12-48 months

Hostos Community College
Children's Center, Inc.

475 Grand Concourse, Room 109A
Bronx, NY 10451 718-518-4176

Thank you for your interest in the Children's Center! Your child is considered enrolled once all of the items below are received by the Children's Center, and space availability has been confirmed.

DOCUMENTS TO BE COMPLETED and SIGNED by PARENTS/GUARDIANS

□ Enrollment form

□ Childcare Schedule

□ Emergency & Escort Authorization

□ CUNY Media Release Form (Child)

□ Consent for Walks

□ Developmental Needs Form

□ Family Social Developmental History (12-48 months)

□ ASQ 3 and ASQ SE

□ Parent Handbook

□ Tuition Agreement form

□ Block grant application

DOCUMENTS TO BE COMPLETED and SIGNED by CHILD'S PHYSICIAN AND/OR PARENT

□ Consent for Emergency Medical Care

□ Consent for Non-Medication Form

□ Health and Dietary Information Form

□ Child & Adolescent Health Examination Form

□ Asthma Action Plan, completed and signed by doctor, if applicable

□ Allergy Action Plan, completed and signed by doctor, if applicable

□ Release of Medical Record Information

DOCUMENTS TO BE PROVIDED:

□ 2 Proofs of Income (pay stub, tax form, letter from employer)

□ Proof of Address (utility bill, Driver's License)

□ Copy of Birth Certificate

□ Proof of Immunizations

□ Copy of Gov't Photo ID (Driver's License, Passport, State I.D.)

□ Copy of College I.D.

□ Copy of student-parent class schedule

HOSTOS COMMUNITY COLLEGE CHILDREN'S CENTER, INC

475 GRAND CONCOURSE, RM 109A, BRONX, N.Y. 10451
TEL NO.: (718) 518-4176

2025/2026

ENROLLMENT FORM

PARENT/GUARDIAN INFORMATION DATE: _____ SEMESTER FOR CHILD CARE: _____

PARENT/GUARDIAN FIRST NAME: _____ LAST NAME: _____

HOSTOS COMMUNITY COLLEGE EMPLID: _____

ADDRESS: _____ APT: _____

CITY/STATE/ZIPCODE: _____

CELL PHONE: (____) _____- _____ HOME PHONE (____) _____- _____

PERSONAL EMAIL ADDRESS: _____ HOSTOS EMAIL ADDRESS: _____

RELATIONSHIP TO CHILD: MOTHER: ___ FATHER: ___ OTHER: _____

FAMILY COMPOSITION: SINGLE_____ MARRIED_____ OTHER_____

HOSTOS COMMUNITY COLLEGE MAJOR OF STUDY_____

EXPECTED GRADUATION DATE: _____

ARE YOU A CLIP STUDENT? □ YES □ NO
ARE YOU AN ASAP STUDENT? □ YES □ NO
ARE YOU A VETERAN? □ YES □ NO

CHILD INFORMATION
CHILD'S FIRST NAME: _____ CHILD'S LAST NAME: _____

CHILD'S DOB: _____ SEX: □ Male □ Female □ X

Below select the ethnicity and racial category for your child

Section I. Ethnic Category

	Hispanic of Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American; or other Spanish culture or origin, regardless of race.
	Not Hispanic of Latino

Section II. Racial Category

	American Indian or Alaskan Native - A person having origins in any of the original People of North or South America, who maintains tribal affiliations or community attachment (includes Aleuts and Eskimos)
	Asian - A person having origins in any of the original peoples of the Far East, Southeast Asia or the Indian subcontinent. This China, Japan, Korea, India, and the Philippine Islands.
	Black of African American – A person having origins in any of the black racial groups of Africa
	Native Hawaiian or other Pacific Islander - A person having origins in any of the original peoples of Hawaii, Guam, Samoa or other Pacific Islands.
	White - A person having origins in any of the original peoples of Europe, North Africa or the Middle East
	Two of more races - two or more of the above racial groups peoples

Primary Language Spoken at Home: _____

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

Hostos Community College
Children's Center, Inc.

CHILDCARE SCHEDULE
HOURS OF OPERATION: 7:45AM TO 5:00PM

WINTER 2025_____ SPRING 2025_____ SUMMER 2025 _____

PARENT/GUARDIAN NAME (FIRST AND LAST) _____

CHILD'S NAME_____

PLEASE CREATE YOUR CHILDCARE SCHEDULE BELOW. **CHILDREN MAY NOT ARRIVE LATER THAN 11:00AM.**

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TOTAL HOURS
From: To:	From: To:	From: To:	From: To:	From: To:	

PARENT/GUARDIAN SIGNATURE_____

DATE: _____

HOSTOS ADMINISTRATOR SIGNATURE: _____

HOSTOS COMMUNITY COLLEGE CHILDREN'S CENTER, INC.

475 GRAND CONCOURSE, RM 109A, BRONX, N.Y. 10451
TEL NO.: (718) 518-4176

Emergency & Escort Authorization 2025 - 2026

TODAY'S DATE: _____ **SEMESTER:** _____

PARENT'S /GUARDIAN'S NAME: _____ **CHILD'S NAME:** _____

The Emergency Consent and Escort Authorization is used in the event of an emergency when the parent/guardian cannot be reached. This form is extremely important because it grants all staff and administrators of Hostos Community College Children's Center, Inc. to release your child to and/or give information to the persons listed below. As a parent/guardian it is your responsibility to update this document as necessary. Only the individuals listed will be contacted in the event of an emergency involving your child, and they will be able to drop off and/or pick up your child. **The individuals must have a valid photo id and be at least 18 years of age. All parents/guardians must list at least three individuals.**

Name of Authorized Person: _____

Relationship to child: _____

Home Address: _____

Contact Info: Cell#:_____ Home#: _____

Work#:_____ E-mail:_____

Name of Authorized Person: _____

Relationship to child:_____

Home Address: _____

Contact Info: Cell#:_____ Home#: _____

Work#:_____ E-mail:_____

Name of Authorized Person: _____

Relationship to child:_____

Home Address: _____

Contact Info: Cell#:_____ Home#: _____

Work#:_____ E-mail:_____

I hereby grant permission to Hostos Community College Children's, Inc. and their designees to contact the aforementioned individuals in the event of an emergency. The aforementioned individuals are too allowed to drop off/pick up my child.

