


## **FORMS CHECKLIST**

The forms listed below need to be signed and returned  
before your child's first day of attendance.

	<b>Forms</b>	<b>Date Received</b>
1	Day Care Enrollment Form	
2	Day Care Registration	
3	Birth Certificate	
4	Fee Agreement	
5	Release Authorization	
6	Emergency Plan	
7	Medical Statement	
8	Medical/Medication/Exclusion Policy	
9	Elijah's Law Addendum	
10	Permission to Administer Epipen	
11	Non-Medication Consent	
12	Infant Feeding Schedule/Parent Agreement	
13	All About Your Child	
14	Photo Release	
15	Napping Agreement	
16	Late Policy	
17	Bedding Schedule Information	
18	DSS Payment Agreement	

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**DAY CARE ENROLLMENT**

	PROGRAM NAME: <b>Our Lady of Grace</b>	ADDRESS: <b>666 Albin Ave</b>	PHONE NUMBER: <b>(631) 422 - 4681</b>	
	CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:		DATE OF BIRTH: / /	
	CHILD'S HOME ADDRESS:		GENDER:	
	NAME OF PERSON ENROLLING CHILD:		RELATIONSHIP TO CHILD: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____	
PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - <input type="checkbox"/> ok to text		ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):		
EMAIL ADDRESS:				
<b>EMERGENCY INFO</b>	<b>EMERGENCY CONTACT NAMES / ADDRESSES</b>	<b>Authorized to Pick Up Child</b>	<b>PRIMARY PHONE NUMBER</b>	<b>OTHER PHONE NUMBER / EMAIL</b>
	PRIMARY CONTACT:	<input type="checkbox"/> Yes <input type="checkbox"/> No	( ) - <input type="checkbox"/> ok to text	( ) - <input type="checkbox"/> ok to text
		<input type="checkbox"/> Yes <input type="checkbox"/> No	( ) - <input type="checkbox"/> ok to text	( ) - <input type="checkbox"/> ok to text
		<input type="checkbox"/> Yes <input type="checkbox"/> No	( ) - <input type="checkbox"/> ok to text	( ) - <input type="checkbox"/> ok to text
<b>FOR PROGRAM USE ONLY</b>		<b>FOR PROGRAM USE ONLY</b>		
DATE OF ENROLLMENT: / /		DATE OF DISENROLLMENT: / /		

CHILD'S FULL NAME:	DATE OF BIRTH: / /
<b>Check boxes below to indicate if your child has any special needs/services:</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (Please list) _____ <input type="checkbox"/> Other _____	
Please provide information here <b>AND</b> 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: ( ) -
<b>Child health care information is available by calling toll-free 1-800-698-4543 or                  the NYS Health Marketplace website: <a href="https://nystateofhealth.ny.gov/">https://nystateofhealth.ny.gov/</a></b>	
<b>AGREEMENTS</b>	
• I consent to emergency medical treatment for my child.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
• I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
• I agree to review and update this information whenever a change occurs and at least once every year.....	<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE: / /

700 Albin Avenue, West Babylon N.Y. 11704

631-422-4681

E-mail: Daycare@ourladyofgrace.net

**DAYCARE REGISTRATION FORM**

**CHILD'S NAME:** \_\_\_\_\_

**NICKNAME:** \_\_\_\_\_

**BIRTH DATE:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TOWN & ZIP:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_

**CIRCLE DAYS TO COME:** MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY

**MOTHER'S NAME:** \_\_\_\_\_

**ADDRESS (if different than child's):** \_\_\_\_\_

**CELL PHONE #** \_\_\_\_\_ **E-MAIL:** \_\_\_\_\_

**PLACE OF EMPLOYMENT:** \_\_\_\_\_

**WORK PHONE #:** \_\_\_\_\_

**FATHER'S NAME:** \_\_\_\_\_

**ADDRESS (if different than child's):** \_\_\_\_\_

**CELL PHONE #** \_\_\_\_\_ **E-MAIL:** \_\_\_\_\_

**PLACE OF EMPLOYMENT:** \_\_\_\_\_

**WORK PHONE #** \_\_\_\_\_

**EMERGENCY CONTACT:** \_\_\_\_\_ **RELATION:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**PARENT'S MARITAL STATUS:** MARRIED SEPERATED DIVORCED SINGLE WIDOWED

