Precious Moments Day Care Center, Inc.

11-02 Clintonville Street • Whitestone, NY 11378
(718) 767-6655 • PreciousMoments2@verizon.net

61-30 Grand Avenue • Maspeth, NY 11357
(718) 416-1624 • PreciousMomentsMaspeth@gmail.com

www.PreciousMomentsNY.com

Dear Parent or Guardian:

Our 3-K and Pre-K for All programs are city funded programs for three-year-old children who will be entering Pre-K the following year and four-year-old children who will be entering kindergarten the following school year.

Please print, complete, and sign the forms included, then submit a FULL package the facility you are applying to (Whitestone or Maspeth). If you have any questions or concerns, please feel free to give us a call at the appropriate number above.

3-K and Pre-K for All Applicant Requirements

- ❑ Federal Parent/Guardian Student Ethnic and Race Identification Form (included in this packet)
- ❑ Housing Questionnaire (included in this packet)
- ❑ Language Needs Survey (included in this packet)
- ❑ Child and Adolescent Health Exam Form (included in this packet)
- ❑ Consent to Photograph (included in this packet)
- ❑ General Permission Slip (included in this packet)
- ❑ Emergency Contact Form (included in this packet)
- ❑ Hospital Release Form – must be notarized (included in this packet)
- ❑ Parent Affidavit of Residency (included in this packet; 2nd page must be notarized by both parties); *this form is applicable only if a parent or guardian is subletting an apartment or home.*

  If more than one family share a living space and there is only one leaseholder or homeowner, the parent or guardian must present a notarized "Parent Affidavit of Residency" signed both by the primary leaseholder as well as the parent or guardian affirming that the family is residing in this home and must attach two proofs of address of the primary leaseholder.
- ❑ Copy of Immunizations
- ❑ Proof of Birth (birth certificate, passport, or baptismal certificate; non-English birth certificates must be translated into English)

Precious Moments Day Care Center, Inc.
3-K and Pre-K for All Applicant Requirements Continued

- [ ] Two (2) Proofs of Address

The following documents may be used as acceptable proofs of residency:

- Water bills or utility bills (gas or electric) issued by National Grid, Con Edison, or LIPA – issued within 60 days of when the document is submitted by the parent or guardian.

- Documentation or a letter on letterhead from a federal, state, or local government agency, including the IRS, City Housing Authority, HRA, or ACS indicating the resident's name and address – issued within 60 days of when the document is submitted by the parent.

  Examples of acceptable letters include, but are not limited to, placement notices from ACS, Medicaid Eligibility letters, and voucher subsidy letters from the Housing Authority. This does not include private insurance forms on behalf of a government agency.

- A lease agreement (must have the tenant and landlord's signature), deed or mortgage statement, or current tax bill for the residence.

- Official payroll documentation from an employer, issued within 60 days of when the document is submitted by the parent or guardian, such as a form submitted for tax withholding purposes or payroll receipt. A letter on the employer's letterhead or tax return forms such as the 1040 form are not acceptable.

Please note that the following documents ARE NOT acceptable proofs of residency:

X Telephone bills

X Cable bills

X Cell phone bills

X Medical insurance cards

X Credit card statements

X Department store bills

X Driver's licenses

X Auto or home insurance bills

New York City Early Childhood Education (3-K and Pre-K) Program Registration Form for the 2022-2023 School Year

School Day and School Year Services

Directions

Please print clearly in blue or black ink, **or** complete this form electronically. In order to be eligible to register for Pre-K or 3-K for All students and caregivers must reside within the five boroughs of New York City. Please be prepared to provide proof of residence along with this registration packet.

