



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)

All forms must be submitted in person only and cannot be submitted electronically



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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](mailto: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

<b>Major:</b>	<b>Est. Graduation Year:</b>
<b>EMPLID:</b>	<b>Primary Language:</b>

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

<b>Child's Last Name</b>		<b>First Name</b>		<b>Middle Name</b>		<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Date of Birth</b> (Month/Day/Year) ____/____/____	
<b>Child's Address</b>				<b>Hispanic/Latino?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Race</b> (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____			
<b>City/Borough</b>		<b>State</b>	<b>Zip Code</b>	<b>School/Center/Camp Name</b>		<b>District Number</b> ____	<b>Phone Numbers</b> Home _____ Cell _____ Work _____	
<b>Health insurance</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (including Medicaid)? <input type="checkbox"/> No		<b>Parent/Guardian</b> Last Name <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Foster Parent		First Name		Email		

## TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

<b>Birth history</b> (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____		<b>Does the child/adolescent have a past or present medical history of the following?</b>					
<b>Allergies</b> <input type="checkbox"/> None <input type="checkbox"/> Epi pen prescribed  <input type="checkbox"/> Drugs (list) _____ <input type="checkbox"/> Foods (list) _____ <input type="checkbox"/> Other (list) _____		<input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability <b>Explain all checked items above.</b>			<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ <b>Attach MAF if in-school medications needed</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		

<b>PHYSICAL EXAM</b> Date of Exam: ____/____/____		<b>General Appearance:</b>					
Height _____ cm (____ %ile)		<input type="checkbox"/> Physical Exam WNL		NI Abnl		NI Abnl	
Weight _____ kg (____ %ile)		<input type="checkbox"/> Psychosocial Development		<input type="checkbox"/> HEENT		<input type="checkbox"/> Lymph nodes	
BMI _____ kg/m <sup>2</sup> (____ %ile)		<input type="checkbox"/> Language		<input type="checkbox"/> Dental		<input type="checkbox"/> Lungs	
Head Circumference (age ≤2 yrs) _____ cm (____ %ile)		<input type="checkbox"/> Behavioral		<input type="checkbox"/> Neck		<input type="checkbox"/> Cardiovascular	
Blood Pressure (age ≥3 yrs) _____ / _____		<input type="checkbox"/> Abdomen		<input type="checkbox"/> Genitourinary		<input type="checkbox"/> Extremities	
		<input type="checkbox"/> Skin		<input type="checkbox"/> Neurological		<input type="checkbox"/> Back/spine	
<b>Describe abnormalities:</b>							

<b>DEVELOPMENTAL</b> (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____		<b>Nutrition</b> < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred <b>Dietary Restrictions</b> <input type="checkbox"/> None <input type="checkbox"/> Yes (list below)		<b>Hearing</b> Date Done ____/____/____ Results < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 years: pure tone audiometry _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	
Describe Suspected Delay or Concern:		<b>SCREENING TESTS</b> Date Done Results <b>Blood Lead Level (BLL)</b> (required at age 1 yr and 2 yrs and for those at risk) _____ µg/dL <b>Lead Risk Assessment</b> (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk		<b>Vision</b> Date Done ____/____/____ Results <3 years: Vision appears: _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <b>Acuity (required for new entrants and children age 3-7 years)</b> Right _____/_____ Left _____/_____ <input type="checkbox"/> Unable to test	
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Hemoglobin or Hematocrit</b> _____ g/dL _____ %		<b>Dental</b> Visible Tooth Decay <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months <input type="checkbox"/> Yes <input type="checkbox"/> No	

CIR Number _____		Physician Confirmed History of Varicella Infection <input type="checkbox"/>		Report only positive immunity:	
<b>IMMUNIZATIONS - DATES</b>				IgG Titers	
DTP/DTaP/DT _____		Tdap _____		Hepatitis B _____	
Td _____		MMR _____		Measles _____	
Polio _____		Varicella _____		Mumps _____	
Hep B _____		Mening ACWY _____		Rubella _____	
Hib _____		Hep A _____		Varicella _____	
PCV _____		Rotavirus _____		Polio 1 _____	
Influenza _____		Mening B _____		Polio 2 _____	
HPV _____		Other _____		Polio 3 _____	

<b>ASSESSMENT</b> <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____		<b>RECOMMENDATIONS</b> <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ <b>Follow-up Needed</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ <b>Referral(s):</b> <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____			
--	--	---	--	--	--

Health Care Practitioner Signature _____		Date Form Completed ____/____/____		<b>DOHMH ONLY PRACTITIONER I.D.</b> _____	
Health Care Practitioner Name and Degree (print) _____		Practitioner License No. and State _____		<b>TYPE OF EXAM:</b> <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____	
Facility Name _____		National Provider Identifier (NPI) _____		Date Reviewed: ____/____/____ <b>I.D. NUMBER</b> _____	
Address _____		City _____ State _____ Zip _____		REVIEWER: _____	
Telephone _____		Fax _____		Email _____	
<b>FORM ID#</b> _____					



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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 repellent.
- This form should NOT be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

**Parent to Complete this section (#1 - #14)**

1. Child's first and last name:	2. Date of birth:		3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:		6. Route of administration:
<p>7A. Frequency to be administered, include times of day if appropriate:</p> <p><i>OR</i></p> <p>7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration):</p>			
<p>8A. Possible side effects:    <input type="checkbox"/> See product label for complete list of possible side effects (parent must supply)</p> <p><i>AND/OR</i></p> <p>8B: Additional side effects:</p>			



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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):**

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<b>12. Parent name (please print):</b>	<b>13. Date authorized:</b>
--	-----------------------------

---

**14. Parent signature:**  
 X

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

<b>15. Program name:</b>	<b>16. Facility ID number:</b>	<b>17. Program telephone number:</b>
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**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.**

<b>19. Staff's name (please print):</b>	<b>20. Date received from parent:</b>
---	---------------------------------------

---

**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)



**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.	_____ The center can give my baby solid foods when I tell them the baby is ready.
_____ I will bring breast milk or formula for my baby.	_____ 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:

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Child's Date of Birth:

---

Child's Gender:

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Parent's Name:

---

Phone Number:

---

Parent's Email Address:

---

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

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Who lives in your child's home?

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

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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?

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**YOUR CHILD'S TEMPERAMENT & EMOTIONS**

How would you describe your child?

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What makes your child upset?

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What soothes your child?

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

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Under what circumstances do they use it?

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**ROUTINES**

What is your child's diapering/toileting routine?

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Do you have any specific diapering/toileting instructions?

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**SLEEPING**

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

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

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Are they sleeping through the night?

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

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

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General mood upon awakening?

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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?

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

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

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What is your child's general attitude toward eating?

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Is your child eating solids and/or purees?

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Is your child self-feeding?

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Does your child have any food allergies or dietary restrictions?

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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:

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

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Ear/hearing problems?

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Eye/vision problems?

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Physical impairments?

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

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## **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?

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

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