Parent/ Guardian Signature:_____ Date:_____

Office of Early Childhood Initiatives
16 Court Street
Brooklyn, NY 11241
Tel: (718) 254-7285 Tel: (646) 664-8833

Media Release Form (Child)

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 and/or film recordings, and/or audio recordings of my child while participating in activities of a CUNY child care 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 child care centers, in perpetuity, in CUNY publications and promotional materials, websites and social media sites, as well as in all other media and manners, whether now known or later developed. I waive any right to inspect and approve such uses. 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.

_____ _____
Printed Name of Parent/Legal Guardian Date

_____ _____
Signature Phone #

_____ _____ _____
Address City State/Zip

Hostos Community College
Children's Center, Inc.

475 Grand Concourse, Room 109A, Bronx, NY 10451
Telephone: (718) 518 – 4176

PARENTAL CONSENT for WALKS

I give permission for my child to participate in walks around the college with appropriate staff supervision.

PRINT PARENT'S NAME:_____

SIGN PARENT'S NAME:_____

CHILD'S NAME:_____

DATE:_____

1/7/2025

Hostos Community College
Children's Center, Inc.
475 Grand Concourse, Room 109A, Bronx, NY 10451
Telephone: (718) 518 – 4176

Developmental Needs

Date: _____

PARENT/GUARDIAN NAME _____
FIRST NAME *LAST NAME*

CHILD'S NAME _____
FIRST NAME *LAST NAME*

CHILD'S DATE OF BIRTH _____/_____/_____ SEX ☐ Male ☐ Female ☐ Other

1. Has your child ever been evaluated for services such as: Occupational Therapy, Speech & Language, Small Center Setting, etc.?

   Yes ☐ No ☐

   a. If yes, did they qualify for Services?

   Yes ☐ No ☐

   b. If so, did you accept or decline?

   Yes ☐ No ☐

2. Does your child have an individualized education plan (IEP-ages 3 and above) or individualized family service plan (IFSP- under age 3)?

   Yes ☐ No ☐

   If so, please provide us with a copy BEFORE enrollment.

   _____

   _____

3. Has your pediatrician ever expressed concern to you about your child's development?

   _____

   _____

4. Do you have any concerns regarding your child's development?

   If so, explain:

   _____

   _____

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FAMILY/SOCIAL/DEVELOPMENTAL HISTORY

COMPLETE IF YOUR CHILD IS 12 MONTHS TO 48 MONTHS OF AGE

Child's Name_____ Date:_____

Date of Birth_____

Parent #1/Guardian _____D.O.B: _____

Never married? _____ Married? ____ Living together? ____ How Long? _____

Separated? ___ How Long? _____ Divorced? ___ How Long? _____

Custody / visiting arrangements? Yes/No

Explain: _____

(Please provide supporting documents)

Are Birth Parent's married or living with another partner? Yes/No

Explain _____

Brothers and Sisters of Child:

Name_____ D.O.B. _____ Lives in home? _____

Name _____ D.O.B. _____ Lives in home? _____

Other persons living in the household (include relationship and age?)

_____

Who cares for child other than parents? _____

Health History:

How would you describe your child's overall health?

_____

What past illnesses has your child had and at what ages?

_____

What hospitalizations or serious accidents has your child had? _____

_____

Does your child have frequent colds? ____ Ear aches? _____ High fevers? _____ Stomach aches? _____ Other illnesses? _____

Social / Developmental History:

At what age did your child: Walk? _____ Talk in simple sentences? _____

Became Toilet Trained?_____ Dress self? _____

Speech:

Does your child express his/her self well? _____ If not, what difficulties is your child having with his/her speech? _____

What language(s) does your child speak? _____

Eating:

How is your child's appetite? Good _____ fair _____ poor _____ irregular _____

Food favorites? _____

Food dislikes? _____

Does child feed self? _____ Fork? _____ Spoon? _____

What if any dietary restrictions do your family have? _____

Food allergies? _____

Sleeping:

What time does your child go to bed? _____ Get up? _____

Where does your child sleep? In own room? _____ In room with? _____

In own bed? _____ In bed with? _____

Does your child sleep through the night? _____

Have bad dreams? _____

If yes, describe? _____

Toileting:

Does your child have toilet control? _____ If accidents, when and what kind?_____

Personality:

How would you describe your child's personality?

_____

How does your child act with adults? _____

With children? _____

What are your child's special interests? _____

What are your child's fears? _____

Discipline:

What method of discipline is used in your home? _____

What is your child's usual reaction? _____

In what area does your child have the most difficulty cooperating?

_____

What do you do to get your child to cooperate? _____

Play/ Activities:

What is your child's favorite: Indoor Play activities? _____

Outdoor Play activities? _____

Has your child had group play experience? _____ Where? _____

What does your child watch on TV? _____

How many hours a week? _____

What play activities does your child dislike? _____

Hostos Community College
Children's Center, Inc.

2025

PARENT HANDBOOK

CONTACT US: 718-518-4176

EMAIL US: PMARTINEZ@HOSTOS.CUNY.EDU

HOURS: 7:45am TO 5:00pm Monday-Friday

ADDRESS: 475 GRAND CONCOURSE, BRONX, NY 10451

A Building-Room 109

Revised 1/8/2025

INTRODUCTION

Welcome to the Hostos Community College Children's Center, Inc.! We first opened our doors almost 40 years ago and continue, today, to provide quality childcare and education in a developmentally appropriate learning environment. Our goal is to work with student-parents to help them become self-sufficient, to achieve their educational objectives, and to graduate, while their children participate in a safe, nurturing, educational program.

The Children's Center (the Center) is a campus-based, 501 (c) (3) non-profit organization. We are licensed by the New York City Department of Health & Mental Hygiene (DOHMH). We provide care for children aged 6 weeks to 5 years old.

OUR EDUCATIONAL PHILOSOPHY

Every child is unique and different. They each have different strengths and challenges. Our goal is to address and support the needs of every child, through differentiated instruction and hands-on implementation of the curriculum. The staff at the Children's Center acknowledge and embrace student diversity while implementing a student-centered approach to education. We strive to meet each child where they are; cognitively, developmentally, as well as socially and emotionally. The Center's focus is on active learning and we have high expectations for our students, staff, and families. Our ideal environment is safe, nurturing, stimulating, and engaging, which motivates children to learn.

