Cornell Cooperative Extension of Schoharie and Otsego Counties

4-H Afterschool Program

Enrollment Checklist

Child's Name : _____ Enrollment Date: _____

Check When Complete	Form Title	FOR OFFICE USE ONLY
☐	Parent Handbook	
☐	OCFS Day Care Registration Card	
☐	4-H Enrollment	
☐	Child Interest Profile	
☐	Pick-up Policy/Transportation Plan/Child Release	
☐	Child Release Authorization	
☐	Consent to Share and Obtain Information	
☐	Emergency Treatment/Medical Release	
☐	OCFS Individual Allergy and Anaphylaxis Emergency Plan	
☐	OCFS Individual Health Care Plan for A Child with Special Health Care Needs	
☐	OCFS Health Screen Attestation	
☐	OCFS Child in Care Medical Statement	
☐	Home Helper Program Pledge	

I confirm that I have read and understand the Parent Handbook with particular attention to *Days of Operation, Admission,* and *Program Costs*/payment responsibilities on page 4.

_____ _____ _____

Printed Name Signature Date

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER:

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 (08/2019) 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 (Please 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 care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child…… ☐ Yes ☐ 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…… ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips…… ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child…… ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation…… ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year…… ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:	DATE:

Part #1: Schoharie County 4-H Member Enrollment Form

4-H Year: 2024-2025

Member Information:

Last Name		**First Name**	
Preferred Name		**Date of Birth (Youth Only)**	
Email		**Primary Phone**	
Cell Phone		**Work Phone**	
Emergency Contact Name		**Emergency Contact #**	
Mailing Address		**Mailing Address 2**	
City		**County (of residence)**	
State		**Zip**	
Township		**M.I**	
Receive Email Newsletters	☐ Yes ☐ No	**Gender**	☐ Male ☐ Female ☐ Gender Identity not listed ☐ Prefer not to respond

Parent/Guardian 1 Information:

Last Name		**First Name**	
M.I		**Preferred Name**	
Mobile Phone		**Work Phone**	
Mailing Address 1		**Mailing Address 2**	
City		**County (of residence)**	
State		**Zip**	
Occupation		**Email**	
Legal Guardian	☐ Yes ☐ No	**Receive Email Newsletters**	☐ Yes ☐ No

"I consent to receiving texts from CCE" My Cell Carrier is:_____ My cell phone number is: _____

Parent/Guardian 2 Information:

Last Name		**First Name**	
M.I		**Preferred Name**	
Mobile Phone		**Work Phone**	
Mailing Address 1		**Mailing Address 2**	
City		**County (of residence)**	
State		**Zip**	
Occupation		**Email**	
Legal Guardian	☐ Yes ☐ No	**Receive Email Newsletters**	☐ Yes ☐ No

"I consent to receiving texts from CCE" My Cell Carrier is:_____My cell phone number is: _____

ES 237 Demographics:

Ethnicity	**Are you of Hispanic ethnicity?** ☐ Yes ☐ No	
Race	☐ White	☐ Native Hawaiian or Pacific Islander
	☐ Black	☐ Asian
	☐ American Indian or Alaskan Native	☐ Prefer Not to State

NYS 4-H Member Enrollment Form

Residence	☐ Farm	☐ Suburb of city more than 50,000
	☐ Town under 10,000 & rural non-farm	☐ Central city more than 50,000
	☐ Town /City 10,000-50,000 & suburbs	
Military	☐ No one in my family is serving in the military	☐ I have a parent serving in the military
	☐ I have a sibling serving in the military	
Branch Component	☐ Air force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy	
	☐ Active Duty ☐ National Guard ☐ Reserves	
	School Grade_____School Name _____	
School Type	☐ Public School	☐ Homeschool/Alternative
	☐ Private School	☐ Magnet/ Specialized School
	☐ Special Education	☐ Charter School

(Youth Only

Enrollment Information:

Status	☐ New ☐ Returning/ Re-Enrollment
Enrollment Category	☐ Member ☐ Cloverbud Club:_____ Date Enrolled:_____ 4-H age:_____ Years In 4-H: _____
Enrollment Fee (if applicable)	Paid : ☐ Yes ☐ No Payment method: ☐ Cash ☐ Check Check #: _____
Is this individual a Youth Volunteer?	☐ Yes ☐ No
Is Youth member a club officer?	☐ Yes ☐ No Club Officer position: _____

Educational Focus:

Clubs	☐ Enroll (New Club):_____ (New Club):_____ (New Club):_____ (New Club):_____
Projects	☐ Enroll (New Project):_____ (New Project):_____ (New Project):_____ (New Project):_____ (New Project):_____ (New Project):_____ (New Project):_____ (New Project):_____
Activities	
Certifications	

Part #2: Acknowledgement of Risk Form – 4-H Member

This form must be completed to participate in 4-H clubs and related activities.

This form may be completed during 4-H enrollment for the full program year for 4-H activities and events designated below at the club, county, state and national level.

I hereby apply for my child to participate in the 4-H club and/or activity indicated below to be conducted by the designated Cornell Cooperative Extension Association and acknowledge as follows:

I fully understand and acknowledge that there are inherent risks and dangers in my child's participation in the 4-H club and activities and my child's participation in said 4-H club and all its activities and use of any equipment related to such activities may result in injury, illness or death and damage to personal property. I understand other participants, accidents, forces of nature or other causes may cause these risks and dangers and I hereby accept these risks and dangers.

My child is in good health and is at or above the minimum age of five (5) for Cloverbud members and eight (8) for regular 4-H members required to participate in this activity and is able to participate in any strenuous physical activity associated therewith.

Cornell Cooperative Extension of Schoharie County

DATE(S): 4-H Program Year: October 1, 2024 - September 30, 2025 4-H CLUB ACTIVITY

Select anticipated program participation:

- ❑ All 4-H activities and events for program year
- ❑ Working with dogs
- ❑ Physical Fitness programs
- ❑ Shooting Sports

For Cloverbuds (*youth 5-8 years old only*):

- ❑ Cloverbud activities
- ❑ Cloverbud working with equine or other animal programs

I have read the above and by signing it I agree it is my intention to have my child participate in the indicated activity and I understand and accept the risks involved.

This shall be binding on my heirs, successors, assigns, administrators and executors. Any claims or disputes arising out of my child's participation in the activity shall be venued in the Supreme Court of the State of New York of the County where the County Extension office is located.

I am at least twenty-one (21) years of age and I am the legal parent/guardian authorized to sign this document on behalf of the child named herein.

PARTICIPANT'S NAME (print) _____

DATE OF BIRTH: _____

ADDRESS: _____

PARENT GUARDIAN NAME (print): _____

SIGNATURE: _____ DATE: _____

This form must be kept on file until participant reaches age twenty-one (21).

F.O.R.M. Code 1501
2018 Edition

Part #2 (continued) Equine Member

This form must be completed to participate in 4-H Equine clubs and related activities.

This form may be completed during 4-H enrollment for the full program year for 4-H equine activities and events designated below at the club, county, multiple county, regional, state and national level.

I hereby apply for my child to participate in the 4-H club and/or activity indicated below to be conducted by the designated Cornell Cooperative Extension Association and acknowledge as follows:

I fully understand and acknowledge that there are inherent risks and dangers in my child's participation in the 4-H club and activities and my child's participation in said 4-H club and all its activities and use of any equipment related to such activities may result in injury, illness or death and damage to personal property. I understand other participants, accidents, forces of nature or other causes may cause these risks and dangers and I hereby accept these risks and dangers.

My child is in good health and is at or above the minimum age of eight (8) for regular 4-H Equine club members required to participate in this activity and is able to participate in any strenuous physical activity associated therewith.