Section 1. STUDENT INFORMATION			
Last Name	First Name		Date of Birth
Current Address (Building #, Street)			Apt #
City	State	Zip Code	Gender (optional)

Section 2. HEALTH INSURANCE (optional)

Does this student have health insurance? ☐ Yes ☐ No

If yes, what type of coverage? ☐ Private Health Insurance ☐ Medicaid ☐ Child Health Plus B

If no, would you like to be contacted about getting coverage ☐ Yes ☐ No

Section 3. FAMILY/CAREGIVER INFORMATION	
Parent/Guardian Last Name	Parent/Guardian First Name
Relationship to Student	
Primary (Cell) Phone Number	
Secondary Phone Number	
Email Address	

NYC Department of Education

SECONDARY/EMERGENCY CONTACT (Other than the primary contact above)	
Emergency Contact Last Name	Emergency Contact First Name
Relationship to Student	
Primary (Cell) Phone Number	
Secondary Phone Number	
Email Address	

FAMILY/CAREGIVER ACKNOWLEDGEMENT	
By signing this form I certify that I understand that my child's daily attendance and punctuality are required. I must arrange for a responsible adult to bring my child to school and pick them up daily. I understand that no transportation is provided.	
Signature	Date

Section 4. HOUSING QUESTIONNAIRE (Chancellor's Regulation A-101)

Information collected in this portion of the registration packet is intended to address the McKinney-Vento Act 42 U.S.C. 11432, and must be completed for each student. **The information you provide is confidential.** Your child will not be discriminated against based on the information provided.

Please complete the question below regarding the student's housing in order to help determine what services your student may be eligible to receive.

Note to NYCEECs/Temporary Housing Liaisons: Please assist students and families in completing this portion of the form. Please be aware that if the student qualifies as residing in temporary housing the **student's family is not required to submit proof of housing or other required documents included in this packet.** The program/DOE may not disclose housing status information without parental consent.

Please identify the student's current living arrangements. Please check **one** box:

Check	Housing Questionnaire Choice
☐	**Doubled Up** With another family or other person because of loss of housing or because of economic hardship
☐	**Shelter** Emergency or Transitional shelter
☐	**Hotel/Motel** Living in what is NOT an emergency or transitional shelter and involves payment

☐	**Other Temporary Living Situation** Trailer park, campground, car, park, public place, abandoned building, street or any other inadequate living space
☐	**Permanent Housing** A fixed, regular, and adequate housing situation

Note: The answer you give above will help determine what services you or your child may be eligible to receive under the McKinney-Vento Act. Students who are protected under the Act are entitled to immediate enrollment in school even if they do not have the documents normally needed, such as proof of residency, school records, immunization records, or birth certificate. After the student has been enrolled, the new school must contact the last school attended to request the student's educational records, including immunization records, and Students in Temporary Housing (STH). Liaison(s) must help the student get any other necessary documents or immunizations. Students who are protected under the McKinney-Vento Act may also be entitled to free transportation and other services. Please refer to Chancellor's Regulation A-780.
This form is accompanied by a one-page attachment titled,
"McKinney-Vento Homeless Assistance Act - Students in Temporary Housing Guide for Parents & Youth."

Parent/Guardian Signature	
Signature	Date

Section 5. FEDERAL PARENT OR GUARDIAN STUDENT ETHNIC & RACE IDENTIFICATION

Dear Families and Caregivers,

Federal law requires the New York City Department of Education to collect and record the ethnic identity and race of public school students, including those participating in City-funded contracted care. This information is kept confidential in accordance with the Family Educational Rights and Privacy Act (1974) and Chancellor's Regulation A-820, which prohibit unauthorized access to student records and unauthorized release of any student record information identifiable by either student name or student identification number.

To fulfill this data-collection requirement we need your help. Please respond to the ethnicity and race questions below. The first question provides an opportunity for you to indicate whether your child is of Hispanic, Latino, or Spanish origin; the second question provides an opportunity for you to indicate your child's race(s). Please be sure to respond to both questions. If you identify more than one race for your child, your child will be counted in a "two or more races" category. Hispanic students of all races will be counted in the Hispanic category.

The NYCDOE and our contracted programs understand the sensitive nature of this process. The options provided by the federal government may not allow for an accurate or complete portrayal of your child's own ethnic or race identification. We encourage you to provide responses using your best judgment. If you decline to respond to either question, federal guidelines require that the NYCDOE or its contracted program's staff make an identification of your child on your behalf.

Children may not be refused admission or enrollment to a program because of race, color, creed, national origin, gender (sex), gender identity, pregnancy, alienage, citizenship status, disability, sexual orientation, religion, weight or ethnicity.

