OCFS-LDSS-0792 (10/2018) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

Child's Full Name: Preferred Name/Nickname:	Date of Birth: / /	Gender:
Child's Home Address:		
Name of Person Enrolling Child:	Relationship to Child: Parent Guardian Caretaker Relative ____ Other ____	
Phone Number(s) of Person Enrolling Child: ( ) - ok to text **Email Address:**	Address of Person Enrolling Child (if different than child):	

EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	Primary Contact:	Yes No	ok to text	ok to text
		Yes No	ok to text	ok to text
		Yes No	ok to text	ok to text

For Program Use Only Date of Enrollment: / /	*For Program Use Only* Date of Disenrollment: / /

OCFS-LDSS-0792 (10/2018) REVERSE

Child's Full Name:	Date of Birth: / /

Check boxes below to indicate if your child has any special needs/services: None

Early Intervention/Special Education Occupational Therapy Speech/Language Physical Therapy

Allergies (list)

Other

Please provide information here **AND** discuss with your child care provider:

Child's Primary Care Physician's Name/ Group:	Phone Number: ( ) -
Preferred Hospital:	Phone Number: ( ) -
Child's Dental Care:	Phone Number: ( ) -

Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/