Cornell Cooperative Extension of Schoharie County

DATE(S): 4-H Program Year: October 1, 2024 - September 30, 2025

4-H CLUB EQUINE ACTIVITY:

- ☐ Participating in an equine club
- ☐ Working with equines beyond club level including clinics, camps, shows
- ☐ Working with equines in mounted "over fences" activities. *I (the parent or legal guardian) am aware that my child will be participating in 4-H Horse Program mounted "over fences" activities at Cornell University Cooperative Extension county, multiple county, regional, or state sponsored events. I give my child permission to participate.* Mounted "over fences" classes in the NYS 4-H Horse Program could include ground rail, cross rail, and/or other over fences classes and obstacles (this does include trail class). The obstacles will be no higher than three (3) foot in any of the 4-H activities.
- ☐ All of the above

Part #3 Photo Release

By signing part #5, I consent and give permission to allow Cornell Cooperative Extension the unlimited right to use photos, videos, direct quotes, and/or audio clips that they have of me participating in Cornell Cooperative Extension programs or events. I agree to give up my rights with regards to Cornell Cooperative Extension photos, videos, direct quotes, and/or audio clips of me. Further, by signing this consent and release form, I acknowledge that I understand and agree to the above request and conditions. I sign this form freely and without inducement.

Please Check: ☐ **Yes OR** ☐ **No**

F.O.R.M. Code 1501
2018 Edition

Part #4: NYS 4-H Code of Conduct

Our first priority is to create a safe, inclusive space for learning, sharing, and collaboration welcoming to people from diverse backgrounds, cultures and perspectives. Diversity includes, but is not limited to: race, color, religion, political beliefs, national or ethnic origin, immigration status, sex, gender, gender identity and expression, transgender status, sexual orientation, age, marital or family status, educational level, learning style, physical appearance, body size, protected veterans, and individuals with disabilities. CCE actively supports equal educational and employment opportunities. No person shall be denied admission to any educational program or activity on the basis of any legally prohibited discrimination. CCE is committed to the maintenance of affirmative action programs that will assure the continuation of such equality of opportunity.

All 4-H Participants—youth, families, volunteers, and Extension staff—in or attending any activity or event sponsored by Cornell University's Cornell Cooperative Extension (CCE) 4-H Youth Development Program are required to uphold the values of the NYS 4-H program and conduct themselves according to these standards. The standards also apply to online activity, including social media internet presence.

Ground Rules

The following Ground Rules apply to all 4-H participants and volunteers. In addition to these expectations, CCE volunteers are accountable to additional expectations outlined in the CCE Volunteer Code of Conduct. Extension staff is accountable to additional standards of professionalism that are outlined by position descriptions and CCE human resource policies.

1. **Create a Welcoming Environment for All**. Encourage everyone to fully participate in CCE and 4-H. Recognize that all people have skills and talents that can help others and improve the community. Though we will not always agree, we must disagree respectfully. When we disagree, try to understand why.
2. **Bring Your Best Self.** Respect and follow Cooperative Extension rules, policies, and guidelines that relate to 4-H Youth Programs and Events. Conduct yourself in a manner that reflects honesty, integrity, self-control, and self-direction. Accept the results and outcomes of 4-H contests with grace and empathy for other participants. Accept the final opinions of judges and evaluators. Be open to new ideas, suggestions, and opinions of others
3. **Obey the Law.** Commit no illegal acts. Do not possess or use illegal drugs, tobacco products, firearms, weapons, or any harmful object with the intent to hurt others at any time. (Firearms are allowed only as part of supervised 4-H Shooting Sports programming.) Do not attend CCE or 4-H activities under the influence of alcohol or controlled substances.
4. **Honor Diversity – Yours and Others'.** Respect and uphold the rights and dignity of all staff, volunteers, families, and youth who participate in CCE and 4-H programs. Follow Cornell Cooperative Extension Non-Discrimination Policy.
5. **Create a Safe Environment.** Do not carelessly or intentionally harm youth or adults in any way (verbally, mentally, physically, or emotionally). Refrain from romantic displays and sexual activities either in public or private situations. Be kind and compassionate towards others. Do not insult or put down other participants. Harassment, bullying, and other exclusionary behavior aren't acceptable. Be considerate and courteous of all youth and adults and their property.
   a. Youth must stay in the designated dormitory lodging areas: boys may not be in girls' dormitory or lodging areas and girls may not be in boys' dormitory or lodging areas.

