Early Childhood Center
BRONX COMMUNITY COLLEGE
Infant/Toddler Program
2155 University Ave, BX, NY 10453
Telephone: 718-289-5461
Fax: 718-289-6432

CAREFULLY READ AND REVIEW THE ENTIRE PACKET.
ENCLOSED ARE THE FORMS YOU NEED TO FILL OUT AND RETURN.

On the day of your scheduled appointment, you will need to bring the following documents to meet with Administration at the Center:

- ☐ Registration Application
- ☐ Tuition Policy
- ☐ Parent Fee Agreement Contract
- ☐ Emergency Contact Form
- ☐ Permission to Pick-Up & Drop-Off
- ☐ Child's Medical Record and List of Immunizations (Must be signed by Doctor)
- ☐ Authorization and Release For Emergency Medical Treatment
- ☐ Non-Medication Consent Form
- ☐ Informed Consent Form
- ☐ Statement Regarding Diapering Supplies
- ☐ Media Release Form
- ☐ CACFP Form
- ☐ Family Social/Developmental History
- ☐ Proof of Address: State ID, NYC ID, Utility Bill, Government Issued Mail
- ☐ Immunization Card/Print Out of Immunizations with Influenza
- ☐ Original Child's Birth Certificate (Copies not accepted)
- ☐ Class Schedule from CUNYFirst with Name, EMPLID and Education Verification
- ☐ BCC Student Identification Card
- ☐ Income Verification and Documentation
  (Current Income Tax, PA Card along with a Notarized Letter, 3-6 Pay Stubs, Child Support Letter, Notarized Statement Letter with Income Status)

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Dear Families:

On behalf of BCC Early Childhood Center, I want to welcome you and your child. We are looking forward to an exciting school year.

Please allow me to introduce myself. My name is Jitinder Walia, and I am the Executive Director of BCC Early Childhood Center. I consider having the opportunity to serve the children and their parents at BCC an honor. My office hours are generally Monday through Friday from 7:30am to 3:30pm. I am also available for evening hours. I encourage parents to stop by to say hello and anticipate meeting your children in the coming weeks. My email address is jitinder.walia@bcc.cuny.edu.

Just a little bit about myself and my extensive experience working with families: I have been in the Early Childhood field for over 35 years. I have three Master's degrees; one with a concentration in Early Childhood Education, one in English, and the other in Social Work. I also have a certification in Administration and Supervision. My experience has been working in private daycare centers, with foster children, parents, adolescents, and substance abusing women. I am most proud of being a graduate of CUNY.

A key component of a good early childhood program is parent involvement. All parents are encouraged to communicate with their child's teacher on a daily basis. This will ensure all parents are informed of the day's activities, as well as upcoming events in the classroom. Please make sure you check your child's cubbies each day.

The staff has planned a creative curriculum that includes art, music, science, cooking, outdoor dramatic play and literacy. In order for your child to participate in all of the activities offered, please have your child arrive at the agreed upon time. This policy will be strictly enforced.

If your child will be absent from school, it is your responsibility to call the center. Please let us know of any schedule changes, or if you need to withdraw your child.

If you have any questions, please do not hesitate to set up an appointment with me. Thank you for your cooperation.

Sincerely,
Jitinder Walia
Executive Director

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Dear Parent/Guardian,

You have selected to begin the enrollment process at BCC Early Childhood Center. Before your child can be accepted into our center, there are some things you need to do and know:

1. First, please **CAREFULLY REVIEW THIS PACKET**. In it are forms that you need to fill out and return on the day of your appointment. ***(You must complete all forms and return them to us before your child can formally be admitted to our program.)***
2. Call to schedule an appointment to register your child. **PLEASE CALL ADMINISTRATION WITH ANY QUESTIONS AT 718-289-5461.**
3. **PLEASE NOTE:** To ensure full classrooms at our center, we often select more parents to begin enrollment than we have immediate room for. This means two things. First, the more quickly you respond and complete the enrollment process, the sooner your child will be able to begin; And second, there is a chance that we will need to place you on our Priority Waiting List until a space opens in a classroom that is age appropriate for your child. Once you are on the Priority Waiting List, your child will automatically be accepted as soon as space becomes available.