CURRICULUM

At the Children's Center, we utilize the Creative Curriculum for Infants, Toddlers, Two's, and Preschoolers. The goal of the Creative Curriculum is to help children become independent, self-confident, inquisitive and enthusiastic learners by actively exploring their environment. Through a series of investigative studies on various themes; children deeply explore topics that build on a foundation in math, science, literacy, social studies and art. As students are immersed in each study, they will be exposed to diverse cultures, languages, family compositions, disabilities, and religions within the classroom. This will encourage empathy, understanding, and acceptance of

all differences, and will be exhibited through the transformation of centers/learning areas and student work.

The Creative Curriculum helps teachers interact with every child in ways that promote their overall development and learning, foster children's social competence, support children's learning through play, create rich environments for learning, and forge strong home-school connections.

We encourage parents to utilize the Curriculum's Family App so that they can continue their child's learning at home based on the studies the children are engaging with in the classroom. Teachers can distribute activities to parents in a digital format, which makes accessibility more convenient, which means parents can view curriculum activities from their phones!

A WORD ABOUT CULTURAL SENSITIVITY

Our teachers have attended training on how to integrate culturally sensitive and inquiry-based language strategies with inquiry tools in the early childhood classroom. Teachers aim to develop their interactions with children through intentional language strategies that consider children's lived experiences. Applying culturally responsive strategies and techniques in early childhood also fosters increased student engagement and participation in the classroom and enhances children's interest and sense of belonging in the classroom.

Quality teacher-student interactions that consider teachers' language and children's funds of knowledge promotes cognitive and language development through the early years.

HOURS OF OPERATION and SCHEDULE

The Center is open for childcare services from 7:45 AM to 5:00 PM, Monday through Friday. Your child can attend the Center based on the parents' class schedule and need for work-study, internships, study time, and clinicals/labs.

The Center follows the Hostos Community College Academic Calendar. The Children's Center is closed on all national holidays followed by Hostos Community College. Each month you will receive a Children's Center calendar which highlights important dates and events happening at the Center. The Center closes at 5:00PM. Please arrive by, or before 5:00PM for pick up. If you run into an emergency and are late, please call the front desk at 718-518-4176.

SCREEN POLICY (ELECTRONICS, TABLETS, COMPUTERS, TVS)

The Center's policy limits the use of screen time for children in that there can be no viewing of more than 30 minutes, once a week, of high-quality educational or movement-based commercial-free programming. Screen time is never used for children birth to age 2.

ADMISSION TO THE PROGRAM

Admission is based on the parent/legal guardian's enrollment in Hostos Community College. The Children's Center serves the children of enrolled, matriculated students and non-matriculated students in the college's Continuing Education Program. We also reserve 10% of our slots for children of faculty and staff, if available.

Hostos students interested in enrolling their children at the Center must complete an initial application. A representative from the Center will contact you to review the documents that must be submitted, and to complete the intake process. During the intake process, your fee will be calculated, and you will sign a tuition agreement.

REQUIRED DOCUMENTS

- Child & Adolescent Health Examination Form; NYC Department of Health & Mental Hygiene, (completed by Child's doctor; form must be less than one year old).
- Child's immunization record
- Copy of Child's Birth Certificate
- Current government issued Photo I.D. (i.e., driver's license, state ID, Green Card, permanent residency card).
- Proof of income (i.e., tax return, 4 weeks of pay stubs, letter from employer on letterhead)
- Copy of parent's class schedule
- ASQ/ASQ3

FEES*

Childcare fees are based on the number of weeks that your child attends. Schedule changes are permitted if there is an open spot available to accommodate the change. We do have a limited number of subsidized awards through the NYS Block Grant to assist with tuition, if you qualify. Eligibility is based on income and family size. If you do not qualify, then student fees for childcare are based on a sliding-fee scale. We also accept HRA Childcare Vouchers

During the enrollment process, our Program & Family Coordinator will work with you to determine your eligibility, and fees.

*Please note fees for faculty/staff are based on a sliding-fee scale.

PAYMENT

The Children's Center enrolls children throughout the year. A Children's Center staff person will provide you with an invoice for tuition payment. The transmittal is brought to the Bursar's Office, Basement, Savoy Building at 120 E 149th St., where payment is received by check or cash. The Children's Center does not accept payments.

EMERGENCY CONTACTS

Parents/guardians are required to complete an Emergency/Escort Authorization Form. The authorized contacts are only the people listed on the Form. All authorized escorts must be 18 years or older. It is important that you notify emergency escorts that they have been designated as an emergency resource. The Center will provide the public safety officer with a comprehensive list of allowed escorts.

If you would like to amend your emergency contacts/authorized escorts information, please see our Program & Family Coordinator or our Administrative Assistant at the front desk, who will assist you and ensure we record the change.

A NOTE ABOUT SEPARATION

Children sometimes have difficulty letting go of their parents at arrival. This is typical behavior which, over time, should decrease as they become more secure in their new environment. Here are a few suggestions to help ease separation:

- Allow adequate time at drop off for arrival adjustment before needing to leave for class.
- While traveling, talk to your child about the classroom, who will be there, etc. This prepares your child for what will occur. When you are rushed, children feel hurried and anxious.
- When you arrive, check your child's diapers and wash their hands. Also, help your child get "settled in" by becoming involved in play.
- Once your child is playing comfortably tell your child it is time for you to go. Please do not "sneak out." Children are establishing their sense of trust and need to see you go and see you return at the end of the day.
- Give hugs and kisses and reassure your child you will be back (e.g., after a snack).

If there is still protest or difficulty, the staff members and teachers are close by to help your child when you leave. Usually, children calm down and begin to play soon after you leave. Remember, even those children who are comfortable in play and in their environment need your attention, affection, and reassurance.

TRANSITIONS FOR CHILDREN

We prefer to have new children ease into the classroom routine. We recommend phasing in for the first three days, gradually lengthening the hours until attending for a full day. This helps your child become familiar with the environment and helps us get acquainted. Please speak to your classroom teacher about a phase-in schedule.

There are other times during the school year when children experience transitional periods. If your child attends the Center for a second year, then they will be transitioning to a new classroom with a new teacher. Before beginning their second year, we work with children to visit their new classroom, to meet their new teacher, and to process saying goodbye to their familiar surroundings, and friends, by reading relative stories and creating art projects.

We have also added to our team. Our staff includes a Mental Health Consultant who will work with children, teachers, families, and staff to ensure that transitions are successful, and that families are given the skills to adjust to new routines. The Children's Center is excited to partner with a community-based organization, Chances for Children, which offers parent-child therapy and parent-child groups and supports both child and parent through separation. These sessions are supportive of children and families who need a program model which provides families access to clinical services. Chances for Children utilizes one of our classrooms on Tuesdays from 9:00AM-5:00PM. At that time, their social worker is on site.