**IF DIVORCED, WHO HAS LEGAL CUSTODY:** \_\_\_\_\_

**DOES THE PARENT NOT LIVING WITH THE CHILD HAVE LEGAL ACCESS TO THE CHILD?** YES \_\_\_\_\_ NO \_\_\_\_\_

**IF NO, PLEASE SUPPLY COURT PAPERWORK**



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631-422-4681  
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**FEE AGREEMENT**  
**For Infant/Toddler/Preschool Care**

Child's Name: \_\_\_\_\_ Weekly Fee: \_\_\_\_\_  
Days of Attendance: \_\_\_\_\_ Total Daily Hours: \_\_\_\_\_  
Arrival Time: \_\_\_\_\_ Pick-up Time: \_\_\_\_\_

An annual \$75.00 registration fee is charged upon enrollment and each year your child's registration anniversary date. This fee is used for paperwork processing which is necessary each program year.

Upon enrolling your child in Our Lady of Grace Day Care, a deposit is required to guarantee the enrollment slot(s). This is credited toward your last month's tuition. This deposit is not refundable nor is it credited if you choose to withdraw your child from the Center before he/she has been in attendance for 90 days or if you withdraw your child with less than 30 days written notice. **NO EXCEPTIONS WILL BE MADE.**

All fees will be paid in advance on the 15<sup>th</sup> day of the month, prior to care being provided (i.e.: September's tuition is due in full no later than August 15<sup>th</sup>). If payment in full is not made by the 20<sup>th</sup> of the month prior, your child's enrollment will be terminated, and your deposit will be forfeited. A \$25 late fee will be incurred for any payment after the 15<sup>th</sup>, unless a written payment agreement is made in the office. Fees are paid in the form of cash or check made payable to: Our Lady of Grace.

Fees are due and payable regardless of the child's absence on a day he/she is scheduled to attend. This is the only method by which we can assure that a place will be maintained for each child on the day that care is needed. Fees exclude holidays and the week between Christmas and New Year's. This time is already accounted for in your monthly bill. In the event of a snow day or other inclement weather, fees are also charged.

**Returned Check Policy:**

The fee for a check returned by the bank is \$10. If a second check is returned, all future payments must be in cash.

**I have read, understand and agree to accept the conditions set forth in the preceding fee agreement.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**





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**Dear Parents,**

**As per New York State Regulations no child may be accepted for care in a child day care center unless the provider, Our Lady of Grace Day Care, is furnished with a written statement signed by a health care provider stating that the child is**

- **Able to participate in child day care.**
- **Currently appears to be free from contagious or communicable diseases.**
- **Receiving health care including appropriate health examinations in accordance with the AAP.**
- **Written statement from Health Care provider stating whether the child has special health care needs and if so, what special provisions are necessary in order for the child to participate in day care.**

**Our Lady of Grace Day Care requires a record of current immunizations. If child is not current on immunizations they may be enrolled but must have a written statement from the Health Care provider with a specific appointment date for when the immunizations will occur. When the child receives their immunizations we will then need a copy of that record.**

*Changing lives through Faith, Caring & Learning*

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**CHILD IN CARE MEDICAL STATEMENT**

**To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner**

Name of Child:	Date of Birth: / /	Date of Examination: / /
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**Immunizations required for entry into day care**

**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).  Yes  No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Date / /	5 <sup>th</sup> Date / /
Polio (IPV or OPV)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Date / /	
Haemophilus influenzae type B (Hib)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Date OR 1 <sup>st</sup> Date (if given on or after 15 months of age) / /	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /	4 <sup>th</sup> Date / /	
Hepatitis B	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /	3 <sup>rd</sup> Date / /		
Measles, Mumps and Rubella (MMR)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> Date / /			
Varicella (also known as Chicken Pox)	1 <sup>st</sup> Date / /	2 <sup>nd</sup> 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. Acceptable tests include Mantoux or other federally approved test. 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.**

*(Continued on reverse side)*



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### **Medication/Medical/Exclusion Policy**

#### **Medication**

Prescribed medication for children with allergies, seizures or chronic illnesses will be given only with the following three items:

1. A labeled prescription bottle
2. A note from the doctor, stating the child's name, the name of the medication, the dosage, the times to administer, and a statement that the child care provider can administer medication.
3. A signed parent permission form to administer medication.