Thank you for your cooperation.

Question 1: Is the student Hispanic, Latino or of Spanish origin? The Federal Government defines "Hispanic, Latino, or of Spanish origin" as a person of Cuban, Dominican, Mexican, Puerto Rican, Central or South American, or other Spanish culture or origin regardless of race.	
☐	**Yes**, Hispanic
☐	**No**, not Hispanic
Question 2: Please check all boxes from the provided racial categories that apply to the student. All definitions are derived from the U.S. Census.	
☐	**American Indian or Alaskan Native** – a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
☐	**Asian** – a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Sub-Continent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
☐	**Native Hawaiian or Pacific Islander** – a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
☐	**Black** – a person having origins in any of the Black racial groups of Africa
☐	**White** – a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
Parent/Guardian Signature	
Signature	Date

Section 6. FOR CBO USE ONLY			
Program Name		Site ID	
Student Seat Type (check only one) ☐ 3-K SDY ☐ Pre-K SDY ☐ Pre-K HD	First Day of Attendance Official Class Code		

Supplementary Documents:	Date Received
Proof of Birth: *(type)*	
Proof of Residence 1: *(type)*	
Proof of Residence 2: *(type)*	
Home Language Survey: *(primary language)*	
Parental Consent to Photograph, Film, or Videotape a Student for Non-Profit Use	
Child and Adolescent Health Examination Form	

Section 7. HOME LANGUAGE SURVEY

Dear Families and Caregivers,

This survey is part of your child's enrollment package and provides your new program with important information about your family's language needs. Please return this form to your program administrator.

Student: Last Name	First Name	Today's Date

Person Completing Survey: Last Name	First Name

Relationship to Student

Program Name

LANGUAGE IN THE HOME

Which language(s) do you speak at home? (please select all that apply)

- ☐ English
- ☐ Spanish
- ☐ Cantonese
- ☐ Mandarin
- ☐ Arabic
- ☐ Bengali
- ☐ French
- ☐ Haitian-Creole
- ☐ Korean
- ☐ Russian
- ☐ Urdu
- ☐ Albanian
- ☐ Punjabi
- ☐ Polish
- ☐ Other (please specify):

Which language(s) does your child speak at home? If your child does not speak, which language(s) do they most commonly understand, or which language(s) do you most commonly use to communicate with your child? (Please select all that apply)

- ☐ English
- ☐ Spanish
- ☐ Cantonese
- ☐ Mandarin
- ☐ Arabic
- ☐ Bengali
- ☐ French
- ☐ Haitian-Creole
- ☐ Korean
- ☐ Russian
- ☐ Urdu
- ☐ Albanian
- ☐ Punjabi
- ☐ Polish
- ☐ Other (please specify):

PRIMARY LANGUAGE PREFERENCES
What is your child's primary language?
What is your first language?
In what language would you like to receive written information from your child's program?
In what language would you prefer to communicate orally with program staff?

Section 8. CONSENT TO PHOTOGRAPH, FILM, OR VIDEOTAPE A STUDENT FOR NON-PROFIT USE (e.g. educational, public service, or health awareness purposes)		
Student Last Name	Student First Name	Today's Date
Program Name		

I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies, or video tapes of the Student named above by the program named above.

I also grant to the program named above the right to edit, use, and reuse said products for non-profit purposes including use in print, on the internet, and all other forms of media.

I also hereby release the New York City Department of Education and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Parent/Guardian Last Name	Parent/Guardian First Name
Signature	Date

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS) ☐☐☐☐☐☐☐☐☐

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth *(Month/Day/Year)* ___/___/___

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race *(Check ALL that apply)* ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough | State | Zip Code | School/Center/Camp Name | District Number ___ | Phone Numbers: Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name | Email

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ______ weeks gestation

☐ Complicated by ______

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ______

☐ Foods *(list)* ______

☐ Other *(list)* ______

Attach MAF in in-school medications needed

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma ***(check severity and attach MAF)***: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Quick Relief Medication ☐ Inhaled Corticosteroid ☐ Oral Steroid ☐ Other Controller ☐ None

