

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
	Parents Handbook	
	OCFS Day Care Registration Card	
	Pick-up Policy/Transportation Plan/Child Release	
	4-H Enrollment	
	Consent to Share and Obtain Information	
	Child Interests Profile	
	Homework Helper Program Pledge	
	Emergency Treatment/Medical Release/Allergy Info	
	OCFS Health Screening Attestation	
	OCFS Child in Care Medical Statement	

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

PHOTO OF CHILD (Optional)		NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES DAY CARE ENROLLMENT					
		PROGRAM NAME:		ADDRESS:		PHONE NUMBER:	
		CHILD'S FULL NAME:			DATE OF BIRTH: / /		GENDER:
		PREFERRED NAME/NICKNAME:					
		CHILD'S HOME ADDRESS:					
		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:							
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up Child	PRIMARY PHONE NUMBER		OTHER PHONE NUMBER / EMAIL	
	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	
FOR PROGRAM USE ONLY			FOR PROGRAM USE ONLY				
DATE OF ENROLLMENT: / /			DATE OF DISENROLLMENT: / /				

CHILD'S FULL NAME:		DATE OF BIRTH:
Check boxes below to indicate if your child has any special needs/services: <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 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.....		<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:

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 late fee will be imposed for every 15 minutes past pick-up time.

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 boardcast 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 and Code Word Authorization

It is LEGAL for either parent to pick up a child unless we have a copy of a court order restricting visitation. Please indicate any orders restricting visitation with your child. This person(s) will not be permitted contact with your child.

NAME: _____

RELATIONSHIP: _____

NAME: _____

RELATIONSHIP: _____

Please chose a 4 - 6 letter CODE WORD to be used by an alternate designated person's use to pick-up your child in the event that you are unable to do so.

CHILD'S NAME: _____

CODE WORD: _____

List up to four persons authorized to pick-up your child. Please remember to keep phone numbers current.

NAME: _____

RELATIONSHIP: _____

PHONE: _____

NAME: _____

RELATIONSHIP: _____

PHONE: _____

NAME: _____

RELATIONSHIP: _____

PHONE: _____

NAME: _____

RELATIONSHIP: _____

PHONE: _____

PARENT/GUARDIAN SIGNATURE: _____

DATE: _____

☐

Schoharie

☐

Otsego

Received by 4-H office _____

4-H Enrollment Form

2023-2024**Deadlines**

New Members may enroll at any time but to participate at county fair and Junior Livestock show, must enroll by May 31.

Re-enrollment for returning members begins October 1.

All returning 4-H members must be enrolled by December 31 in order to exhibit as a 4-H member at County Fair or at the Junior Livestock Show.**Re-enrollments received after January 1 will be charged a \$5.00 late fee and are ineligible to exhibit at County Fair or the Junior Livestock Show.**

Age

Requirements

Youth ages 5-7 are Cloverbuds. Cloverbuds must turn 5 by January 1 of the 4-H club year.

To enroll as a 4-H member, youth must turn 8 by January 1 of the 4-H year and not turn 19 prior to January 1 of the 4-H year. The 4-H year is October 1 through September 30 of the following year.

Youth Last Name _____ First Name _____

Mailing Address _____ City _____

ST NY Zip _____

Phone (home) _____ Phone (work) _____ ok to call? Y N

Birthdate ____/____/____ Phone (cell or other) _____

School _____ Grade _____

E-mail _____

Does youth have an immediate relative serving in the military? (circle any that apply) *Army, Navy, Air Force, Marine Corp, Coast Guard, Army Reserve, Navy Reserve, Marine Corp Reserve, Air Force Reserve, Coast Guard Reserve, Naval Reserve, Army Guard, Air Guard*

Demographic Information of youthHow would you like the Power of Youth Newsletter received

Ethnicity (Select One): [] Not Hispanic [] Hispanic

Mailed: Y N Emailed: Y N

Gender (Select One): [] Male [] Female

Race (Select One): [] Asian [] White [] Black [] American Indian [] Hawaiian & Pacific Islander

Residence (Select One): [] Farm [] Rural or Town of Less than 10,000 [] Large Town of 10,000-50,000

Youth is enrolling as: _____ New Member _____ Returning Is youth a Cloverbud (5-7)? _____

Club Name: _____ Independent _____

Secondary club _____

PROJECT INFORMATION:

Projects: Every 4-H member must be enrolled in at least one project. Projects are expected to include at least 6 hours of educational activities such as club meetings, clinics, or tours. Please tell us what projects you plan to work on. Contact the 4-H Office if you need a project list.