TRANISTION TO KINDERGARTEN FOR FOUR YEAR OLDS

If your child will be transitioning to kindergarten, we also work to help children understand they will be starting a new school, with new friends! We assist families by presenting workshops and tabling events dedicated to learning about the various kindergarten options in New York City, and how to navigate the application process.

CHANGING OF CLASSROOMS

Children stay enrolled in their assigned classrooms throughout the Academic Calendar. Children do not move to a higher aged room once they have a birthday. Early Childhood Best Practice is to not move a child during a calendar year. The Teachers in the room will adjust their lessons to meet the needs of every child where there are academically, so there may be a shift in their current classroom of developmentally appropriate practices to accommodate skill levels with differentiated instruction.

MOVING UP CEREMONIES

Each May, the Center celebrates all children's last day of school with a Center-wide moving up ceremony. Parents and friends are invited to acknowledge our oldest children who may be moving on to Kindergarten, and all other students that have successfully completed their time at the Center. We also acknowledge all student-parents that are graduating. Detailed information will be provided to families closer to that date.

ARRIVAL

Student-parents/guardians and authorized escorts should bring their child to the classroom for drop-off. The Children's Center utilizes the **Brightwheel app in order** to scan your child in and out of the Center. Once you are enrolled, you will receive an invitation to download the app onto your phone, or you may scan in on the Center's iPad at the reception desk. Additionally, staff will conduct a health and wellness check of your child as part of the arrival process. If your child arrives to school with any signs of minor injury (scratch, bump, bruise), the teacher will record that on the sign-in sheet, and you may be asked to sign a form indicating that you are aware of the injury that occurred outside of the classroom.

Student-parents/guardians should ensure their child arrives in unsoiled diapers or pull-ups. When your child arrives, please check their diaper/change/clean and wash hands for the child before signing in the child in your child's classroom. Lastly, please stop at the sink to wash your hands when entering the classroom, and after a diaper change.

Student-parents/guardians are required to inform the Center staff if a child was given medication prior to arrival. Disclosing the medication, the child was given will help ensure the child is treated appropriately in an emergency situation.

A NOTE ABOUT LATE DROP-OFF

We ask that you arrive at your regularly scheduled time. That is the time you agreed to arrive by during your enrollment into the Center. We understand that occasionally you may be late. Please know that we cannot accept children past 11:00AM. At 11:00, children in the classroom are getting ready for lunch and nap and have concluded several educational portions of their day.

PICK-UP

Children are picked up from the child's respective classroom. **Please be on time**. It is very important for children to have predictability, and to take comfort in knowing they will be picked up along with everyone else. All student-parents/guardians must scan out through Brightwheel at the time of pick up

FOOD POLICY

At this time, we are **not** providing meals for children. Breakfast, lunch, and snack are provided by the student-parent/guardian. Our Food Service Coordinator will prepare and serve each child's food. To promote healthy eating, please send in fresh fruit, vegetables, protein, grains, or grain substitute, and 100% fruit juice. NO COOKIES, CAKES, CANDY, OR POTATO CHIPS. Please do not send in food that contains bones. Please do not send in whole grapes, popcorn, or any other item that is larger than your child's airway.

Please be sure to label all food containers with your child's name. Please note we are a **NUT-FREE AND SEAFOOD-FREE ENVIRONMENT. Do not send in any food items containing nuts or fish/shellfish.** Occasionally, we may require that an additional food item not be allowed into the Center. That decision is made based on our enrolled children's medical needs. You will be informed it we have to limit an additional food category.

You can always speak to our on- site nurse if you have any questions relating to your child's nutrition.

BIRTHDAY POLICY

We celebrate birthdays once per month. Due to food allergies, we do not permit sending any birthday food items or special snacks. Candy and chewing gum are not allowed as they are potential choking hazards for young children. If you are sending in party bags, please do not send in small toys that are choking hazards.

CLOTHING AND SUPPLIES

Please make sure your child has two complete changes of clothing at the Center at all times. If soiled clothes are sent home, please be sure to replace them the next day. If your child wears diapers or pulls ups, please make sure to send in those supplies as well on a regular basis. Open-toed shoes are not permitted for children's safety.

SHEETS:

All children must have two cot sized sheets for their daily rest period. Sheets are a NYC Department of Health & Mental Hygiene regulation. We will send sheets home every Friday to be washed and returned on Monday. The Center has a supply of sheets, should you forget your child's sheet.

ABSENCE/LATENESS

Please call (718-518-4176) or message us on Brightwheel if your child is going to be absent or late. Please note that if you are receiving Block Grant funding for your tuition,

there are specific absence guidelines about the number of days your child can be absent. These guidelines were explained during your enrollment process. If you would like to learn the absence guidelines again, please contact our Program & Family Coordinator.

SICK POLICY

If your child is not well and you are concerned about their condition worsening, please keep your child at home. They should be symptom free for 24 hours without assistance from over-the-counter medications before returning to the Center. Please notify the Center immediately when your child's absence is due to illness.

In the event that your child becomes ill while at the Center, you will be notified immediately (for example, fever, diarrhea, rash, vomiting). If illness prevents your child from participating in scheduled classroom activities, the Center expects a parent/guardian to pick up the child and to take them home. In order to return to school, your child should be symptom free for 24 hours without assistance from over-the-counter medication. If your child is absent 3 days in a row due to illness, you will be asked to provide us with a medical clearance letter from a Healthcare Provider noting the date the child is safe to return to school.

MEDICATION

If necessary, The Children's Center will administer basic first aid such as wound care and cold compresses. The Center is also trained to administer Emergency Medication, i.e., inhalers and epi-pens. Additionally, two of our staff are MAT certified (Medical Administration Training) and can administer over-the-counter medications, and prescription medications. We must have a ***Medication Consent Form*** **signed by your doctor on file for your child** if you authorize us to administer prescription medications. This form is only valid for 6 months, unless otherwise specified by your child's healthcare provider. The nurse will notify you of when an updated form is needed. The nurse will also notify the parent of any expired medications, which will then be returned to the parent for safe disposal. A record of medication administration will be recorded on our medicine log. A ***NON-Medication Consent Form*** should also be signed in order for us to administer any over the counter creams, lotions, and/or non-prescription medication.

All medication brought to school by parents must be: non-expired, labeled with child's name and date of birth. Medication will be stored in your child's classroom in a locked, medicine cabinet.

