

**FOR OFFICE USE ONLY**

Program:  T - TH  
 M - W - F  
 Preschool Plus

Acceptance Date: \_\_\_\_\_  
Discharge Date: \_\_\_\_\_  
Immunization Records Submitted:



We build strong kids, strong families, strong communities.

**YMCA Buffalo Niagara**

Ken Ton Family YMCA ♦ 535 Belmont Avenue ♦ Buffalo, NY 14223 ♦ 874-5051

**2010-11 Preschool Education Program Information Form**

**Child Information**

Child's Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Year Going into Kindergarten: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_  
Home Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Swimming Ability:  Terrified of Water  Never Swam  Beginner  Intermediate  Advanced  
Siblings:  Yes  No If yes, please list names \_\_\_\_\_

**Application Information**

Name of person applying for child: \_\_\_\_\_  
Relationship of person applying for child:  Parent  Guardian  Caretaker/Relative  Other: \_\_\_\_\_  
Address of person applying for child: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**In case of an emergency, notify** (List contact information for hours during Day Care - for example work address and phone if at work)

Mother: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Father: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Other Responsible Person: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician or Medical Svc: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Names of individuals authorized to pick up child who are NOT listed above:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_  
Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**Health Information**

The following information must be filled in by the parent/guardian. The intent of this information is to provide staff the background to provide appropriate care. Provide complete information so that we can be aware of your child's needs.

**Allergies**

Describe reaction and management of the reaction

Medications (e.g., penicillin) : \_\_\_\_\_  
 Food (e.g., eggs, dairy) : \_\_\_\_\_  
 Other (e.g., insect stings, hay fever): \_\_\_\_\_

**Medications**

Medications require a separate form. Please contact the Child Care Staff for more information.

**Insurance**

Is participant covered by family medical/hospital insurance?  Yes  No Carrier/plan name: \_\_\_\_\_  
Policy holder SS# or insurance ID #: \_\_\_\_\_ Group # \_\_\_\_\_ Carrier Address: \_\_\_\_\_  
Name of insured \_\_\_\_\_ Relationship to participant \_\_\_\_\_

**Health History-Has participant had**

- |  |                              |                             |  |                              |                             |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Measles   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 12. Skin Problems (e.g., itching rash, acne)     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Chicken Pox   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 13. Recent injury, illness or infectious disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. German Measles  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 14. Chronic or recurring illness/condition       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Mumps   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 15. Heart defect/disease/murmur                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Hepatitis A/B/C   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 16. Eating disorder                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Mononucleosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 17. Orthodontic appliance (e.g., retainer)       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Frequent ear infections   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 18. Wear glasses, contacts or protective eyewear | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Emotional difficulties  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 19. Hypertension (high blood pressure)           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Frequent headaches  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 20. Head Injury                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Knocked unconscious  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | 21. Dizzy/passed out after physical activity     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Any specific activities that child cannot participate in or needs one-on-one assistance. |                              |                             |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Is your child currently being treated or followed by a medical professional for any of the following:

- |                   |                              |                             |                       |                              |                             |
|-------------------|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|
| Asthma            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diarrhea/constipation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sickle Cell Trait | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sickle Cell Disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Seizures/Convulsions  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please explain any "YES" answers

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Any additional information about the participant's behavior and physical, emotional or mental health the staff should be aware of:

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**Special Information** – AFO's, walkers, wheelchairs, assistance with toileting, behavior issues, Diets, habits, etc

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**Publicity Photographs**

May we use your child in publicity photographs?  Yes  No

**Agreement**

- Enrollment:** I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding fees, transportation and the services provided by the facility and the New York State Department of Social Services regulations under which it operates.
- Field Trips and Transportation:** I give consent for this child to take part in field trips or excursions away from the facility under proper supervision, including transportation provided by or arranged for by the school-age child care program.
- Swimming:** My child is permitted to participate in swimming activities.
- Emergency Medical Care:** I agree that in the case of accident or injury, emergency medical care may be given in the event I or the person(s) designated cannot be reached.
- Correct Information given:** I have provided special information on this registration to assist the facility in caring for this child (diet, habits, allergies, medical issues, etc)
- Parent Handbook:** I accept the policies and procedures contained in the Preschool Education Parent handbook. I have read and fully understand all policies and procedures contained within and agree to abide by them. I further understand that failure to abide by the policies and procedures contained in this handbook could result in dismissal from the program.

Signature-Parent or person(s) legally responsible: \_\_\_\_\_ Date: \_\_\_\_\_