Kids Connection Parent Checklist:

As a parent of a Kids Connection child, you should receive:

____ KC Handbook
____ KC Calendar

The following must be completed and turned into the JCC PRIOR to your child's start date.

____ Kids Connection Contract

____ OCFS (Blue) Registration Card

____ Emergency Child Information Sheet

____ Transportation Permission Form

____ Authorization for Pick-up Form

____ Vestal Hill's Pickup Permission Slip (if applicable)

____ Medical Form
(not a copy of any existing form, filled out by your medical care provider)

____ CACFP Form

____ KC Swimming Consent Form

____ DSS Supported Family Addendum (if applicable)

Please call the JCC at 724-2417 ext. 421 with any questions
Katie Long – JCC Youth Director

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:

Date:_____/_____/_____

KIDS CONNECTION EMERGENCY CHILD INFORMATION

Child's Name_____ Age_____

Permanent Address_____ Home Phone # _____

Date of Birth_____ Grade as of September 2023_____

Mother/Guardian #1:_____ Primary Number_____

Where Employed_____

Father/Guardian #2:_____ Primary Number_____

Where Employed_____

Other Members in Household (include age/relationship) _____
_____

MEDICAL INFORMATION

Emergency Hospital Preference _____
Child's Physician _____
Child's Dentist _____ Other Medical Specialist _____

If we are not able to contact the child's mother of father, we will contact the persons listed on your child release form

Does your child have any allergies? If so please list (examples: bee stings, colors, foods, etc)?
_____
Does your child take any medication regularly? If so, please indicate dosage, time and purpose?
_____
Other information about the child that we should be aware of?
_____

HEALTH HISTORY OF THE CHILD

Does the child have: frequent colds ☐ vomit easily ☐ ear aches ☐ run high fevers ☐

Does the child wear: glasses/contact lenses ☐ hearing aids ☐ corrective shoes ☐ prosthesis ☐

STATUS OF PARENTS/GUARDIANS

Married ☐ Separated ☐ Divorced ☐ Step-Father/Mother ☐ Foster Parents ☐

Child lives primarily with: _____

Remarks:_____

It is legal for either parent to pick up a child unless we have a copy of a court order restrictions, custody and visitation arrangements.

KIDS CONNECTION TRANSPORTATION PERMISSION

I, _____ (parent/guardian) agree to allow my son/daughter _____, to participate in Kids Connection Trips through the JCC. This includes walking around the facility and crossing Clubhouse Rd.

I authorize the JCC staff to obtain the best available public medical care for my child in the event of an emergency at which time I cannot be reached; realizing that all reasonable means will be made to contact me prior to the rendering of any medical treatment, and that such medical treatment shall be on an emergency basis as decided by a qualified physician and I assume responsibility for such treatment.

_____ _____ _____

Parent/Guardian Signature Emergency phone #1 Emergency phone #2

Insurance Policy Name _____

Policy Number_____

Allergies_____

PERMISSION TO PHOTOGRAPH

I, _____(parent/guardian) agree to allow my son/daughter _____ to be photographed and for the photograph to be displayed, used in our brochure, put on our JCC Facebook page or placed in the local newspaper.

_____

Parent/Guardian

I DO NOT want to my child to be photographed. _____

Parent/Guardian

Date: _____/_____/_____

Authorization for Pick-Up

The Kids Connection program will dismiss your child ONLY to persons you authorize. List the name and phone number(s) of anyone who has your permission to pick up your child. Please advise each of them that they will be required to show identification each time they pick up, as the staff on duty changes from day to day.

Be sure to list anyone that you feel could be of assistance in the case where we are unable to reach both parents. **It is a <u>state requirement</u> that at least one other person, in addition to the parents, is added to this list in case of emergencies.**

Additions or amendments to this list are made exclusively by the parent/guardian **<u>IN PERSON</u>**, with the Kids Connection staff. Phone calls or emails will not be accepted as the parent's permission. This is done to ensure the safety of your child and other children in the program.

Child's/Children's Name(s): _____

Pick-up Person's Name	Relationship to Child	Phone Number
1. Parent/Guardian 1		Cell: Work:
2. Parent/Guardian 2		Cell: Work:
3.		Cell: Work:
4.		Cell: Work:
5.		Cell: Work:
6.		Cell: Work:
7.		Cell: Work:
8.		Cell: Work:
9.		Cell: Work:
10.		Cell: Work:

Date:_____/_____/_____

Dear Vestal Hills Kids Connection Families,

Vestal provides all children attending Vestal Hills free bus transportation to the JCC. Please complete the bottom portion of this letter and return to the JCC with your paperwork to ensure your child's transportation from Vestal Hills to the JCC Kids Connection Program.

