Field of Dreams Preschool
181 Guinea Hill Road
Slate Hill, NY 10973
(845) 355 - 3232

ENROLLMENT AND REGISTRATION FORM

I am enrolling my child in the (please choose age, days and session):

Choose ⬇	Choose ⬇	Choose ⬇	
□ 2 Year Old Program	2 Days	□ Tue/Thu	□ 9:00AM - 11:00AM
□ 3 Year Old Program	2 Days	□ Mon/Wed	□ AM □ PM □ Both
	2 Days	□ Tue/Thu	□ AM □ PM □ Both
	3 Days	□ Mon/Wed/Fri	□ AM □ PM □ Both
	3 Days	□ Tue/Thu/Fri	□ AM □ PM □ Both
	5 Days	□ Mon - Fri	□ AM □ PM □ Both
□ 4 Year Old Program	3 Days	□ Mon/Wed/Fri	□ AM □ PM □ Both
	5 Days	□ Mon - Fri	□ AM □ PM □ Both

* 4 Year Old Program enrollment please read & sign Univ. Pre-K Form attached.

The undersigned parent / guardian has enrolled their child, _____
in the Field of Dreams Preschool Program.

The total tuition for the year will be: $_____
We agree to pay the first of each month the amount of: $_____

Our school year is from September through June and we follow the Minisink Valley School Schedule.

Child's Name: _____
Date of Birth: _____
Address: _____
_____
Siblings: _____
Home Telephone: ( ) _____-_____ Work Telephone: ( ) _____-_____
Mother's Mobile: ( ) _____-_____ Father's Mobile: ( ) _____-_____

Teacher requests will be taken into consideration, however, will not be guaranteed. We at Field of Dreams place the children at our discretion. We take many factors into consideration to make our classrooms evenly balanced.

_____ _____
Parent/Guardian Signature Date

IMPORTANT NOTICE REGARDING REGISTRATION:

In the event you choose to drop out of the Field of Dreams Program, you must notify us prior to May 1st in order to receive a refund of your deposit less the registration fee of $25.00. If you notify us after May 1st, you will be forfeiting your deposit and registration fee. In the event you receive Universal Pre-K, your refund check will be issued on November 1st.

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Field of Dreams follows the following policy for Universal Pre-Kindergarten
(Pending District Approval of Government Grant)

In the event your child is chosen for the NY State Lottery to receive Universal Pre Kindergarten, please note the following:

1. If you are signed up for 3 full days, you will receive:

   5 half (1/2) days paid for by the Universal Pre-Kindergarten.
   Parental requests for an AM or PM time slot will be overwritten and the children will be placed solely at the discretion of Field of Dreams.

   You will, however, be responsible to pay for the 3 Afternoon sessions of the Monday / Wednesday / Friday class that you contracted for.

2. If you are signed up for 5 full days, you will receive:
   5 half (1/2) days are paid for by the Universal Pre-Kindergarten.

   You will, however, be responsible to pay tuition at the price of the 5 half day sessions.

IMPORTANT NOTICE:

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EMERGENCY MEDICAL CONSENT FORM

I give my permission to Deirdre Post to seek emergency treatment for my child: _____ in the event that I cannot be immediately contacted.

Signature of Mother: _____ Date: _____
Signature of Father: _____ Date: _____

Emergency Contact Number: _____

Alternative contact person (relative or neighbor) who may be called when the parents or guardians cannot be reached in case of emergency:

Name: _____
Phone Number: _____
Relation to Child: _____

Field of Dreams Preschool has the following doctor on call:

James N. Wapshare, MDPC
30 Hatfield Lane
Goshen, NY 10924
(845) 291-7059

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PERSONAL HISTORY

Child's Name: _____

Language spoken at home: _____

With what does your child usually play? _____

Are his/her playmates, if any, older/younger? □ Older □ Younger

Does he/she get along with these playmates? □ Yes □ No

What time does he/she usually go to bed? _____

What time does he/she usually get up? _____

Does he/she sleep well? □ Yes □ No

Does he/she stay dry all night? □ Yes □ No

Does he/she take a daytime nap? □ Yes □ No

Does he/she tell an adult when he/she needs to use the toilet? □ Yes □ No

Do you need to remind him/her? □ Yes □ No

Does your child dress him/herself? □ Yes □ No

Can he/she put on his/her coat or sweater? □ Yes □ No

Can he/she button, zipper, put on his/her shoes? □ Yes □ No

Does your child suck his/her thumb or fingers, bite his/her nails, have temper outbursts or any other such habits? □ Yes □ No

Does your child have any special fears? □ Yes □ No

If so, please describe: _____

How does your child behave when angry, upset or afraid? _____

Who is responsible for the discipline of your child? _____

How is your child disciplined and how does he/she react to discipline?

_____

Is there anything we should know to better understand your child?

_____

What do you hope your child will get out of his/her preschool experience?

_____

Are you planning to car pool? □ Yes □ No

If so, with whom: _____

Please give the names of two persons we may contact if you are not home:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

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MEDICAL HISTORY

Child's Name: _____

Date of Birth: _____ Sex □ Male □ Female

Address: _____

_____

Home Phone: _____

Mother

Name: _____ Occupation:_____

Business Address: _____

Business Phone: _____

Father

Name: _____ Occupation:_____

Business Address: _____

Business Phone: _____

Siblings or other children living in household (oldest to youngest please):

Name: _____ Sex □ Male □ Female Age:_____

Name: _____ Sex □ Male □ Female Age:_____

Name: _____ Sex □ Male □ Female Age:_____

Name: _____ Sex □ Male □ Female Age:_____

Is there any family history pertinent to child's experiences such as:

□ divorce □ recent births

□ adoption □ other _____

Does your child have ANY allergies? □ Yes □ No

If so, please list them here: _____

Restrictions, ailments, disabilities or other concerns we should know about:

□ Vision _____

□ Hearing _____

□ Speech _____

□ Diet _____

□ Motor Skills _____

□ Other _____

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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

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

Medical Statement of Child in Childcare

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.

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.

ADDITIONAL INFORMATION ON REVERSE SIDE ➔

Medical Statement of Child in Childcare

(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 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 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.