Asthma Control Status ☐ Well-controlled ☐ Poorly Controlled or Not Controlled

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability

☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ Hospitalization
☐ Surgery
☐ Other (specify) ______

Explain all checked items above. ☐ ***Addendum attached.***

Medications ***(attach MAF if in-school medication needed)*** ☐ None ☐ Yes *(list below)*

PHYSICAL EXAM Date of Exam: ___/___/___

Height ______ cm (____ %ile)

Weight ______ kg (____ %ile)

BMI ______ kg/m² (____ %ile)

Head Circumference *(age ≤2 yrs)* ______ cm (____ %ile)

Blood Pressure *(age ≥3 yrs)* ______ / ______

General Appearance:

☐ Physical Exam WNL

Nl Abnl	Nl Abnl	Nl Abnl	Nl Abnl	Nl Abnl
☐ ☐ Psychosocial Development	☐ ☐ HEENT	☐ ☐ Lymph nodes	☐ ☐ Abdomen	☐ ☐ Skin
☐ ☐ Language	☐ ☐ Dental	☐ ☐ Lungs	☐ ☐ Genitourinary	☐ ☐ Neurological
☐ ☐ Behavioral	☐ ☐ Neck	☐ ☐ Cardiovascular	☐ ☐ Extremities	☐ ☐ Back/spine

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

Validated Screening Tool Used? ☐ Yes ☐ No Date Screened ___/___/___

Screening Results: ☐ WNL

☐ Delay or Concern Suspected/Confirmed (specify area(s) below):

☐ Cognitive/Problem Solving ☐ Adaptive/Self-Help
☐ Communication/Language ☐ Gross Motor/Fine Motor
☐ Social-Emotional or Personal-Social ☐ Other Area of Concern: ______

Describe Suspected Delay or Concern:

Child Receives EI/CPSE/CSE services ☐ Yes ☐ No

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

≥ 1 year ☐ Well-balanced ☐ Needs guidance ☐ Counseled ☐ Referred

Dietary Restrictions ☐ None ☐ Yes *(list below)*

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	___/___/___ ___/___/___	______ µg/dL ______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	___/___/___	☐ At risk *(do BLL)* ☐ Not at risk
— Child Care Only —		
Hemoglobin or Hematocrit	___/___/___	______ g/dL ______ %

Hearing	Date Done	Results
< 4 years: gross hearing	___/___/___	☐ Nl ☐ Abnl ☐ Referred
OAE	___/___/___	☐ Nl ☐ Abnl ☐ Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐ Nl ☐ Abnl ☐ Referred

Vision	Date Done	Results
<3 years: Vision appears:	___/___/___	☐ Nl ☐ Abnl
Acuity (required for new entrants and children age 3-7 years)	___/___/___	Right ___/___ Left ___/___ ☐ Unable to test
Screened with Glasses?		☐ Yes ☐ No
Strabismus?		☐ Yes ☐ No

Dental

Visible Tooth Decay ☐ Yes ☐ No

Urgent need for dental referral *(pain, swelling, infection)* ☐ Yes ☐ No

Dental Visit within the past 12 months ☐ Yes ☐ No

CIR Number ☐☐☐☐☐☐☐☐☐☐

Physician Confirmed History of Varicella Infection ☐

IMMUNIZATIONS – DATES

DTP/DTaP/DT, Td, Polio, Hep B, Hib, PCV, Influenza, HPV: ___/___/___ (6 entries each)

Tdap, MMR, Varicella, Mening ACWY, Hep A, Rotavirus, Mening B, Other: ___/___/___ (3 entries each)

Report only positive immunity:

IgG Titers	Date
Hepatitis B	___/___/___
Measles	___/___/___
Mumps	___/___/___
Rubella	___/___/___
Varicella	___/___/___
Polio 1	___/___/___
Polio 2	___/___/___
Polio 3	___/___/___

ASSESSMENT ☐ **Well Child** (Z00.129) ☐ **Diagnoses/Problems** *(list)* **ICD-10 Code**