b. Report any and all accidents, physical or verbal abuse or unsafe conditions that threaten the emotional or physical well-being of others or yourself to the NYS 4-H, Extension staff, and Event Coordinators as soon as possible.

6. **Be a Team Player.** Work cooperatively with Extension staff, volunteers, 4-Hers, and all involved in 4-H programs and activities. Be responsive to the reasonable requests of the person in charge. Respect the integrity of the group and the group's decisions.
7. **Participate Fully.** Participate in all of the planned programs, be on time and follow through on assigned tasks/responsibilities (including the completion of required records or reports) in a manner that insures the safety, well-being, and quality of the educational experience for self and others. Have fun!
8. **Watch What You Wear.** Use your best judgment. Wear clothing suited for the activity you will participate in. Clothing promoting alcohol and other intoxicants, or displaying messages that are racist, sexist, homophobic, or any other degrading message that detrimentally impacts the dignity and respect of members of our community are never acceptable. Don't wear revealing clothing, such as short skirts or shorts, midriff-baring tops, and sagging pants. If you are unsure about what is appropriate, contact the local CCE 4-H Educator in charge in advance.
9. **Be a Positive Role Model.** Act in a mature, responsible manner, recognizing you are role models for others, and that you are representing yourself, CCE, and the 4-H Youth Development Program. Be responsible for your behavior, use positive and affirming language, and uphold exemplary standards of conduct at all 4-H activities.

Consequences

Any of the following may be used, depending on severity of the situation:

1. Participant will receive a verbal warning.
2. Participant may remain at the event/activity, but may possibly be barred from a future event.
3. Participant may be asked to leave the event/activity/program. If a youth, the parent(s) will be called and the youth will be sent home at family's expense.
4. Additional consequences including suspension or termination of membership may be considered at the County level to ensure the health, safety and well being for all participants.

Part #5: Signatures

With my signature, which I voluntarily affix to this document, I acknowledge that this information is accurate to the best of my knowledge, and I have read and understand the terms of all acknowledgments and agreements herein, specifically including parts #1 Member enrollment information, #2 Acknowledgment of Risk, #3 Photo Release, and #4 Code of Conduct.

PARTICIPANT'S NAME (print): _____

DATE OF BIRTH: _____

ADDRESS: _____

PARENT GUARDIAN NAME (print): _____

SIGNATURE: _____ **DATE:** _____

YOUTH SIGNATURE: _____

Cornell Cooperative Extension of Schoharie and Otsego Counties
4-H Afterschool Program

Child Interests Profile

What does your child enjoy doing the most?

What are your child's favorite toys?

Does your child have any siblings?

What type of foods does your child enjoy/dislike?

Does your child have any fears?

Does your child have any special interests?

How would you describe your child's personality?

Special Comments:

Pick-up Policy / Transportation Plan

The 4-H Afterschool Program operates on full school days as planned using the regular school calendar. The hours of operation are from class dismissal until 5:30 PM. It is your responsibility to pick-up your child by 5:30PM every day. We are prohibited from providing transportation for children. A $10 late pick up fee will be imposed for the first 5 minutes past 5:30 PM, then $1.00 per minute thereafter. If we have not heard from you and the child(ren) are not picked up by 6:30 PM local authorities will be called.