#### **Medical**

Our Lady of Grace Daycare requires an annual medical of each enrolled child that includes all up to date immunizations and any information regarding special needs in a daycare setting.

#### **Exclusion**

For the safety and health of your child and the other children, please do not send your child back to the facility if they:

- Have a fever or has had a fever during the previous 48 hours. Especially if fever is accompanied by behavior change, stiff neck, a rash, unusual irritability, poor feeding, vomiting or excessive crying. Fever means:
  - ❖ Oral Temperature above 101° Fahrenheit
  - ❖ Rectal Temperature above 102° Fahrenheit
  - ❖ Axillary (armpit or ear) above 100° Fahrenheit
- Are still in the first 24 hours of antibiotic treatment
- Have signs of heavy nasal discharge that is any color other than clear
- Have a persistent cough
- Have symptoms of a possible communicable disease (RED ITCHY EYES, SNIFFLES, SORE THROAT, PAINFUL EARS, STOMACH PAIN, HEADACHE, OR DIARRHEA)
- Persistent diarrhea, defined as three or more stools in a 24 hours period, when that pattern represents:
  - ❖ An increased number of stools compared to the child's normal pattern
  - ❖ Increased stool water
  - ❖ Diarrhea accompanied with symptoms of dehydration, such as, sunken eyes, dry skin, concentrated urine or small amounts of urine, or no urine in four hours; or diarrhea accompanied with blood in the stool
- Lice
- Chicken Pox
- Strep Throat
- Pink Eye
- Undiagnosed skin rash and/or infected skin patches
- Vomiting two or more times in a previous 24 hour period accompanied by symptoms of dehydration or other signs of illness
- Are not themselves, are sleepy, tired and/or irritable
- Until a medical evaluation allows inclusion

I have read, fully understand, and agree to accept the conditions set forth in Our Lady of Grace Daycare medication/medical/exclusion policy.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

# ELIJAH'S LAW

## ALLERGY AND ANAPHYLAXIS POLICY

### **Anaphylaxis Prevention**

- Upon enrollment and whenever there are changes, parents/guardians will be required to provide the program with up-to-date information regarding their child's medical conditions, including any allergies the child may have and any emergency medications prescribed for potential anaphylaxis. The parents/guardians will work in conjunction with the program and the child's physician to complete the documents required for any allergy that the child may have. These documents will guide all staff in the necessary actions to take during an allergic or anaphylactic reaction. The program will keep these documents and any emergency medications in a designated area known to all staff members as outlined in the program's health care plan and will ask for updated paperwork when necessary.

### **Documents**

- Any child with a known allergy will have the following documents on file when applicable:
  - NYS OCFS form 7006 – Individual Health Care Plan for a Child With Special Healthcare Needs or approved equivalent
  - NYS OCFS form 6029 – Individual Allergy and Anaphylaxis Emergency Plan or approved equivalent
  - NYS OCFS form 7002 – Medication Consent Form or approved equivalent
- In addition, the child's allergies will be indicated on their enrollment form.
- These forms will be completed by the child's parents in conjunction with the program and the child's physician. In the event of an anaphylactic reaction, staff will call 911 and follow the instructions outlined in these documents.

### **Staff Training**

- All staff members will be trained in the prevention, recognition, and response to food and other allergic reactions and anaphylaxis upon hire and at least annually thereafter. A number of staff will also maintain certifications in CPR, First Aid, and medication administration. If a child with an allergy requires the administration of epinephrine or other emergency medications, the parents will be required to train any staff member caring for that child on the administration of the prescribed medication.

### **Strategies to Reduce the Risk of Exposure to Allergic Triggers**

## Elijah's Law Policy

I have read the Elijah's Law Policy. I understand my responsibilities in communicating the health status of my child and preparing for them to have a specific epipen in the event that one is required.

I understand the program's policies exceed the OCFS requirements pertaining to the adherence to the law.

I understand that the program and OCFS are held-harmless under Good Samaritan laws in the event that an epipen is administered.