The following forms must be completed and returned to the office on the day of your appointment:

- Registration Application
- Tuition Policy
- Parent Fee Agreement Contract
- Emergency Contact Form
- Permission to Pick-Up & Drop-Off
- Child's Medical Record and List of Immunizations
- Authorization and Release For Emergency Medical Treatment
- Non-Medication Consent Form
- Informed Consent Form (signed)
- Statement Regarding Diapering Supplies
- Media Release Form
- CACFP Form
- Proof of Income (Acceptable proof includes: Current Tax Return, Pay Stubs, PA Card, Notarized Letter of Support with Income Tax, Unemployment Papers)
- Child's Birth Certificate **(Original only, copies not accepted)**
- Your complete class schedule and education verification from CUNYFirst
- BCC Student Identification Card
- Proof of Address (Acceptable proof includes: State ID, NYC ID, Utility Bill, Government Issued Mail)

  Most of these forms are required by law, but they also help us bring in the funding that keeps our parent fees low and help us protect and meet the needs of your child.

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BCC Early Childhood Center Infant/Toddler Program
Registration Application

This application is the first step towards enrolling your child at BCC Early Childhood Center. Once you are called, you will need to contact us immediately (by telephone or in person) to schedule a visit to the center. The full process must be completed before your child can be accepted into our program.

This information refers to the **BCC STUDENT-PARENT**. Please print clearly.

Parent's Name:

_____

(Last) (First) (Middle Initial)

Parent's Address:

_____

(Street Number) (Apt. #)

_____

(City) (State) (Zip Code)

Telephone: _____ **SS#: XXX-XX-** _____

Email: _____

Race: _____ **Are you Latino/Hispanic?** ○ Yes / No ○

Major:	**Est. Graduation Year:**
EMPLID:	**Primary Language:**

I have read and completed this application fully and carefully.

_____ _____

(Signature) **(Date)**

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This information refers to the CHILD for whom the services will be provided. Please print clearly.

Child's Name:

_____

(Last) (First) (Middle Initial)

Date of Birth: **Gender:**

_____ _____

Child's Address:

_____

(Street Number) (Apt. #)

_____

(City) (State) (Zip Code)

Parental Information	Parent/Guardian # 1	Parent/Guardian # 2
Name		
Date of Birth		
Occupation		
Work Address		
Daytime Phone Number		
Email Address		

Marital Status: (Check One) ☐ Single ☐ Married ☐ Separated ■ Divorced

Other Members of the Household		
Name	Date of Birth	Relationship to Child

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Tuition Policy

Tuition

Bronx Community College Early Childhood Center offers childcare at a heavily subsidized rate of $10 per day. Along with our rates, there is also a New Student registration fee of $25. Every semester after, there will be a re-enrollment fee of $15 per semester. Tuition is calculated based on the total number of weeks in your enrolled semester. How do I calculate the number of weeks per semester? That's easy, the answer is:

Fall or Spring Semester: 16 weeks x days per week x $10 = Total tuition
Winter Semester: 3 weeks x days per week x $10 = Total tuition
Summer Semester: 3-8 weeks (depending on class) x days per week x $10 = Total tuition

NOTE: Some courses may extend longer than others. In this event, your tuition will reflect the total number of weeks for that course.

Tuition is charged on a weekly basis for the days you are scheduled in the entire semester. **Non-attendance or college closure will not be a reason to adjust your tuition.** Tuition **MUST** be paid prior to your child's identified start date. It may be paid in full or in installments on the 23rd of each month during your enrolled semester. All payments should be made at the BCC Bursars office. **Unpaid tuition will result in a hold in your CUNYFirst account and an interruption of services and will remain interrupted until the balance is satisfied.**

Currently, HRA vouchers are not accepted for the Infant/Toddler Program

Record Keeping

You are responsible for maintaining an accurate record of your validated receipts. Do not discard your receipts as it will assist in verifying payments that have been made towards your account.

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PARENT FEE AGREEMENT

PLEASE INCLUDE YOUR PROOF OF INCOME

(Current Income Tax, Paycheck Stubs, PA Card, Notarized Statement Letter)

Parent's SS#: XXX-XX- _____ **Number in Household:** ☐2 ☐3 ☐4 ☐5 ☐6+

Semester: _____ ☑**Full Time / Part Time** ☐ **Year:** _____

I/We, _____ **parent(s)/legal guardian(s) of**
Parent/Guardian's Name

_____ **enter this agreement with BCC Early**
(Child's Name)

Childhood Center located at 2155 University Avenue, Bronx, NY 10453 for the provision of child care. I/We agree to the following terms:

1. I agree to pay the center a New Student registration fee of **$25.00**. (This fee is **not** refundable.)
2. I agree to pay the center a re-enrollment fee of **$15.00** every time I re-enroll my child/ren.
3. I agree to pay the Center a subsidized fee for the entire semester I register for childcare services. (This fee should be paid to the bursar's office.)
4. I affirm that I am a BCC student majoring in _____ and I am presently taking # _____ course hours.
5. These amounts listed are based on family size of _____ and gross annual income of $ _____.
6. **THE CENTER RESERVES THE RIGHT TO TERMINATE THE CONTRACT AT WILL.**

_____ _____
Parent/Guardian's Signature **Date**

NO REFUND FOR NON ATTENDANCE

FOR OFFICE USE:

Registration Fee:$_____ + Semester Tuition:$_____ = Total Tuition:$_____

_____ _____
(Administrator) **(Date)**

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EMERGENCY CONTACT FORM

CHILD'S INFORMATION

Child's Name: _____ Date of Birth: _____

Allergies:_____

Medications:_____

PARENT/LEGAL GUARDIAN INFORMATION

Full Address: _____

Home Phone #: _____ Cell Phone #:_____

Alternate #:_____

EMERGENCY CONTACT 1

Name: _____ Date of Birth: _____

Home Phone #: _____ Cell Phone #: _____

Full Address: _____

Relationship to Child: _____

EMERGENCY CONTACT 2

Name: _____ Date of Birth: _____

Home Phone #: _____ Cell Phone #: _____

Full Address: _____

Relationship to Child: _____

……

PLEASE READ CAREFULLY; SIGN AND DATE WHERE INDICATED

I hereby grant permission for the Director or a member of the staff of The Early Childhood Center at Bronx Community College to take whatever steps may be necessary to obtain emergency medical care for my child, if warranted. These steps may include, but are not limited to the following:

a. Contact student-parent on campus.

b. Contact persons listed on emergency contact form.

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c. Obtain emergency medical care or referral from the Bronx Community College Health Services Center.

d. Transport the child by emergency medical vehicle to the nearest hospital.

e. **NOTE:** People on the Emergency Contact List **may not** pick-up your child/ren unless they are also included on the Pick-Up Release Form.

The Center will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

The Center will not assume responsibility for a child who has not been signed in when they arrive for the day.

SIGNATURE: _____

DATE: _____

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Pick-Up/Drop-Off Permission Form

I, _____, parent of _____,
(Parent/Guardian's Name) (Child's Name)

do hereby give permission for the following people to drop-off/pick-up my child:

Name: _____

Relation to Child: _____

Phone Number: _____

Date of Birth: _____

Name: _____

Relation to Child: _____

Phone Number: _____

Date of Birth: _____

Name: _____

Relation to Child: _____

Phone Number: _____

Date of Birth: _____

I agree to drop off and pick up my child at the times set in my class schedule. If any changes occur, I agree to give at least a one (1) day written notice. I am aware the Infant/Toddler Program closes and my child must be picked up by 4:00pm.

_____ _____

(Parent's Signature) **(Date)**

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

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

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

City/Borough | **State** | **Zip Code** | **School/Center/Camp Name** Bronx Community College Early Childhood Center | **District Number** __ __ __ | **Phone Numbers** Home _____ Cell _____ Work _____

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

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: _____ weeks gestation

☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* _____

☐ Foods *(list)* _____

☐ Other *(list)* _____

Attach MAF if in-school medications needed

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

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

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

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

☐ Anaphylaxis
☐ Behavioral/mental health disorder
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes ***(attach MAF)***
☐ Orthopedic injury/disability
Explain all checked items above.

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

Medications ***(attach MAF if in-school medication needed)***

☐ None ☐ Yes *(list below)*

_____
_____
_____
_____

PHYSICAL EXAM **Date of Exam:** ___ /___ /___

Height _____ **cm** (___ ___ %ile)

Weight _____ **kg** (___ ___ %ile)

BMI _____ **kg/m²** (___ ___ %ile)

Head Circumference *(age ≤2 yrs)* _____ **cm** (___ ___ %ile)

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

General Appearance:

☐ Physical Exam WNL

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

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)*

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

Screening Results: ☐ WNL

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

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

Describe Suspected Delay or Concern:

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

Nutrition

< 1 year ☐ Breastfed ☐ Formula ☐ Both

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

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

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

Hearing

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

Vision

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

Dental

Visible Tooth Decay	☐ Yes ☐ No
Urgent need for dental referral *(pain, swelling, infection)*	☐ Yes ☐ No
Dental Visit within the past 12 months	☐ Yes ☐ No

CIR Number

Physician Confirmed History of Varicella Infection ☐

Report only positive immunity:

IMMUNIZATIONS – DATES

DTP/DTaP/DT	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Tdap	___/___/___	___/___/___
Td	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	MMR	___/___/___	___/___/___	___/___/___
Polio	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Varicella	___/___/___	___/___/___	___/___/___
Hep B	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening ACWY	___/___/___	___/___/___	___/___/___
Hib	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Hep A	___/___/___	___/___/___	___/___/___
PCV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Rotavirus	___/___/___	___/___/___	___/___/___
Influenza	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Mening B	___/___/___	___/___/___	___/___/___
HPV	___/___/___	___/___/___	___/___/___	___/___/___	___/___/___	Other _____	___/___/___	_____	___/___/___

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

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

_____ _____
_____ _____
_____ _____

RECOMMENDATIONS ☐ Full physical activity

☐ Restrictions (*specify*) _____

Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: __ __/__ __/__ __

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

☐ Other _____

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

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

Facility Name | **National Provider Identifier (NPI)**

Address | **City** | **State** | **Zip**

Telephone | **Fax** | **Email**

DOHMH ONLY **PRACTITIONER I.D.**

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

Comments:

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

REVIEWER:

FORM ID#

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Authorization and Release For Emergency Medical Treatment

Child's Name:	Date of Birth:

I am the parent/legal guardian of the above named child. My child is enrolled at **Bronx Community College Early Childhood Center**. By signing this form. I authorize BCC Early Childhood Center to obtain emergency medical care for my child if my child is injured or becomes ill while in the Center's physical custody and the Center deems such care to be necessary. I also authorize the Center to arrange for any needed transportation for my child if my child needs emergency medical care.

In addition, by signing this form, I acknowledge that:

1. I have been advised that New York City's Department of Health is now requiring center based childcare programs, including the Center, to give epinephrine to a child with symptoms of anaphylaxis (severe allergic reaction that can be caused by certain foods, insect stings, latex or some medications). I understand that anaphylaxis can be life-threatening and requires emergency treatment. Epinephrine is widely regarded as an appropriate treatment.
2. I have been advised that if a child shows symptoms of anaphylaxis, the epinephrine will be administered by trained staff using an epinephrine auto-injector (dosed for children) with a retractable needle, consistent with New York City's Department of Health regulations (Articles 43 and 47 of the NYC Health Code).

By signing this form. I authorize the Center to administer epinephrine using an epinephrine auto-injector (dosed for children) with a retractable needle if my child shows symptoms of anaphylaxis (severe allergic reaction). I understand that if I have provided a written, individual health care plan to the Center indicating the specific medications that can be administered and the schedule of such administration(s) for my child, including in cases of emergency, and there is a direct conflict between such plan and any of my other authorizations in this Authorization and Release, then the Center will follow my child's individual health care plan.

I hereby release and forever discharge BCC EARLY CHILDHOOD CENTER, BRONX COMMUNITY COLLEGE, CUNY, The Research Foundation of CUNY, New York State, New York City, and the directors, officers, employees and agents of each of them from any and all liability arising in law or equity as a result of the Center providing emergency treatment in conformance with this Authorization and Release, provided that the Center has used reasonable care in carrying out such actions.

I HAVE READ & UNDERSTAND THIS AUTHORIZATION AND RELEASE. I AM SIGNING IT VOLUNTARILY.

Name:	**Signature:**	**Date:**

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NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

Non-Medication Consent Form

- 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 repellant.
- 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)

<table>
<tr><td colspan="2">1. Child's first and last name:</td><td colspan="2">2. Date of birth:</td><td>3. Child's known allergies:</td></tr>
<tr><td colspan="2">4. Name of product (including strength):</td><td colspan="2">5. Amount to be administered:</td><td>6. Route of administration:</td></tr>
<tr><td colspan="5">7A. Frequency to be administered, include times of day if appropriate:

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration):</td></tr>
<tr><td colspan="5">8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects:</td></tr>
</table>

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9. What action should the child care provider take if side effects are noted: ☐ **Contact parent** **Other (describe):**
10A. Special instructions: ☐ **See package insert for complete list of special instructions (parent must supply)** ***AND/OR*** **10B. Additional special instructions:**
11. Reason(s) for use (unless confidential by law):

12. Parent name (please print):	**13. Date authorized:**
14. Parent signature: **X**	

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

15. Program name:	**16. Facility ID number:**	**17. Program telephone number:**
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):		**20. Date received from parent:**
21. Staff's signature: **X**		

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Informed Consent Form

Access: I will be able to nurse my infant/toddler in the lactation room at any time during the day.