INCIDENTS AND ACCIDENTS

The Center strives to maintain a safe environment for all our children and staff. If a child sustains an injury during the school day the following procedure is in place:

1. The Children's Center staff will administer first aid immediately.
2. The parent or legal guardian will be contacted via phone and/or the Brightwheel app.
3. More serious injuries will require that the College's Public Safety Office be notified, and more qualified assistance summoned.
4. If an injured or sick child must go to the hospital with paramedics, a Children's Center staff member will travel with the child if the parent cannot be reached.

Please note that the Children's Center cannot assume responsibility for accidents or situations that stem directly from false information provided at the time of enrollment. The Center will not be responsible for any changes or updates in a child's medical status that has not been officially communicated to the Center by the parent or guardian in writing.

You will be provided with a copy of a completed incident/accident report for your records. The Center will maintain the original report in your child's file.

PARENT TEACHER CONFERENCES

Conferences are held 2 times per year, once in the Fall, and once in the Spring. Parent/Teacher conferences provide opportunities for parents and teachers to discuss the child's growth, development, and progress. Parents are encouraged to be active partners in their child's educational lives. Assessments and Portfolios are also shared at this time.

ASSESSMENT

Best practices and policies in early childhood care and education requires that our program has in place a child observation and assessment system that includes the collection, and protection of assessment results, and the sharing of that information with families. Student assessment enables instructors to measure the effectiveness of their teaching by linking student performance to specific learning objectives. As a result, teachers can implement effective teaching choices and revise ineffective ones in their practices.

The program documents the Developmental / Social Emotional status of each child within 45 days of entering / starting the program using a child developmental screening tool. This tool is called the ASQ and the ASQ-SE. This screening assesses each child for basic developmental and social emotional levels to help define individual learning goals and identify any potential special needs. Copies of the screening and assessments for each child are kept completely confidential and will be a part of each child's private record. Parents complete this tool, with the support of their child's

teacher, or our mental health consultant, and then they are scored by our Mental Health Consultant. Results of the screenings or concerns are shared individually with parents.

Teachers also collect data on children's cognitive, developmental, social / emotional, and academic skills by using an assessment tool called Teaching Strategies Gold – Checkpoints. The results of these assessments will be shared with parents during Parent / Teacher Conferences. This information is also kept completely confidential and is a part of each child's private record.

CHILDREN WITH SPECIAL NEEDS/EVALUATION PROCESS

If your child has support services in place, or you are interested in having your child evaluated, it is very important to please discuss this information with our enrollment coordinator, and our Mental Health Consultant, at the time you are completing your enrollment process. Our enrollment coordinator will then inform our Mental Health Consultant, who will be the main person to assist you through the evaluation process.

The Children's Center accepts children working with NYC's Early Intervention program for children under the age of 3, and the Department of Education's Committee on Preschool Education for children 3 and 4 years old, **as long as** we are able to meet the needs of the child as outlined in their individual education plans. Related services can be held by outside providers at the Children's Center. Copies of the evaluation, IEP/ IFSP must be reviewed by us PRIOR to the child's start date.

Our teachers will implement appropriate modifications and provide support so that children identified with special needs are able to be fully included in the program's activities. For children, whose needs might be greater than a regular childcare center can provide, we will work with the family to find the most suitable educational arrangement, by providing referrals and outreach on your behalf.

WORKSHOPS AND REFERRALS FOR PARENTS

As part of our partnership with parents and community organizations, the Children's Center regularly offers and hosts family workshops and events. Examples of past workshops include Managing Asthma and EpiPen Injector, Nutrition and Health, How to Manage your Finances, Understanding the Early-Intervention Process, etc. Information and details will be provided on the monthly calendar. We are also available to provide you with Campus resources and referrals offered by the department of Student Development and Enrollment Management.

OPPORTUNITIES FOR PARENT PARTICIPATION

The program provides regular opportunities for parents/guardians/families to participate in program level decisions, through the formation of our Parent Committee,

and also through the Center's By-laws which mandates that one student parent be a voting member of the Board of Directors.

At the beginning of the Fall semester, each classroom identifies a class parent. Class parents then invite other parents to join the committee and to convene as the Parent Committee to meet regularly in order to be involved with planning of special events, activities, and to make recommendation for the improvement of the program. Class

UPDATE TO CHILD/PARENT INFORMATION

All changes of information must be reported to a Children's Center administrator. Student-parents/legal guardians are responsible for updating all information, i.e., address, telephone numbers, escort lists, email address, orders of protection, emergency contacts, class schedules, internships, etc. If you have a change in schedule that will have an impact on your weekly or monthly fee, you must bring this to the attention of our Program & Family Coordinator.

END OF THE YEAR PARENT SURVEY

The Children's Center values our parents' input and opinions regarding your overall experience at the Children's Center. In May of each year, you will receive a brief, electronic survey for your completion. The results are reviewed by administration and teaching staff, and used for program improvement.

MANDATED REPORTING

All staff members of the Children's Center are considered Mandated Reporters. Therefore, the Center staff is required by law to report any suspicions of child abuse or neglect to the New York State Child Abuse Central Registry.

The Children's Center Lost Child Protocol

Daily attendance is taken when children arrive at school.

Parents will check-in their child through a software application which is on an iPad kiosk at the Center's front desk. Parents may also check-in their child on their cell phones. The Center has the ability to run a daily attendance list of present children.

The Center's Administrative Assistant will telephone, or message parents that have not yet arrived at their scheduled arrival time.

Teachers record attendance, manually, in real time, as children arrive, in classroom attendance records books.

At departure time, parents will check-out their child through the software application which is on an iPad kiosk at the Center's front desk. They may also check-out on their cell phones.

Teachers will sign off on the classroom's daily health check at each child's departure time.

Ratios

The Center employs a master schedule for all teaching and administrative staff, which includes lunch breaks, meeting times, and prep time, which is distributed Center-wide, and updated regularly.

Staff to child ratios are maintained from the arrival of the first child at the start of the day to the departure of the last child at the end of the day.

Ratios are maintained during nap according to the guidelines outlined in Article 47.

Ratios are maintained during outdoor play and the use of bathroom facilities.

Teachers and staff are trained in the beginning of the school term and throughout the school term as a refresher training.

Special Events

The Center does not participate in class trips. Children may attend on campus events located in the College.

Parental approval is required for children to participate in events.

Teachers and staff are informed of the event details via email notification from the Director.

Roles are assigned to staff.

Attendance taken prior to start of activity through name to face recognition.