I understand that the administration of the epipen means that the child will be taken via ambulance to the hospital, that the child is to remain out of care for at least 24 hours; and that the child is now identified as having anaphylaxis, will need a specific epipen, and will need updated healthcare forms before care can resume.

\_\_\_\_\_ At the time of the signing of this Policy, there are no known anaphylaxis reactions

\_\_\_\_\_ At the time of the signing of this Policy, there are know reactions to \_\_\_\_\_ AND we have completed additional specialized healthcare forms that are required under Elijah's Law. AND we have an epipen that will remain in childcare.

\_\_\_\_\_  
Child's Name

/ \_\_\_\_\_  
Birthdate

\_\_\_\_\_  
Parent's name

\_\_\_\_\_  
Parent's signature



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**Permission to Administer Epipen**

Child's Name: \_\_\_\_\_

Allergy: \_\_\_\_\_

I am supplying an **epipen** for my child on \_\_\_\_\_ and the doctor's authorization  
for use (attached).  
DATE

This **epipen** expires on \_\_\_\_\_ and I understand it is my responsibility to supply the  
DATE  
Center Director with a new **epipen** at least one week prior to this expiration date.

I further understand that if there are any changes in the MD's authorization or specific directions for  
administration of the **epipen** I must notify the Center immediately.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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E-mail: Daycare@ourladyofgrace.net

**Daycare Emergency Plan**

In the event of a serious accident or injury to a child, the Director immediately contacts the Fire/Rescue and have them send an ambulance to the center, and proceed to Good Samaritan Hospital Medical Center, (*if your child needs emergency care while on a field trip, the Director, if unavailable, the person in charge, will call 911, request an ambulance to their location and have the child taken to the nearest hospital emergency room for treatment.*) The Director (if unavailable, the staff person in charge) will accompany the child to the hospital with the child's medical information and emergency treatment form. The Director or their designee will call the parent (if unavailable, the emergency contact) and have them meet the child at the hospital.

Good Samaritan Hospital Medical Center is located at 1000 Montauk Hwy., West Islip.

If your child is ill while in the care of Our Lady of Grace Daycare, but does not require emergency treatment, you will be contacted at: HOME—WORK (circle one).

**EMERGENCY INFORMATION**

**PARENTS:**

**MOTHER:** \_\_\_\_\_

**FATHER:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

Other responsible person in the event parent(s) cannot be reached:

**Name:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Phone#:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**DOES YOUR CHILD HAVE ANY ALLERGIES?** \_\_\_\_ Yes \_\_\_\_ No

**IF YES, PLEASE**

**LIST:** \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY TREATMENT**

I hereby give my consent to an adult caretaker representing Our Lady of Grace Church to authorize medical, surgical, and/or dental treatment including hospitalization for my child

\_\_\_\_\_  
(Print Child's Name)

should it be necessary while my child is in the care of the Our Lady of Grace Daycare Program.

I, \_\_\_\_\_, the parent/legal guardian of the above mentioned child, do hereby certify that the information provided is valid and agree not to hold Our Lady of Grace Church, or any employees or volunteers of Our Lady of Grace Church, responsible for any accidental injury my child might incur while in the care of the Our Lady of Grace Daycare Program.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness (Notary) \_\_\_\_\_ Date \_\_\_\_\_

**THIS FORM MUST BE NOTARIZED**

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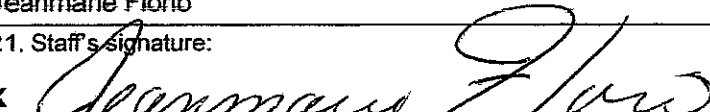
NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**NON-MEDICATION CONSENT FORM**  
Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellent.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

**PARENT TO COMPLETE THIS SECTION (#1 - #14)**

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:
7A. Frequency to be administered, include times of day if appropriate: _____		
<b>OR</b>		
7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____		
8A. Possible side effects: <input type="checkbox"/> See product label for complete list of possible side effects (parent must supply)		
<b>AND/OR</b>		
8B. Additional side effects: _____		
9. What action should the child care provider take if side effects are noted:		
<input type="checkbox"/> Contact parent _____		
Other (describe): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (parent must supply)		
<b>AND/OR</b>		
10B. Additional special instructions: _____		
11. Reason(s) for use (unless confidential by law): _____		
12. Parent name (please print):	13. Date authorized:	
14. Parent signature:		
<b>X</b>		

**DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)**

15. Program name: Our Lady of Grace	16. Facility ID number: 532148	17. Program telephone number: 631-422-4681
18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.		
19. Staff's name (please print): Jeanmarie Florio		20. Date received from parent:
21. Staff's signature:		
<b>X</b> 		





**Our Lady of Grace Daycare**

**700 Albin Avenue**

**West Babylon, NY 11704**

**631-422-4681**

**Email: Daycare@ourladyofgrace.net**

**ALL ABOUT YOUR CHILD**

**DATE:** \_\_\_\_\_

Child's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Any brothers & sisters? If so, what are their ages/names? \_\_\_\_\_

How does your child react when you leave them? \_\_\_\_\_

What is your child's normal disposition? \_\_\_\_\_

Does your child have any bad habits? \_\_\_\_\_

Are there any restrictions to play or activities? \_\_\_\_\_

Any speech / hearing /vision problems? \_\_\_\_\_

Is your child prone to any illness (such as headaches, tummy aches, etc.)? \_\_\_\_\_

How is your child most easily settled? \_\_\_\_\_

What are your child's favorite activities? \_\_\_\_\_

**EATING**

What are your child's favorite foods? \_\_\_\_\_

What are your child's least favorite foods? \_\_\_\_\_

Does your child eat with utensils? Which one(s)? \_\_\_\_\_

Are there any foods that your child cannot have due to religious beliefs or any other reason?

Please list: \_\_\_\_\_

**SLEEPING**

What time does your child wake up? \_\_\_\_\_

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**Photo, Quote and Video Image Release**

I, (please print name) \_\_\_\_\_, give Our Lady of Grace Daycare Center without compensation, the absolute right and permission to use, for a period of five (5) years from signing the date, my photograph, quote and/or identity of me in Our Lady of Grace Daycare newsletters, annual report, press release, direct mail piece, website or other publications or other promotional or fundraising materials. I release Our Lady of Grace Church, the Diocese of Rockville and the Bishop thereof, their officers, employees, agents, designees, photographers, writers, the editors, the publishers from liability for any violation of any personal or proprietary right I may have in connection with such use. I am 18 years of age or older.

YES \_\_\_\_\_ NO \_\_\_\_\_

IF NO, CLASSROOM PICTURES ONLY: YES \_\_\_\_\_

Child's  
Name: \_\_\_\_\_

\_\_\_\_\_  
PRINT PARENT/GUARDIAN NAME

\_\_\_\_\_  
SIGNATURE PARENT/GUARDIAN

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**CHILD DAY CARE CENTER**  
**SLEEPING AND NAPPING AGREEMENT**

This form may be used to meet the regulatory requirement that, other than for school-age children, sleeping and napping arrangements must be made in writing between the parent and the program.

<b>Name of Child in Care:</b>	<b>Date of Birth</b>
-------------------------------	----------------------

<b>Name of Parent/Guardian:</b>	
<b>Name of Program: Our Lady of Grace</b>	<b>Facility ID# 532148</b>

<b>Napping or sleeping surface (Check all that apply): Mat, Crib</b>
<b>How will the child be supervised? By the staff in the room.</b>

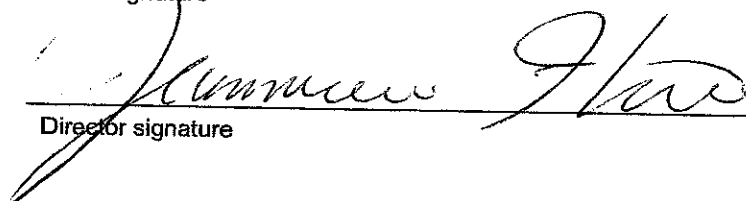
- All applicable regulations must be followed, including, but not limited to, those listed below. Contact your regulator with any questions.
- In a child day care center, children may not sleep or nap in car seats, baby swings, strollers, infant seats, or bouncy seats, unless otherwise prescribed by a health care provider. Should a child fall asleep in one of these devices, they must be moved to an approved sleeping surface.
  - Sleeping arrangements for infants through 12 months of age require that the infant be placed flat on their back to sleep, unless medical information from the child's health care provider is presented to the program by the parent that shows that arrangement is inappropriate for that child.
  - Cribs for infants through 12 months of age must include an appropriately sized fitted sheet and must not have bumper pads, toys, stuffed animals, blankets, pillows, wedges, or infant positioners. Wedges or infant positioners will be permitted with medical documentation from the child's health care provider.
  - The resting/napping places must be located in approved day care space; be located in safe areas of the program; be located in a draft-free area; be where children will not be stepped on; be in a location where safe egress is not blocked; allow a person to move freely and safely within the napping area in order to check on or meet the needs of children; and be at least two feet apart from each other.
  - Children unable to sleep during nap time shall not be confined to a sleeping surface but instead must be offered a supervised place for quiet play, after a 20 minute rest period. If a child falls asleep during the rest period their body needs the sleep so we will allow them to sleep.
  - A copy of this agreement must be kept on file at the program and accessible for review.