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions *(specify)* ______

Follow-up Needed ☐ No ☐ Yes, for ______ Appt. date: ___/___/___

Referral(s): ☐ None ☐ Early Intervention ☐ IEP ☐ Dental ☐ Vision

☐ Other ______

Health Care Practitioner Signature | Date Form Completed ___/___/___

DOHMH ONLY **PRACTITIONER I.D.** ☐☐☐☐☐☐

Health Care Practitioner Name and Degree *(print)* | Practitioner License No. and State

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments:

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

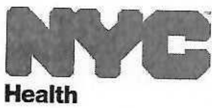
Date Reviewed: ___/___/___ **I.D. NUMBER** ☐☐☐☐☐☐

REVIEWER:

Telephone | Fax | Email

FORM ID# ☐☐☐☐☐☐☐

CH205 Health Exam 2016_r4-16_FINAL.indd



Authorized Escorts List Form

The New York City Health Code requires child care centers to obtain and maintain, for every child, a list of all persons authorized by the parent/ guardian to escort the child from child care. The child care center shall not release any child to any individual who has not been identified by the parent/ guardian as a person who is authorized to escort a child out of the center.

***Instructions**: The parent/ guardian must complete, sign, and return this form to the child care center upon enrollment and update this form immediately when there is any change in authorized escort information.*

I, ________________________________, authorize this child care center to release my child,
(parent/ guardian name)

________________________________, to the individuals I have identified below.
(child name)

Name:		
Relationship to child:		
Home address:		
Preferred contact:	☐ Mobile/Cell Telephone ☐ Home Telephone ☐ Work Telephone ☐ Text (Mobile) ☐ E-mail	
Telephone:	*Mobile/Cell:*	
	Home:	*Work:*
E-mail:		

Name:		
Relationship to child:		
Home address:		
Preferred contact:	☐ Mobile/Cell Telephone ☐ Home Telephone ☐ Work Telephone ☐ Text (Mobile) ☐ E-mail	
Telephone:	*Mobile/Cell:*	
	Home:	*Work:*
E-mail:		

Parent/ Guardian Signature: ________________________________

Date: ________________________________

In accordance with the requirements of the New York City Health Code, Article 47, Section 47.57(h)(1) child care centers must obtain and maintain for every child a list of the name, relationship to child, address and contact information of every person the parent has authorized to escort a child from the child care service. The permittee shall not release any child to any individual who has not been identified by the parent(s)/guardian(s) as a person who is authorized to escort a child out of the service.

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EMERGENCY CONTACT INFORMATION

Child's Last Name	*First Name*	*Middle Initial*
Date of Birth	*ID#*	*Sex*
Parent/Guardian #1 (child resides with)	*Written Language Preference*	*Spoken Language Preference*
Home Phone	*Cell*	*Work*
Personal Email	*Business Email*	
Street Address, Apt.#	*City, State*	*Zip*
Parent/Guardian #1 (Child resides with)	*Written Language Preference*	*Spoken Language Preference*
Home Phone	*Cell*	*Work*
Personal Email	*Business Email*	
Street Address, Apt.#	*City, State*	*Zip*

ALTERNATIVE EMERGENCY CONTACTS

List below names of three (3) persons who may be called in case of emergency or if child is sick in school.
CHILD WILL BE RELEASED ONLY TO PERSONS NAMED ON FORM.

Full Name	*Home + Mobile Phone*	*Relationship*
Full Name	*Home + Mobile Phone*	*Relationship*
Full Name	*Home + Mobile Phone*	*Relationship*

If there is a person who may NOT HAVE ACCESS to your child, please indicate:

Full Name	*Relationship*	*Does an Order of Protection Exist?*

Principal must be notified in writing of any changes to the info on this form.

Parent/Guardian Signature

Grade	*Class*	*Room*	*Teacher*

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HEALTH INFORMATION – Student:

Name of Physician/Clinic *Telephone*

HEALTH ALERTS

Does your child have any condition(s) that may affect their participation in physical activities? ☐ Yes ☐ No

Please list limitations (e.g. stair climbing, participation in gym):

Allergies

504 services for the year? ☐ Yes ☐ No 504 services for last year? ☐ Yes ☐ No

INSURANCE COVERAGE

Private health insurance? ☐ Yes ☐ No Medicaid ☐ Yes ☐ No No health insurance? ☐ Yes ☐ No

If you do not have health insurance, are you willing to share your contact information to learn about insurance options? ☐ Yes ☐ No

If none of the listed emergency contacts can be reach, what do you wish the school to do if you child is sick or injured?