Arrival and Departure: I will make sure that my child arrives at the Center no earlier than 15 minutes prior to the start of my scheduled class. To ensure my child's safety, the center will only accept my child from or release my child to those persons I have authorized on the Pick-Up Release Form. I will pick up my child no later than 15 minutes after my last class scheduled ends for the day. I am aware that the Infant/Toddler program closes at 4:00pm sharp. I am also aware that there is no drop-off between 10:00am-1:45pm.

Staff: Qualified staff will be present at all times in staff-to-child ratios meeting the New York City Department of Health regulations.

Meals: Parents are asked to supply meals/snacks and/or bottles for your child. All items must be labeled daily with the child's full name and date.

Trips: I give permission for my child to participate in stroller rides around the college campus with appropriate staff supervision.

Media: I give consent for the Center to use media images (i.e. photographs, videotapes) for documentation of the classroom program, research, public education, promotion and news reports. I will be asked for additional permission before my child is individually identified in a published photograph.

Research: BCC students and faculty and those from other colleges may conduct observational research of my child. If my child is to participate in any interactive research, I will be asked to sign a release.

Emergency Medication and Treatment: In case of illness, I will be called and possibly required to pick up my child as soon as possible. In case of simple injury, (abrasion, skinned knees, splinters, etc.), the center staff will perform routine first aid measures, such as washing wounds and applying bandages. I will be informed of any incidents and the actions that were taken when I arrive to pick up my child. In case of a medical emergency, I will be called and will take responsibility for obtaining the necessary medical treatment. If, in the judgment of the Center staff, circumstances require immediate or professional care, 911 services will be called by BCC's Office of Public Safety. In the event emergency

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treatment is required I give consent for my child to be taken to a nearby medical facility for treatment by a qualified physician. Costs incurred from treatment of an injury or illness occurring within the program is my responsibility.

Children's Records: All children's records are kept confidential. Upon written request, I may receive a copy of my child's records. Except in the case of appropriate state and city officials, who have the right to inspect center files at any time, my child's records will not be released to anyone unless authorized by me in writing.

Group Care and My Child: To the best of my knowledge, my child has no condition that restricts his/her full participation in the Center program. If in the future any restrictions are necessary, I will inform the Center in writing. BCC/ECC adheres to the guidelines of the Americans with Disabilities act. We serve children who are able to function in a group setting and will make every effort to facilitate this. However, occasionally, if we are unable to meet the needs of a particular child, the Center may ask the family to withdraw their child.

Child Abuse and Neglect: BCC Early Childhood Center operates accordingly to a plan designed to protect children from any danger of abuse or neglect. Center staff members are required by law to report to the State's Child Abuse and Maltreatment Hotline any evidence that a child has been or is in danger of being abused or neglected.

I have read, understand, and agree to the terms of this consent form.

Child's Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Date: _____

Parent Signature: _____

BCCECC Administrator: _____ Date: _____

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STATEMENT REGARDING DIAPERING SUPPLIES

BCC Early Childhood Center offers to provide Pampers brand diapers and wipes for your child. In the event we are unable to purchase the Pampers brand for any reason, we will purchase whichever substitute is made available to us. This form must be completed by the parent/guardian to either accept or decline BCC Early Childhood Center's offer. Please indicate whether you accept or decline the offer for **each** of the following:

Child's Name: _____ Date of Birth: _____

I **ACCEPT** the provider's offer to supply the following: **(Circle All That Apply)**

Diapers ☐ Wipes ☐

I **DECLINE** the provider's offer to supply the following: **(Circle All That Apply)**

Diapers ☐ Wipes ☐

Signature: _____ Date: _____

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Media Release Form

I am the parent or legal guardian of _____ (child's name). I hereby grant permission to The City University of New York and anyone acting pursuant to its authority (collectively "CUNY") to take photographs, video recordings and/or audio recordings of my child while participating in activities of a CUNY childcare center. I authorize the use of such recordings, for any purpose that CUNY may deem appropriate, including without limitation educational uses and promotion of CUNY and its programs and activities, including in particular CUNY childcare centers, in perpetuity, in CUNY publications and promotional materials, websites and social media sites, as well as in an other media and manners, whether now known or later developed. I waive any right to inspect and approve such uses. I understand that such recordings of my child may identify the CUNY childcare center that my child attends, but they will not identify my child by name. I understand that CUNY will be the owner of all rights in and to such photographs, videos and uses and that neither I nor my child will receive any monetary or other compensation for such uses.