\_\_\_\_\_  
Child's name

\_\_\_\_\_  
Parent signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director signature



# Late Policy

## **Late Payment**

### **Monthly**

A \$25.00 fee will be charged to your account if payment is late.

If you pay through We-share it takes 5 to 7 days for us to receive the payment. On the 7th day we will charge your account a \$25.00 late fee.

If your account is not up to date for two months we will ask you to keep your child home until you can bring it up to date.

### **Weekly**

If paying with cash or check it must be handed in, in the office the Friday before the week of daycare or by Wed. if using We Share. If this is not collected we will have to ask you not to bring your child until payment is made.

## **Late Pick-up**

We ask for a phone call if you are going to be more than 10 minutes late.  
(631-422-4681)

For every 15 minutes late, we will charge your account 10 dollars.  
Most of the time it is less expensive to adjust your hours.

Thank you for understanding. Jeanmarie Florio

Parent Name \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Our Lady of Grace Day Care  
700 Albin Avenue, West Babylon N.Y. 11704  
631-422-4681  
E-mail: [Daycare@ourladyofgrace.net](mailto:Daycare@ourladyofgrace.net)

**FEE AGREEMENT for DSS Recipient**  
**For**  
**Infant/Toddler/Preschool Care**

Child's Name: \_\_\_\_\_ Weekly Fee: \_\_\_\_\_

Hourly Absence Fee: \_\_\_\_\_ Per Diem Amount: \_\_\_\_\_

Days of Attendance: \_\_\_\_\_ Total Daily Hours: \_\_\_\_\_

Arrival Time: \_\_\_\_\_ Pick-up Time: \_\_\_\_\_

DSS Monthly Payments: \_\_\_\_\_

Monthly Fees not covered by DSS-- required payment from Parent/gaurdian \_\_\_\_\_

An annual \$30.00 registration fee is charged each year of your child's enrollment. This fee is used for paperwork processing which is necessary each program year.

Upon enrolling your child in Our Lady of Grace Day Care, this registration fee is required to guarantee the enrollment slot(s) **This fee is not refundable. NO EXCEPTIONS WILL BE MADE.**

All fees will be paid in advance on the 15th day of the month, prior to care being provided.(i.e.: September's tuition is due in full no later than August 15<sup>th</sup>). If payment in full is not made by the 20<sup>th</sup> of the month prior, your child's enrollment will be terminated, and your deposit will be forfeited. A \$25 late fee will be incurred for any payment after the 15<sup>th</sup>, unless a written payment agreement is made in the office. Fees are paid in the form of cash or checks made payable to: Our Lady of Grace. You can also make a payment on WeShare, our online giving site. Go to Our Lady of Grace website and click on the WeShare symbol.

Parents/guardians are responsible for the daily fees which DSS does not cover. If you pick your child up before the 9 hours or if DSS does not cover our complete fees, you will be responsible for the excess. You will receive a bill at the end of the month for any hours your child was not here and thus DSS did not pay for. When DSS reports to us about the fees they are covering, an agreement will be written up and signed.

We charge for sick days and absences. DSS does not pay us for these days so you are required to pay for them. Children are allow 7 days per year as sick days, and non payable with a Dr.s note. After the 7 absences, you will be charged a per diem amount for any other absences. After 3 missed payments I will have to take your child off my roster. After 5 consecutive days absent, by law, we have to contact DSS. If you have any questions please feel free to ask.