Periodic monitoring and retaking of attendance through name to face recognition.

Children are paired in a buddy system.

Prior to departure from the Center, and after arrival at a destination, name to face recognition count is conducted and attendance is taken.

Prior to returning to the Center, and after arrival at the Center, name to face recognition count is conducted and attendance is taken.

If departing the Center, teaching staff are responsible to bring along with them: first aid kit, class roster, list of emergency contacts, cell phones, and daily attendance record.

Periodic monitoring and retaking of attendance through name to face recognition.

Increased supervision rates are implemented to ensure that the child/teacher ratio is above the allowable ratio. Additional staff such as floaters, Assistant, Parent, and/or Administrators are utilized to accompany classroom teachers.

Lost Child Procedures

In the event a child cannot be accounted for:

Assemble the children in a secure place under teacher supervision.

Notify the Director immediately.

Notify the Office of Public Safety immediately.

Institute a systematic search of both indoor and outdoor areas.

Maintain communication with staff and Director via phone and in person.

Notify the Department of Health and Mental Hygiene within 24 hours.

Incident documented by Director within 24 hours to the NYC Department of Health & Mental Hygiene and the NYS Central Registry for Child Abuse and Maltreatment.

Established instructions for the reporting of missing children:

Reports of missing children will be submitted immediately to the Police Department, the NYC Department of Health & Mental Hygiene, the NYS Central Registry for Child Abuse and Maltreatment, and the Office of Public Safety at Hostos Community College. Reports will be made by the Director, or the Senior Education Director of the Center.

Parents and/or Guardians of the missing child will be notified immediately by telephone and the Center's Brightwheel application.

Procedures for initiating and carrying out the search for the missing child:

Staff that are not needed to maintain ratio in classrooms will conduct the search, at the time of the incident, and will include the Director, the Senior Education Director, Program & Family Coordinator, and the Administrative Assistant.

The staff identified above will be joined by Hostos Community College Office of Public Safety Officers.

Remaining groups will be asked to stay in place at the Center under teacher supervision, until the close of business.

The Center does not utilize public transportation. Trips are contained to Hostos Community College Campus locations that do not include exiting the building of the Children's Center location.

Search area parameters will be based on the location at which child went missing, and will include all floors of the building location, and will continue until the child is located.

Search parties will communicate via cell phones, radios, and land lines, as necessary.

The Office of Public Safety will determine when it is necessary to include emergency services personnel beyond the Hostos Community College Office of Public Safety in a search.

FIRE/EMERGENCY EVACUATION POLICIES FOR ALL CLASSROOMS

All staff must be familiar with all emergency exits and the evacuation route for each area within The Hostos Children's Center and surrounding exits throughout Hostos Community College in the A-Building.

Parents, if you arrive during the time that a fire-drill/emergency evacuation is in progress, please stay with your child, and do not enter the Center.

- All staff have a responsibility to account for, supervise, evacuate, and ensure the safety of children during emergency situations.
-
- Use the nearest and safest exit, stairwell/pathways to leave the building immediately, do **NOT** use elevators in emergency situations.

- Do not return until it is declared safe to do so by a Fire Department Official/Public Safety and/or the Director of the Hostos Children's Center.

- Our emergency meeting location is the M Building / Academic Advisement Center – 429 Grand Concourse.

- In all emergency situations please call Public Safety immediately at 718-518-6888 and provide the dispatcher with any and all information available to ensure a prompt response.

Thank you for participating in our programs and we are excited about working with you to guide you and your child along a pathway to learning! Always reach out to me if you have any questions or concerns.

Catherine Garcia-Bou, Director

ADMINISTRATIVE STAFF

Director	Catherine Garcia-Bou	cgarciabou@hostos.cuny.edu
Senior Education Director	Monique van Putten	mvanputten@hostos.cuny.edu
Administrative Assistant	Elias Advincola	eadvincola@hostos.cuny.edu
Family & Program Coordinator	Paulina Martinez	pmartinez@hostos.cuny.edu
Mental Health Consultant	Cassie Elliot	celliot@hostos.cuny.edu
Registered Nurse	Xyannie De La Rosa	xdelarosa@hostos.cuny.edu

INFANT/TODDLER ADDENDUM TO PARENT HANDBOOK

INTRODUCTION

Hello parents and guardians and welcome to our newest program for infants and toddlers at the Hostos Community College Children's Center! We are now licensed by the NYC Department of Health & Mental Hygiene to allow programming for children ages 6 weeks through 24 months old. Our infant room can accommodate 8 babies, and our 12-month-old to 24-month-old rooms can accommodate 10 toddlers each. Each room is staffed with a Lead Teacher and an Assistant Teacher. A floater works between both classrooms every day.

PROGRAM INFORMATION

This addendum is attached to the Children's Center Parent Handbook which provides a comprehensive overview of all information regarding day-to-day policies and procedures for all ages. Additional program information, specific to infants and toddlers, is below.

FOOD POLICY

At this time, we are not providing formula or food for infants and toddlers. All bottles and food items should be prepared at home and sent in a clearly marked bottle and/or container/sippy cup. These items will go home at the end of the day for return the following day. Each classroom has a refrigerator to store milk, formula, and food. If

your child is allergic to any foods, that information should be clearly identified on your child's physical. You should also notify Paulina Martinez, our Program & Family Coordinator. If you have a food preference for your child, you should notify us as well, and we will do our best to not have that item available.

DAILY SUPPLIES

Please send your child with the following items:

Diapers
Formula
Cereal (if child is eating)
Baby Food or Toddler Food
Wipes
Bottles, sippy cups, preferred bowl, or spoon
Pacifier
2 changes of clothing
2 Crib Sheets or cot sheet
1 Blanket (no blankets for infants)
Bibs

*Teachers will remind you if your supplies are running low, but please check to make sure the above items are always in your child's cubby.

THE CHILD PROJECT (Climate of Healthy Interaction for Learning and Development)

The Children's Center has partnered with the Robin Hood Foundation to implement the Child Project in our Infant/Toddler Classrooms. CUNY has secured funding through the Robin Hood Foundation to allow teachers at the Children's Center to be coached and participate in the CHILD project voluntarily. Their participation will involve monthly coaching along the framework of the Climate of Healthy Interaction for Learning and Development (CHILD) to build their practice to support the social and emotional environments and climate of early childhood classrooms. The mental health climate is rooted in relationships and experiences. We use the CHILD Toolkit to build a climate that supports both children and adults by encouraging healthy positive interactions.