In the event of an unplanned early school dismissal or cancellation of the ASP due to inclement weather or staffing issues, we will notify you via a broadcast messaging service. The school will then release your child(ren) in the manner prescribed by you below. This transportation plan will be used unless the school receives alternative instructions by you **for that day.**

CHILD'S NAME: _____ AGE: _____ GENDER: _____

SCHOOL: _____ GRADE: _____ BUS NO: _____

TRANSPORTATION PLAN:

- ☐ MY CHILD WILL BE PICKED UP FROM SCHOOL PER INSTRUCTIONS ON THE REVERSE
- ☐ MY CHILD WILL RIDE THE BUS HOME
- ☐ MY CHILD WILL RIDE THE BUS BUT BE DELIVERED TO: _____
- ☐ MY CHILD WILL WALK HOME

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

Child Release Authorization

It is legal for either parent/guardian for child to pick up a child. List up to four additional persons to pick-up your child. Please chose a 4-6 letter CODE WORD to be used by alternate designated pick-up person. Please remember to keep their phone numbers current.

Child's Name: Code Word:

Name	Relationship to Child	Phone Number

Please indicate any orders restricting visitation with your child. This person(s) will not be permitted contact with your child. Afterschool Program must have a copy of a court order restricting contact.

Name	Relationship to Child

Parent/Guardian Signature: _____ Date: _____

Cornell Cooperative Extension of Schoharie and Otsego Counties
4-H Afterschool Program

Consent to Share and Obtain Information

I,_____ consent to the sharing of information between the 4-H Afterschool Program and the school district regarding attendance and any other relevant information regarding my child (children), _____

This information may be used solely for the purpose of administering the safety and effectiveness of the program. I understand I have the right to see shared information at any time. This consent does not automatically renew and will expire at the of the program annually.

By my signature below, I affirm that I have read this release, or it has been read to me, and I understand its content.

_____ _____
Signature of Parent/Guardian Signature of ASP Coordinator

_____
Address

_____ _____
City, State, Zip Date

Cornell Cooperative Extension of Schoharie and Otsego Counties
4-H Afterschool Program

Emergency Treatment / Medical Release Form

Child's Name:_____ Age:_____ Date of Birth: _____ School:_____

Full Mailing Address:_____

Please list any health concerns, physical activity restrictions, allergies (*see reverse*), or other information you would want the staff to know of on behalf of the welfare of your child:

Primary Care Physician/Group: _____ Phone: _____

Medicines child is taking: _____

In the event of an extreme emergency, as deemed by the CCE Executive Director or Acting Director, paramedics or medical personnel will be notified IMMEDIATELY to escalate medical attention for the child. All efforts will be made to notify the parents or guardian, immediately, as well. In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the authorized staff in charge to arrange for x-rays, hospitalization, proper treatment and/or order injection, anesthesia, surgery, or dental care for my child as named above.

Due to insurance regulations, paramedics or ambulance must transport injured or ill children to a hospital, when necessary. School van or school personnel cannot transport the child.

I hereby grant permission for my child to use all the play equipment and participate in all activities provided by the 4-H Afterschool Program.

_____ _____ _____
Parent or Guardian Print Name Signature Date

Mother's Name:_____
Phones:_____
Work Cell

Father's Name: _____
Phones:_____
Work Cell

In case the above person cannot be reached notify:

Alternate 1 Name:_____
Phones: _____
Work Cell
Relationship to child: _____

Alternate 2 Name:_____
Phones: _____
Work Cell
Relationship to child: _____

Family Medical & Hospitalization Coverage

Insured By:_____

Plan Name:_____

Phone Number:_____

ID Number:_____

Group Plan No:_____

Name of Enrollee:_____

Employer (if group insurance):

_____

CODE WORD:_____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
INDIVIDUAL ALLERGY AND ANAPHYLAXIS EMERGENCY PLAN

Instructions:

- This form is to be completed for any child with a known allergy.
- The child care program must work with the parent(s)/guardian(s) and the child's health care provider to develop written instructions outlining what the child is allergic to and the prevention strategies and steps that must be taken if the child is exposed to a known allergen or is showing symptoms of exposure.
- This plan must be reviewed upon admission, annually thereafter, and anytime there are staff or volunteer changes, and/or anytime information regarding the child's allergy or treatment changes. This document must be attached to the child's Individual Health Care Plan.
- Add additional sheets if additional documentation or instruction is necessary.