Primary Project _____

Additional Projects _____

PARENT INFORMATION

PARENT 1 Legal Guardian: Yes No

Name _____ Parent Email _____

(fill in address only if different from child's address on front)

Address: _____ NY _____
Street City zip

Home Ph _____ Cell Ph _____ Other _____

PARENT 2 Legal Guardian: Yes No

Name _____ Parent Email _____

(fill in address only if different from child's address on front)

Address: _____ NY _____
Street City zip

Home Ph _____ Cell Ph _____ Other _____

PART 3: CHILD/CUSTODIAL RELEASE

If there are any restrictions regarding the release of information or custody as to either parent, please provide on an additional sheet all such restrictions, and supporting documentation. If there is any uncertainty or lack of clarity regarding particular release issues, Cornell Cooperative Extension Schoharie and Otsego Counties will request a joint meeting with the parents and 4-H Leader to discuss and resolve such issues.

Parent/Guardian: Please initial: _____

PART 4: PHOTO RELEASE

By signing this form, 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 Circle: Yes No Parent/Guardian: Please initial: _____

Cooperative Extension Schoharie and Otsego Counties

Schoharie County Mailing address: 173 South Grand St., Suite 1
Cobleskill, NY 12043-4649

Otsego County mailing address: 123 Lake Street
Cooperstown, NY 13326

PART 5: CODE OF CONDUCT

YOUTH CODE OF CONDUCT

4-H members participating in or attending club, county, regional, district, state and national programs, activities, events, shows, and contests sponsored for youth by the 4-H Youth Development Program of Cornell Cooperative Extension Schoharie and Otsego Counties are required to conduct themselves according to the following Code of Conduct.

The following are not permitted at 4-H sponsored programs, activities, or events:

- ❖ Clothing printed with:
 - ♦ Advertisements for tobacco or alcohol
 - ♦ Inappropriate, lewd, or suggestive messages
- ❖ Revealing clothing such as (but not limited to):
 - ♦ Inappropriately short skirts or shorts;
- ❖ Revealing (including midriff-baring) tops;
 - ♦ Pants worn to show underwear
- ❖ Possession, consumption or distribution of alcohol.
- ❖ Possession, use, or distribution of illegal drugs.
- ❖ Possession or use of all tobacco products.
- ❖ Sexual activity.
- ❖ Boys in girls' dormitory or lodging areas and girls in boys' dormitory or lodging areas.
- ❖ Cheating or misrepresenting project work.
- ❖ Theft, destruction, or abuse of property.
- ❖ Violation of an established curfew.
- ❖ Unauthorized absence from program site.
- ❖ Physical, verbal, emotional, or mental abuse of another person.
- ❖ Possession or use of a weapon (except as part of an authorized shooting sports event or other staff-authorized use).
- ❖ Possession or use of a harmful object with the intent to hurt or intimidate others.
- ❖ Other conduct deemed inappropriate for the youth development program by Cornell Cooperative Extension Schoharie and Otsego Counties staff, or a 4-H volunteer leader.

If this code is violated, the following steps may be taken:

- ❖ The adult chaperone for the youth involved in the violation (extension staff or 4-H leader) will be made aware of the situation.
- ❖ The parent(s) may be called and arrangements made for transportation home at the parent's expense.
- ❖ The 4-H'er may be barred from participating in 4-H.
- ❖ When a violation occurs at a competitive event, 4-H members may be disqualified from the contest and may be ineligible for any awards. Competition in later contests may also be barred.
- ❖ If any laws are violated, the case may be referred to the police.