PHYSICAL WELL BEING AND HEALTH

Infants need freedom of movement to build strength and motor skills. Our program provides infants and toddlers daily opportunities to move freely under adult supervision to explore both indoor and outdoor environments, including tummy time when awake. It is important to keep families informed of their child's daily routines. The program will communicate with parents of infants through daily written reports on our parent-friendly communication, app – Brightwheel. You will receive, and /or will be able to, access daily reports about care-giving routines, such as feeding, sleeping, diapering/toileting. Please read Brightwheel messages daily.

BREASTFEEDING

The Children's Center supports breastfeeding for children. There are proven health benefits and development advantages associated with breastfeeding. We have a quiet, private space available in the Center to all parents. Please see a staff member if you are interested in using this space. The program is certified in the Child and Adult Food Program's Breastfeeding Friendly Certificate.

The Center recognizes that breastfeeding is the ideal method of feeding and nurturing infants, providing many health benefits to both infant and mother. We encourage and support families who choose to breastfeed their infants and strive to protect their ability to continue providing breast milk while their infant is in our care. We promote a philosophy that advocates breastfeeding as the normal feeding process and are committed to helping families have a successful experience.

I have read the Hostos Community College Children's Center, Inc. Parent Handbook, which summarizes each of the center's policies. I agree to the terms, I understand that this handbook is subject to change and I will be given an updated copy.

Child's Name (PRINT)_____

Student-Parent/Legal Guardian (PRINT)_____

Student-Parent/Legal Guardian (SIGNATURE)_____

Date:_____

Updated 8/22/2024

Hostos Community College Children's Center, Inc.

475 Grand Concourses, Room 109-A, Bronx, New York 10451, Tel: (718) 518-4176
2024-2025

DATE:_____ **SEMESTER:**_____

PARENT'S/GUARDIAN'S NAME:_____ **CHILD'S NAME:**_____

STUDENT-PARENT TUITION CONTRACT

(Subject to change if there is a change in the amount of time your child attends)

The Hostos Community College Children's Center, Inc. has available funding for income eligible students to cover a percentage, or all, of childcare tuition. If you are not eligible, tuition is based on a sliding fee scale.

Tuition policies/Payment Policies

- Tuition is charged based on the number of weeks per academic semester and schedule for which you register. Increases in amount of time your child utilizes the Center may result in an increase in fees in which case a new tuition agreement must be completed.

- If it is determined that you are eligible for Block Grant Funding, all tuition payments are required, whether your child is present or absent. You will sign a separate contract for the Block Grant.

- If your child is absent for two consecutive weeks and you have not been in communication with us,
- we will withdraw your child from the program. You will be responsible for tuition from the time your child was registered through the last week your child was present.

- Withdrawal: Should you decide to withdraw your child, you must complete a withdrawal form. You will be responsible for paying tuition for the time your child was registered in the Center through the last week your child was present.

- Tuition is not charged for College-observed holidays, absence due to illness, or closings for inclement weather.

- An invoice will be provided to you when tuition is due. Payments can only be made at the Bursar's Office, D Building. The Bursar only accepts cash and checks. Payments may not be made at the Children's Center.

- CLIP Student's tuition is $15.00 weekly.

Childcare Rates, Fee and Payment Terms

Start date: _____ End date: _____ Fee $ _____ x # Of weeks:
Other: $_____ Total Due: _____

Payment Plan: __ One Installment ___Two Installments ___Three Installments ___Four Installments

1st Installment due date: _____ Amount: $_____ 3rd Installment due date: _____ Amount: $_____

2nd Installment due date: _____ Amount: $_____ 4th Installment due date: _____ Amount: $_____

Statement

1. **I understand that I am expected to meet my financial responsibility and to make payments on time. I understand if I do not pay on time, a late payment fee will be applied. Only a Hostos Children's Center administrator can change any installment due dates.**

2. **I reviewed the tuition policies and procedures with a Hostos Children's Center Administrator and received a signed copied of the document. I agree to abide with the policies and regulations outlined in the contract.**

3. **I understand that if a change to my schedule results in my child attending the Center for more hours, then a revised tuition contract must be signed. If a change to my schedule results in my child attending the Center for less hours, than this contract states, then my rate will be automatically adjusted.**

Parent/Guardian name (print):_____

Signature:_____ Date:_____

Hostos Administrator (signature):_____ Date:_____

Hostos Community College Children's Center, Inc.

475 Grand Concourses, Room 109-A, Bronx, New York 10451, Tel: (718) 518-4176

2025 – 2026 HOSTOS CAMPUS STAFF TUITION CONTRACT

DATE:_____ **SEMESTER:**_____

PARENT'S/GUARDIAN'S NAME:_____ **CHILD'S NAME:**_____

COSTS

The tuition of the Hostos Community College Children's Center, Inc. is based on a sliding fee scale for faculty and staff. Please speak with our Program & Family Coordinator to understand how your fee is calculated, based on income.

Tuition policies/payment policies

- Hostos children's Center charges tuition for childcare based on the number of weeks and the schedule for which you register. A schedule can adjust the childcare tuition; therefore, a schedule change form must be completed. Increases in time are permitted if an open slot is available.
- If your child misses 2 consecutive weeks of childcare and you have not been in communication with the Hostos Children's Center about the absences, Hostos Children's Center will withdraw your child from the program. You will responsible for paying tuition for the time your child was registered in the center through the last week your child was present.
- Should you decide to withdraw your child, you must complete a withdrawal form. You will be responsible for paying tuition for the time your child was registered in the center through the last week your child was present.
- Hostos Children's Center does not charge tuition for College-observed holidays, absence due to illness, or inclement weather days. If your child needs to be absent for an extended period of time for an emergency or hardship circumstances, please communicate with an administrator to adjust the tuition.

Payment Method

- Payments are due monthly on the last business day of the month. You will receive an invoice via the Brightwheel app.
- Payments are to be made at the Bursar's Office (cash or money orders only). Please provide the Center with proof of payment from the Bursar.