Child's Name: Date of Plan: / /
Date of Birth: / / Current Weight: lbs.
Asthma: ☐ Yes (higher risk for reaction) ☐ No

My child is reactive to the following allergens:

Allergen:	**Type of Exposure**: (***i.e., air/skin contact/ingestion, etc.***):	**Symptoms include but are not limited to:** (***check all that apply***)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)
		☐ Shortness of breath, wheezing, or coughing ☐ Pale or bluish skin, faintness, weak pulse, dizziness ☐ Tight or hoarse throat, trouble breathing or swallowing ☐ Significant swelling of the tongue or lips ☐ Many hives over the body, widespread redness ☐ Vomiting, diarrhea ☐ Behavioral changes and inconsolable crying ☐ Other (specify)

If my child was LIKELY exposed to an allergen, for ANY symptoms:
☐ give epinephrine immediately

If my child was DEFINITELY exposed to an allergen, even if no symptoms are present:
☐ give epinephrine immediately

Date of Plan: / /

THE FOLLOWING STEPS WILL BE TAKEN IF THE CHILD EXHIBITS SYMPTOMS including, but not limited to:

- **Inject epinephrine immediately and note the time when the first dose is given**.
- **Call 911/local rescue squad** (Advise 911 the child is in anaphylaxis and may need epinephrine when emergency responders arrive).
- Lay the person flat, raise legs, and keep warm. If breathing is difficult or the child is vomiting, allow them to sit up or lie on their side.
- If symptoms do not improve, or symptoms return, an additional dose of epinephrine can be given in consultation with 911/emergency medical technicians.
- Alert the child's parents/guardians and emergency contacts.
- After the needs of the child and all others in care have been met, immediately notify the office.

MEDICATION/DOSES

- Epinephrine brand or generic:
- Epinephrine dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

- Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than the mid-outer thigh. If a staff member is accidentally injected, they should seek medical attention at the nearest emergency room.
- If administering an auto-injector to a young child, hold their leg firmly in place before and during injection to prevent injuries.
- Epinephrine can be injected through clothing if needed.
- Call 911 immediately after injection.

STORAGE OF EPINEPHRINE AUTO-INJECTORS

- All medication will be kept in its original labeled container.
- Medication must be kept in a clean area that is inaccessible to children.
- All staff must have an awareness of where the child's medication is stored.
- Note any medications, such as epinephrine auto-injectors, that may be stored in a different area.
- Explain here where medication will be stored:

MAT/EMAT CERTIFIED PROGRAMS ONLY

Only staff listed in the program's Health Care Plan as medication administrant(s) can administer the following medications. Staff must be at least 18 years old and have first aid and CPR certificates that cover all ages of children in care.

- Antihistamine brand or generic:
- Antihistamine dose:
- Other (e.g., inhaler-bronchodilator if wheezing):

***Note: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.**

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

All medication will be kept in its original labeled container. Medication must be kept in a clean area that is inaccessible to children. All staff must have an awareness of where the child's medication is stored. Explain where medication will be stored. Note any medications, such as asthma inhalers, that may be stored in a different area.

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

The following strategies will be taken by the child care program to minimize the risk of exposure to any allergens while the above-named child is in care (add additional sheets if needed):

Document plan here:

EMERGENCY CONTACTS – CALL 911	
Ambulance: ( ) -	
Child's Health Care Provider:	Phone #: ( ) -
Parent/Guardian:	Phone #: ( ) -
CHILD'S EMERGENCY CONTACTS	
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -
Name/Relationship:	Phone#: ( ) -

Parent/Guardian Authorization Signature:	Date: / /
Physician/HCP Authorization Signature:	Date: / /
Program Authorization Signature:	Date: / /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

CHILD NAME:	CHILD DATE OF BIRTH: / /
NAME OF THE CHILD'S HEALTH CARE PROVIDER:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

PROGRAM NAME:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER: ( )
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: **X**		

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

Signature of Parent:

X	DATE: / /

OCFS-6040 (Rev. 06/2021)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

COVID-19 HEALTH SCREENING ATTESTATION

The New York State Department of Health Interim Guidance for Child Care Programs requires all individuals to complete a daily health screening questionnaire before arriving to a child care program or upon arrival to a child care program.