ADULT CODE OF CONDUCT

Parents/Guardians (of youth involved with Cornell Cooperative Extension Schoharie and Otsego Counties programs) are expected to accept and adhere to the following standards of behavior when their child(ren) is/are engaged in CCESO Youth Development Program activities as stated here.

As a CCESO Parent or Guardian I will:

- ❖ Respect and adhere to CCESO rules, policies and guidelines that relate to specific CCESO Youth Programs. Conduct myself in an ethical manner.
- ❖ Model kindness and compassion for others. Recognize that all young people have skills and talents that can be used to help others and improve the community.
- ❖ Teach and model fair-mindedness by being open to ideas, suggestions and opinions of others. This includes the final opinions of judges/evaluators for all Youth Programs.
- ❖ Fulfill my parental/guardian duties, including completion of required records or reports, in a timely manner.
- ❖ Work cooperatively with CCESO Extension staff and volunteers.
- ❖ Avoid and prevent put-downs, insults, name-calling, yelling and other verbal and non-verbal conduct as well as written items (including social networking, Internet, etc.) likely to offend, hurt or set a bad example.
- ❖ Be responsible for my behavior, exhibit good sportsmanship, use appropriate language and uphold exemplary standards of conduct at all CCESO youth activities
- ❖ Respect and uphold the rights and dignity of all staff, other volunteers, and all individuals who participate in CCESO programs recognizing that people's values, beliefs, customs, and strengths differ.
- ❖ Respect individuals of diverse backgrounds, cultures, and perspectives.
- ❖ Not possess, sell, offer, consume or use alcohol and/or controlled substances at CCESO youth events/activities, or attend CCESO youth activities under the influence of alcohol and/or controlled substances.
- ❖ Model the importance of obeying the laws and rules as an obligation of citizenship and commit no illegal or abusive act.
- ❖ Provide a safe environment, not carelessly or intentionally harming youth or adults in any way: verbally, mentally, or physically.

PART 6: ACKNOWLEDGEMENT OF RISK

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

I hereby apply for my child to participate in the 4-H club/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 5 for Cloverbud members and 8 for regular members required to participate in this activity and is able to participate in any strenuous physical activity associated therewith.

4-H Program Year: October 1 through September 30.

please check all anticipated program participation

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

Cloverbud Members

- ☐ Cloverbud Activities
- ☐ Cloverbud working with equine or other animal programs

4-H Equine (Horse) Activities

- ☐ Participating in an equine club
- ☐ Working with equines beyond club level including clinics, camps, shows
- ☐ Working with equines in mounted "over fences" activities. **(this does include trail class).**

I (the parent/legal guardian) am aware that my child will be participating in 4-H Horse Program mounted "over fences" activities at Cornell University Cooperative Extension Schoharie and Otsego Counties, 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. The obstacles will be no higher than 3 foot in any of the 4-H activities.

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.

Part 7 Signatures

With my signature, which I voluntarily affix to this document, I acknowledge that the information is accurate to best of my knowledge, and I have read and understand the terms of all releases, acknowledgements and agreements herein, specifically including parts: #3 Custodial Release, #4 Photo Release, #5 Code of Conducts, #6 Acknowledgement of Risk, #7 Signatures.

Youth Signature: _____

Parent Guardian Signature: _____

Parent/Guardian (please print name) _____ 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

Child Interests Profile

What does your child enjoy doing the most?

What are your child's favorite toys and/or electronic devices?

Are there 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:

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

**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: _____

Allergy Information

If you indicated on the front of this form that your child has an allergy, please provide additional information and be as complete as possible. Thank you.

Child's Name: _____ Parent's Signature: _____

Allergic to: _____

What reaction occurs? _____

Severity and duration: _____

Indicate any other important information to provide to school nurse and/or medical personnel.

Allergic to: _____

What reaction occurs? _____

Severity and duration: _____

Indicate any other important information to provide to school nurse and/or medical personnel.

Allergic to: _____

What reaction occurs? _____

Severity and duration: _____

Indicate any other important information to provide to school nurse and/or medical personnel.

Allergic to: _____

What reaction occurs? _____

Severity and duration: _____

Indicate any other important information to provide to school nurse and/or medical personnel.

NEW YORK 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.

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)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd 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) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> 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