If you have any questions, please contact Katie Long, JCC Youth Director at 724-2417 ext. 421 or KatieL@binghamtonjcc.org

Katie Long
JCC Youth Director

Vestal Hills Transportation Permission Slip

I, _____give my consent for my child

_____to ride the Vestal School bus from Vestal Hills Elementary to the JCC in order to attend Kids Connection.

_____ _____
Parent/Guardian Signature Date

BOTH SIDES OF FORM MUST BE COMPLETED AND RETURNED

OCFS-LDSS-4433 (Rev. 4/2008) FRONT

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

JCC Fax: (607) 724-2418

BOTH SIDES OF FORM MUST BE COMPLETED AND RETURNED

OCFS-LDSS-4433 (Rev. 4/2008) REVERSE

Medical Statement of Child in Childcare

(continued)

JCC Fax: (607) 724-2418

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.

ADDITIONAL INFORMATION ON REVERSE SIDE ☞

CACFP Information Form

Child's Name _____

Day's Attending (please circle) M☐ T☐ W☐ Th☐ F☐

Approximate daily schedule Arrival _____ Departure _____

Meals Received (please circle) am snack☐ lunch☐ pm snack☐

Parent Signature _____

Date _____

Dear Kids Connection Parents/Guardians,

Although our snack and hot lunch program is very successful, it costs more to run then we charge. The JCC qualifies for a subsidy through the NYS Department of Health called CACFP - Child and Adult Care Food Program. We are currently receiving this monthly subsidy and will continue to do so, contingent upon periodic review of our records.

It is imperative that this form is completed and returned by **ALL** of our KC families. For our program to continue with the additional funding it requires we greatly need your cooperation. By filling out the application the JCC will get the subsidy it needs whether you are within or beyond our financial guidelines.

Please fill out the attached "Income Eligibility Guidelines" form and return it to the JCC Office with your other camp paperwork. We need to have this form returned to us no matter what your income is. Your confidentiality will, of course, be respected. Thank you

Sincerely,

Katie Long

Youth Director

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household
1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____
7. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER [ ][ ][ ][ ]

DATE _____

USDA is an equal opportunity provider and employer.

KC Swimming Consent Form

One of the great assets the Jewish Community Center has to offer our families and students is our pool. Kids Connection swims Tuesdays & Thursdays (subject to change) from 4pm-5pm and during all days off from school including half days, long days and snow days. Flotation belts are available to be used by the children if needed. Kids Connection staff is always stationed around the pool as extra eyes in addition to the lifeguard on duty in the high lifeguard chair.

As **of June 1, 2015** the New York State Office of Family and Children requires a permission slip signed by the parents for each child. Please sign this form as permission for your child to swim with Kids Connection.

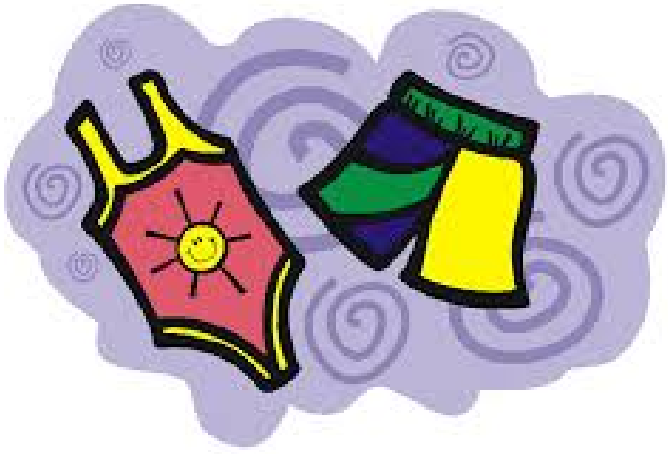
Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____



ONLY For Families Supported by DSS

Parent/Guardian must initial each statement:

_____ I understand that the JCC does not accept DSS as payment in full for Kids Connection Contracts.

_____ I understand that if my child attends Kids Connection on days or times that I am not working or hours beyond what DSS allows, I am responsible for the balance of Kids Connection tuition.

_____ I understand that if my child's attendance exceeds the hours that DSS has designated, I am responsible for any fees/balances.

_____I understand that I am solely responsible for the annual registration fees

_____ I understand that my DSS stated co-pay may not satisfy the weekly KC tuition fee and I am responsible for the balance.

_____ I understand that DSS will not pay for times that I am not working

_____ I understand that I am expected to adhere to the KC payment policies and that I will be subject to late fees for failure to pay timely.

Please refer to Kids Connection Contract for tuition costs and your DSS contract for the portion of support provided by DSS.

_____ _____/_____/_____

Parent/Guardian Signature Date

_____

Parent/Guardian Name

_____

Contracted Child Name(s)