If an individual answers "Yes" to any of the screening questions, they cannot enter the child care program, except as otherwise indicated.

Screening Questions:

1. Is your temperature higher than or equal to 100.4 degrees Fahrenheit?

2. Have you had any known close or proximate contact with a person confirmed (by diagnostic test) or suspected (based on symptoms) to have COVID-19 in the past 10 days? Note: Close contact is defined by DOH as being within 6 feet of an individual for 10 minutes or more within a 24-hour period, starting from 2 days before symptom onset or, if asymptomatic, 2 days before the date the positive sample was collected through when they are isolated. Close contact does not include individuals who work in a health care setting wearing appropriate, required personal protective equipment.

Exception: Asymptomatic staff and children may attend if the staff/child is fully vaccinated or has recovered from laboratory confirmed COVID-19 in the previous 3 months and has not been placed on quarantine. Note: Fully vaccinated is defined as being 2 weeks or more after either receipt of the second dose in a 2 dose vaccine series, or 2 weeks or more after receipt of one dose of a single-dose vaccine.

3. Are you currently experiencing or have you recently, (within the past 10 days) experienced ANY COVID-19 symptoms?

Note: *Symptoms may occur with pre-existing medical conditions, such as allergies or migraines. You should only answer "Yes" if your symptoms are new or worsening.*

- Cough
- Shortness of breath
- Trouble breathing
- Fever (equal to or above 100.4 degrees Fahrenheit)
- Chills
- Muscle pain or body aches
- Headache
- Sore throat
- Loss of taste or smell
- Fatigue
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

4. Have you tested positive for COVID-19 through a diagnostic test within the past 10 days?

5. Have you traveled within the past 10 days and not complied with requirements of the New York State Travel Advisory?

Attestation: I agree that I will self-monitor these symptoms each day, report the outcome to the child care program, and not enter any child care program if any of the above symptoms or conditions are present.

X _____ _____
Signature Date

X _____ _____
Signature Date

Note: *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*

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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:

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)	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. 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)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

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 child 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 child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

Phone

Date

Cornell Cooperative Extension of Schoharie and Otsego Counties
4-H Afterschool Program

Homework Helper Program

Homework help is open for 45 minutes per day, Monday through Thursday. The children are provided a quiet workspace and adults are there to assist, similar to the school's study hall. The staff does not correct the child's work but will offer support and guidance in the subjects. The children are encouraged to attend and asked to present homework assignment journals. We check the journals but cannot verify if your child has incorrectly entered or omitted information. If they refuse, we cannot force them to attend and will notify the parent of refusals.

Student Pledge & Responsibilities

I realize that in order to be successful in this program I must accept the following responsibilities. I will:

- Have my assignments journal complete and up-to-date.
- Bring all necessary homework, textbooks, and reading assignments.
- Raise my hand when I need help and patiently wait for assistance.
- Be cooperative with helpers and follow instructions.
- Complete any additional homework or study at home if I'm not able to complete it at the program.
- Be respectful and not disturb other students.
- Be respectful of the space by keeping the room/space tidy and not disturbing things that aren't part of the program.
- Understand that if I do not follow these responsibilities consequences may include verbal warnings, redirection to another seat/area, asked to take a break and write a letter home explaining my behavior, and loss of privileges for the day, or even permanently.

I have read and understand these responsibilities:

Parent Signature

Student Signature