**Returned Check Policy:**

The fee for a check returned by the bank is \$10.00. If a second check is returned, all future payments must be made in cash.

**I have read, understand and agree to accept the conditions set forth in the preceding fee agreement.**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

*Changing lives through Faith, Caring & Learning*

# Remind

I'm using Remind to help keep you informed about classroom activities and assignments. Remind is a free service that lets me send quick messages to everyone involved with daycare. Find out about special activities and daycare closings. You can also send individual messages to your child's teacher. Signing up for my messages on Remind is easy.

**Receive messages via text message**

**Text my class code to 81010    Class code @689bch4**

- **Reply to the message from the Remind team with your first and last name, and you're in!**
- **If you have any questions about Remind, please feel free to contact me. I look forward to connecting with you!**

Jeanmarie

## Bedding Information

- I want my child's bedding to stay in the classroom for the week. I understand the bedding will be placed in a large black bag and tied after each use.
  
- I want my child's bedding sent home each day and I will bring fresh bedding each morning.

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Child's Name

---

Parent's Name

---

Parent's Signature

Date

## **What is childhood lead poisoning?**

Lead is a metal that can harm children when it gets into their bodies. Lead can harm a young child's growth, behavior, ability to learn and can also cause anemia, kidney damage, and hearing loss. There are many sources of lead. Lead can be found in dust, air, water, soil, and in some products used in and around our homes.

Children under six years old are more likely to get lead poisoning than any other age group. Most often, children get lead poisoning from breathing in or swallowing dust from old lead paint that gets on floors and windowsills, hands and toys. Lead can also be passed from mother to baby during pregnancy.

Although lead poisoning is preventable, lead continues to be a major cause of poisoning among children. Thousands of children are still at risk. Learn more about what you can do to reduce the risks of lead poisoning to babies and young children.

## **When is lead tested and what do your child's lead test results mean?**

At each well-child visit, your health care provider should assess children 6 months to 6 years of age for risk of high lead exposure. Your health care providers may use a questionnaire to determine if your child is at higher risk of lead poisoning and needs a lead test. They may also refer children at higher risk for a blood test. If you don't know where to bring your child for testing, you can also call your local health department.

During a lead test, a small amount of blood is taken from a finger prick or vein and tested for lead. Blood can be drawn at a doctor's office, hospital, clinic or lab. Children with lead test results greater than 5 micrograms per deciliter may require additional follow-up actions to address possible sources of lead exposures.

## **What is New York State doing to end childhood lead poisoning?**

Great progress has been made, but lead is still a threat to many children. The NYS DOH has strong programs, plans and laws working to prevent childhood lead poisoning statewide. These programs also help those children who have lead poisoning. Local health departments identify new cases, provide care coordination and environmental case management and in-home visits to help families reduce their environmental risks. The Advisory Council on Lead Poisoning Prevention provides guidance to the NYS DOH concerning development of these programs, plans, and laws.

## ► What Are Adverse Childhood Experiences (ACEs)

Adverse childhood experiences (also known as ACEs) are stressful or traumatic events, such as neglect and/or violence during childhood. ACEs are strongly related to brain development and a wide range of health problems throughout a person's lifetime.

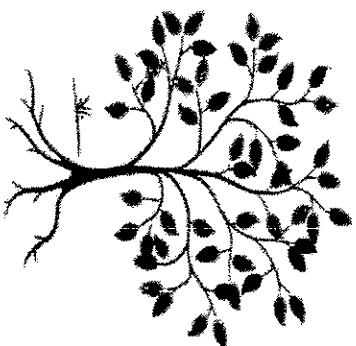
*ACEs may include but are not limited to: physical or sexual abuse, domestic violence, living in poverty, parental mental illness, discrimination, substance use disorder or incarceration.*



## ► Why is it Important to Consider ACEs and Their Impact?

### Research has shown that:

- When families experience historical and systemic racism or living in poverty for generations, the effects of ACEs can add up over time.
- ACEs are very common in every population group.
- ACEs can have a significant impact on a child's ability to succeed in school, causing a negative impact on their mental health and general well-being.
- Adults who have experienced ACEs may have higher rates of negative health outcomes, including depression, obesity, substance abuse, anxiety, smoking and early death.