It is understood that in the final disposition of an emergency case, the judgment of the school authorities will prevail. The recommendation of the parent as indicated above will be respected as far as possible

SIBLINGS

Last Name	*First Name*	*Current School*
Last Name	*First Name*	*Current School*
Last Name	*First Name*	*Current School*
Last Name	*First Name*	*Current School*

FOR SCHOOL USE – Relevant records from health record:

Date	*Contact*	*Reason*	*Disposition*
Date	*Contact*	*Reason*	*Disposition*
Date	*Contact*	*Reason*	*Disposition*

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Hospital Release

____
Child's full legal name *Date*

____
Child's preferred name *Birthdate* *Sex*

____
Name of family physician *Telephone*

____
Name of family dentist *Telephone*

____
Allergies of child *Date of last DPT or tetanus shot*

Has child had: Surgery__________ Accidents__________ Serious Illness__________

Burns __________ Other __________

List identifying scars, birthmarks, skin discolorations:

____

____
Health Insurance Company *Policy #*

____
Automobile Insurance Company *Policy #*

I hereby give my consent to any hospital and/or licensed physician to administer necessary treatment to the above named child in the event of an emergency at which time (it is imperative/I cannot be reached). I give my consent for my child to be transported by ambulance if the situation warrants.

____
Parent/Guardian Signature

NOTARIZATION REQUIRED

Witness my hand and official seal, this__________day of______________,________.

My commission expires______________________________.

____
Notary

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General Permission

This is a general permission slip that will be used for the entire school year for which my child is enrolled, beginning on______________________________.

If I choose to decline, I understand that my child will stay in school under the supervision of another adult until his/her class returns from its nature walk or trip.

To the Director and the Staff of Precious Moments Day Care Center, Inc.:

I, ____, hereby

- ❑ Give my permission
- ❑ Do not give my permission

to allow my child, ____, to be taken out of Precious Moments Day Care Center, Inc. to visit a nearby park or on nature walks.

I understand fully that my child will always be under adult supervision.

I also agree that I will not hold Precious Moments Day Care Center, Inc. liable for any injuries sustained outside the school.

____

Parents Signature *Date*

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Consent to Photograph, Film, or Videotape

I hereby consent to the participation in interviews, the use of quotes, and the taking of photographs, movies, or video tapes of my child:

____

I also grant to Precious Moments Day Care, Inc. the right to edit, use, and reuse said products including use in print, on the internet, and all other forms of media. I also hereby release Precious Moments Day Care, Inc. and its agents and employees from all claims, demands, and liabilities whatsoever in connection with the above.

Signature of Parent/Guardian:_______________________________________Date: __________________

Address of Parent/Guardian: ____

★★★★★★★★★★★★
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★★★★★★★★★★★★

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HEALTH HISTORY FORM

Child's Name: ____

Date of Birth: ______________________________ Age at Registration: __________

Does your child have or had any of the following:

Any serious medical illness? ☐ YES ☐ NO

Any birth defects? ☐ YES ☐ NO

Any surgeries? ☐ YES ☐ NO

Has or had a heart murmur? ☐ YES ☐ NO

Has or had febrile seizures? ☐ YES ☐ NO

Has a history of asthma or wheezing? ☐ YES ☐ NO

Had coxsackie? ☐ YES ☐ NO

Had broken bones/ frequent or severe sprains? ☐ YES ☐ NO

Has nursemaid's elbow? ☐ YES ☐ NO

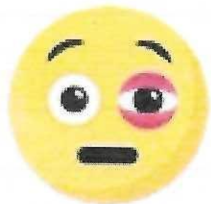
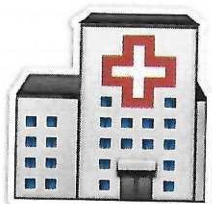
Has any mental or behavioral problems? ☐ YES ☐ NO

Has any bleeding problem? ☐ YES ☐ NO

Has any allergies? ☐ YES ☐ NO

Takes any medication, including vitamins? ☐ YES ☐ NO

I NEED TO STAY HOME IF ...

