_____

- ☐ Signed Registration Form (which includes the following)
  - Name, Birth Date, Address, Enrollment Date
  - Parent Employer Info
  - Permission for Medical Emergencies
  - Signature Confirming Expulsion Policy
  - Email Address
- ☐ Child in Care Medical Statement w/ Doctor's Name & Phone
  - Immunization Record
- ☐ Prescription if applicable:_____
- ☐ Custody Documents if applicable
- ☐ Daycare Registration form with Emergency Contact Information
- ☐ EFT Authorization Form
- ☐ Financial Agreement
- ☐ Identification Form
  - Id from parent 1:_____
  - Id from parent 2:_____
- ☐ Medication Administration Policy
- ☐ Child Image Usage Consent Form
- ☐ If needed:
  - Special Care Plan for Children w/ Special Health Needs
  - Food Allergy & Anaphylaxis Care Plan
  - Asthma Action Plan

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- ☐ Entered into QuickBooks
- ☐ Entered into Procare
- ☐ Logged immunizations into Procare
- ☐ Entered into Tadpoles
- ☐ Entered EFT paperwork into Bank
- ☐ Emailed Parent Handbook link
- ☐ Added to the appropriate place on the Class List
- ☐ Added to Lunch plan (Regular or Vegetarian)
- ☐ Added to Pizza list
- ☐ Given extracurricular sign up forms
- ☐ Check if in FranConnect database, if so mark enrolled
- ☐ Add Child Registration Card with emergency contact information to Office Emergency Binder
- ☐ Give copy of the Registration Card with emergency contact information to the child's classroom teachers
- ☐ If any allergies or food restrictions, add to list, print updated Allergy list
- ☐ If signing up for extracurricular classes, or optional services, add to list and print updated lists
- ☐ If custody issues scan and add custody documents to child's Procare account
- ☐ If permission to use photo is not approved, add to Do Not Photograph Quick List in Tadpoles

Permission to use photo for school publicity
_____No
_____Yes Date_____

Permission to send child's photo via the tadpoles system.
_____No
_____Yes Date_____

File Completed Date: _____ Initials: _____