I hereby release and hold harmless CUNY from liability for any and all claims by me in connection with CUNY's activities as authorized by this consent and release.

I understand that I am not required to sign this release as a condition of enrollment of my child in a CUNY childcare center or participation in a center's programs and activities.

_____ _____

(Printed Name of Parent/ Legal Guardian) **(Date)**

_____ _____

(Signature) **(Telephone)**

_____

(Address) **(City)** **(State/Zip)**

CACFP Agreement #_____

NEW YORK STATE | Department of Health | Child and Adult Care Food Program

INFANT FEEDING STATEMENT

Child's Name_____ Date of Birth _____

Dear Parent/Guardian:

This center participates in the Child and Adult Care Food Program and we will give your baby _____ and solid food. If you want to bring breast milk or your own
NAME OF FORMULA
formula or food, you can do that instead. Also, we encourage moms to come to the center to nurse their babies.

Please indicate your choice below.

BREAST MILK/FORMULA (CHECK ONE)	FOOD (CHECK ONE)
_____The center can give my baby the formula they buy. _____I will bring breast milk or formula for my baby.	_____The center can give my baby solid foods when I tell them the baby is ready. _____I will bring solid foods for my baby.

Parent's Signature _____ Date _____

This institution is an equal opportunity provider.

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FAMILY/SOCIAL/DEVELOPMENTAL HISTORY

Child's Name:

_____

Child's Date of Birth:

_____

Child's Gender:

_____

Parent's Name:

_____

Phone Number:

_____

Parent's Email Address:

_____

Sibling(s) (Name, Age, Gender):

_____

_____

Who lives in your child's home?

_____

_____

Has your child previously attended school or family day care? Where? How long?

_____

_____

If so, what was their reaction to the experience away from home?

_____

_____

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How do you feel when you leave your child in someone else's care?

_____

_____

YOUR CHILD'S TEMPERAMENT & EMOTIONS

How would you describe your child?

_____

_____

What makes your child upset?

_____

_____

What soothes your child?

_____

_____

Does your child have a special blanket, toy, pacifier, or other security object to which they are attached?

_____

Under what circumstances do they use it?

_____

ROUTINES

What is your child's diapering/toileting routine?

_____

_____

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Do you have any specific diapering/toileting instructions?

_____

_____

SLEEPING

Where does your child sleep at home (with others, own room, bed or crib, etc.)?

_____

Describe your child's bedtime/nap ritual (how you put them to sleep):

_____

_____

Are they sleeping through the night?

_____

What do you do if your child wakes in the night?

_____

_____

What time does your child usually wake up in the morning?

_____

_____

General mood upon awakening?

_____

What times, where, and for how long does your child generally nap?

_____

_____

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EATING

Does your child drink breast milk and/or formula?

_____

Does your child take a bottle? If yes, is it warmed?

_____

Describe. What are they eating, when, and how much?

_____

_____

What is your child's general attitude toward eating?

_____

_____

Is your child eating solids and/or purees?

_____

_____

Is your child self-feeding?

_____

_____

Does your child have any food allergies or dietary restrictions?

_____

_____

Any other special instructions about eating?

_____

_____

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HEALTH HISTORY

Is there anything about your pregnancy or birth experience that we need to know?

If yes, please explain:

_____

_____

Has your child had any serious illnesses or been hospitalized? If yes, please explain:

_____

_____

Ear/hearing problems?

_____

Eye/vision problems?

_____

Physical impairments?

_____

Do you have any concerns about your child's development? Please explain:

_____

_____

RELATIONSHIP WITH BCC EARLY CHILDHOOD CENTER

What are your expectations of BCC Early Childhood Center?

_____

_____

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Do you have any specific questions/concerns for us?

_____

_____

Please tell us anything else you would like us to know about your child and/or your family:

_____

_____