## ► Resilience, Protective Factors

### What is resilience?

Resilience is the ability to bounce back from challenges and hardship.

Parental and child resilience have been shown to reduce the negative impacts of ACEs.

## ► Protective Factors

Protective factors that may boost child or parental resilience may include:

- supportive and caring relationships and social connections
- programs that understand a person's background and culture
- a healthy lifestyle, which may include regular exercise, mindfulness, getting sufficient sleep and eating a healthy and nutritious diet
- economic support/stability for families
- quality child care and education early in life



## State Agencies and Organizations

Family Child Care Association of NYS  
PO Box 5486  
Albany NY 12205-0486  
(518) 452-1818  
[www.fccanys.org](http://www.fccanys.org)

NYS Association for the Education of Young Children  
230 Washington Avenue Extension  
Albany, NY 12203  
Phone (518) 867-3517  
[www.nysaeyc.org](http://www.nysaeyc.org)

NYS Center for Sudden Infant Death  
School of Social Welfare  
Health Sciences Center  
Stony Brook University  
Stony Brook, NY 11794-8232  
(631) 444-3690  
(800) 336-7437  
[www.stonybrookmedicalcenter.org/sids](http://www.stonybrookmedicalcenter.org/sids)

Early Care & Learning Council  
(formerly the NYS Child Care Coordinating Council)  
230 Washington Avenue Extension  
Albany, New York 12203  
(518) 690-4217  
[www.earlycareandlearning.org](http://www.earlycareandlearning.org)

NYS Department of Health  
Empire State Plaza  
Albany, NY 12237-0618  
(518) 473-8600  
[www.health.state.ny.us](http://www.health.state.ny.us)  
CACFP Web site:  
[www.health.state.ny.us/prevention/nutrition/cacfp/](http://www.health.state.ny.us/prevention/nutrition/cacfp/)  
Child Health Plus (children's insurance program):  
(800) 698-4543  
[www.health.state.ny.us/nysdoh/chplus/](http://www.health.state.ny.us/nysdoh/chplus/)  
Healthy NY (low-cost health insurance):  
(866) 432-5849  
[www.healthyny.org](http://www.healthyny.org)

NYS Department of Insurance  
Empire State Plaza, Agency Building 1  
Albany, NY 12257  
(518) 474-6600  
[www.ins.state.ny.us](http://www.ins.state.ny.us)

NYS Department of Labor  
State Office Building Campus, Room 500  
Albany, NY 12240-0003  
(518) 457-9000  
Employer Hotline: 1-800-HIRE-992 (1-800-447-3992)  
[www.labor.state.ny.us](http://www.labor.state.ny.us)

NYS Education Department  
Office of Vocational and Educational Services for  
Individuals with Disabilities (VESID)  
One Commerce Plaza  
Albany, NY 12234  
(518) 486-7462  
[www.vesid.nysed.gov](http://www.vesid.nysed.gov)

NYS Head Start Association  
230 Washington Avenue Extension  
Albany, NY 12203  
(518) 452-9746  
[www.nyheadstart.org](http://www.nyheadstart.org)

NYS Infant-Toddler Coalition  
c/o Child Care Resources of Rockland, Inc.  
235 North Main Street, Suite 11  
Spring Valley, NY 10977  
(845) 425-0009  
[www.childcarerockland.org](http://www.childcarerockland.org)

NYS Small Business Development Centers  
Empire State Development Division for Small Business  
30 South Pearl Street  
Albany, NY 12245  
1-800-STATE NY (1-800-782-8369)  
[www.nylovesmallbiz.com](http://www.nylovesmallbiz.com)

NYS Office of Children and Family Services  
52 Washington Street  
Rensselaer, NY 12144  
(518) 408-3005  
[www.ocfs.state.ny.us](http://www.ocfs.state.ny.us)  
(see also OCFS Regional Offices on page 161)

Early Childhood Education and Training Program  
Professional Development Program  
22 Corporate Woods Blvd., 3rd Floor  
Albany, NY 12211  
(518) 443-5940  
Educational Incentive Program: (800) 295-9616  
[www.ecetp.pdp.albany.edu](http://www.ecetp.pdp.albany.edu)