I HAVE A FEVER	I AM VOMITING	I HAVE DIARRHEA	I HAVE A RASH	I HAVE HEAD LICE	I HAVE AN EYE INFECTION	I HAVE BEEN IN THE HOSPITAL
						
Temperature of 100 degress F or higher	Within the past 24 hours	Within the past 24 hours	Body rash with itching or fever	Itchy head, active head lice	Redness, itching, and/or pus draining from eye	Hospital stay and/or emergency room visit

I AM READY TO GO BACK TO SCHOOL WHEN I AM ...

Fever free without the assistance of medication for 24 hours (i.e. Tylenol, Motrin, Advil)	Free from vomiting for 24 hours	Free from diarrhea for 24 hours	Free from rash, itching or fever. I have been evaluated by my doctor, if needed.	Treated with appropriate lice treatment at home.	Free from drainage and/or have been evaluated by my doctor if needed.	Released by my medical provider to return to school.

If your child has strep throat or another bacterial infection, he/she should stay home until the antibiotic has been given for at least 24 hours and your health care provider has given permission for your child to return to school. We encourage you to seek medical attention when your child is sick and to follow your health care provider's recommendations about returning to school and other activities.

Precious Moments
Day Care Center, Inc.

Special Notes
For Day Care, 3K for All, and Pre-K for All

- All of our staff is Certified in CPR & First Aid. They all have been finger-printed with the Federal Bureau of Investigation (FBI) and with the Department of Education (DOE): they have successfully passed the background check requirements of the NYC Bureau of Day Care and have been cleared medically to work with children.
- Our School is open from 7:30 am to accommodate early drop-offs at no extra charge (Excludes Pre K for All)
- We close at 6:00 pm! If you are going to be late please call us and let us know. Late fees are imposed as follows: $20 in cash, due upon pick-up at 6:01 pm: $40 in cash, due upon pick-up at 6:31 pm. This fee goes to the staff employee in charge of your child.
- All children should be in by 9:00 am in order for us to be in ratio compliance with the Department of Health. If you will be late please call and inform us.
- Tuition is due on the 1st of the month and payments can be made by cash, personal check or Money order made out to "Precious Moments." Tuition is due on Mondays if you are paying weekly. A late fee of $25 is automatically added to your child's account for payments made after the 10th of the month. A $30 fee will be charged for a returned check.
- Registration fee is $200 per school year and $50.00 for the summer camp program. The registration fees are non - refundable.
- We follow the public schools decision regarding school closings/delays. School closing information can be found on our local news channels and radio stations as well as our Facebook page. If the public schools close for a snow day, we are either closed or we'll offer remote learning that day.
- We have electronic surveillance and staff-operated entry at both our facilities. We do NOT under any circumstances release children to any person who does not have a photograph on file or not received a call from a parent or guardian identifying the new person.
- Our bus service is owned by Precious Moments, our drivers work for us, and are specially licensed and screened by the DOT & the NYC Bureau of Day Care: in addition, we only transport children that are registered at Precious Moments.
- There are no refunds for days missed due to sickness, weather conditions, family vacations, or holidays. Your tuition includes all educational materials, arts and crafts materials, and all snacks and beverages. We plan for supplying all of these items every day to your child and so these are fixed operating costs that must be covered regardless of missed days.
- If your child is sent home sick, they can only return with a doctor's clearance. Your child must be fever free for 24 hours without the aid of medication. If your child was sent home with a fever they may not return the next day since they would not be considered 24 hours fever free.
- We make every effort to connect calls from you to your child's teacher or care-giver during business hours: however, there may be times when your call will be returned after the teacher's day is over.
- A school calendar is included in your welcome package, noting all holidays and seasonal breaks. You will also receive periodic newsletters to keep you up-to-date on activities in your child's class. All tuition fees are due regardless of your attendance.