Childcare Rates, Fee and Payment Terms

Childcare tuition

Start date: _____ End date: _____ Fee $ _____ X # Of weeks.
Other: $_____ Total Due: _____

Payment Plan: __ One Installment ___Two Installments ___Three Installments ___Four Installments

1st Installment due date: _____ Amount: $_____ 3rd Installment due date: _____ Amount: $_____

2nd Installment due date: _____ Amount: $_____ 4th Installment due date: _____ Amount: $_____

Statement

1. I understand I'm expected to meet my financial responsibility and make payments on time. Only a Hostos Children's Center administrator can change installment due dates.
2. I reviewed the Hostos Children's Center the tuition policies and procedures with a Hostos Children's Center administrator, and received a signed copied of the document. By signing contract, **I agree to abide with the policies and regulations outlined in the contract.**

Parent/Guardian name (print):_____

Signature:_____ Date:_____

Hostos Administrator (signature):_____ Date:_____

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Children's Center, Inc.

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Telephone: (718) 518 – 4176

NEW YORK STATE CHILD CARE DEVELOPMENT BLOCK GRANT (CCDBG)

Annually, Hostos Community College Children's Center, Inc. is awarded the NYS Child Care and Development Block Grant. These funds are used to subsidize childcare tuition; eligibility is based on family size and income guidelines.

To be considered for the CCDBG, the following requirements must be met:

- Verification of Income.
- All semester fees and outstanding tuition must be up to date.
- Grant application must be on file.

You will be responsible for the childcare fee that you will pay based on the grant's family size and income guidelines. Failure to pay this fee may result in withdrawal from the program.

Absences:

The grant only allows:

- 12 "routine" absences within a 3-month period.
- 8 additional absences under "extenuating circumstances".

Definition of "Extenuating Circumstances"

- Need for the child or the child's caretaker to appear in court or keep other appointments related to the provision of preventive, foster care, adoption or child protection services, or other needs set for in the child's service plan.
- Need for the child and or student parent to receive medical care and/or routine medical treatment.
- The child's caretaker is participating in an approved education or training program and the child's absence coincides with the temporary suspension of such programs for purposes of including but not limited to, holidays, school conferences and snow days.

Supporting documentation must be presented to explain absences under extenuating circumstances.

Our Program & Family Coordinator is available to assist you with the completion of the CCDBD application if necessary. Please call 718-518-4209.

1/2025

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INSTRUCTIONS FOR COMPLETING THE APPLICATION FOR CHILD CARE ASSISTANCE

SECTION 1: APPLICANT INFORMATION

- Print your legal name, including, first name, middle initial and last name; home telephone number, and the full address where you currently live.
- MAILING ADDRESS: Complete if your mailing address is different from your residence.

FORMER MAILING ADDRESS: If you have moved in the last year, enter your previous address.

- OTHER PHONE NUMBERS: Enter the phone numbers where you can be reached.

SECTION 2: HOUSEHOLD MEMBERS INFORMATION

- List the names of everyone who lives with you.
- PRINT your full name first. Then PRINT the names of the other people who live with you.
- PRINT the date of birth and sex for each person applying. Those considered applying are: the child (or children) in need of care, their parents (including a stepparent) and siblings under the age of 18 who are in the household.
- You may, but do not have to list social security numbers. Social security numbers may be used by federal, state, and local agencies to prevent duplication of services and fraud, and for federal reporting.
- Check Yes or No to tell us with child needs Child Care Assistance.
- For each person in the household, PRINT how they are related to you (for example: wife, son, friend, etc.)
- Check Yes or No to indicate if each person applying is Hispanic or Latino, or not.
- Enter Y (YES) or N (N) for each of the race/ethnic codes. Race/Ethnic codes: I- Native American or Alaskan Native, A – Asian, B – Black or African American, P- Native Hawaiian or Pacific Islander, W – White.
- Note: This information is required by the Federal government; but is for statistical purposes only.
- List any aliases or maiden names of you or anyone in your household.
- For anyone in the household under the age of 21, you must list the individual's name and the absent parent's name and address.

SECTION 3: INCOME INFORMATION

Answer all the questions in this section.

SECTION 4: LEGAL STATEMENTS

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Children's Center, Inc.

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- Read this section carefully or have someone read it to you. You must complete and sign this written certification of citizenship for the children in need of Child Care Assistance.
- Sign your name. If you have filled out the application for someone else, sign your name. Date the application. If your spouse lives with you, both of you must sign the application.

CONSENT TO WITHDRAW

If you decide you no longer wish to apply for Child Care Assistance, sign your name and enter date. You may reapply at any time.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

APPLICATION FOR CHILD CARE ASSISTANCE

ATTENTION: This application is used to apply ONLY for Category 2 or 3 Child Care Assistance. To apply for Public Assistance or other benefits, including Category 1 Child Care Assistance, you must use the *New York State Application for Certain Benefits and Services* (**LDSS-2921**).

CASE NAME	CASE #	REGISTRY #	OFFICE	UNIT	WORKER	APP DATE / /

DISTRICT:	CASE TYPE: 40	Services Transaction Type: ☐ New Open ☐ Reopen ☐ Recert.	Disposition: ☐ Denial Reason Code				☐ Withdrawal

SECTION 1. APPLICANT'S INFORMATION

FIRST NAME	M.I.	LAST NAME (Please include any ALIASES or MAIDEN names in parentheses.)		PHONE NUMBER ( ) -	

STREET ADDRESS	APT NO.	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APT NO.	CITY	STATE	ZIP CODE

FORMER ADDRESS (IN PAST YEAR)	OTHER PHONE NUMBERS WHERE YOU CAN BE REACHED

Marital status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary language? ☐ English ☐ Spanish ☐ Other (specify) **Email (optional):**

SECTION 2. LIST EVERYBODY WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU. *LIST YOURSELF ON THE FIRST LINE.*

LN	First Name, Middle Initial, Last Name (Please include any ALIASES or MAIDEN names in parentheses)	DATE OF BIRTH (MM-DD-YY)	SEX (M/F)	RELATIONSHIP TO YOU	Gender Identity *Optional:* Male, Female, Non-Binary, X, Transgender, Different Identity [Please describe]	SOCIAL SECURITY NUMBER (SSN) *Optional*	Enter Y (Yes) or N (No) if Hispanic or Latinx (Optional) H	Enter Y (Yes) or N (No) for each Race*(Optional) I	A	B	P	W	Does this child need child care? (Y/N)	FOR EACH CHILD in need of child care, answer Yes/No: Child is U.S. Citizen/National or Has Satisfactory Immigration Status?	Does child have special needs?	Do both parents reside in the home?
1				SELF												
2																
3																
4																
5																
6																
7																
8																

* **Racial Affiliation Codes: I** – Native American or Alaskan Native, **A** – Asian, **B** – Black or African American, **P** – Native Hawaiian or Pacific Islander, **W** – White

You may use additional pages if you need more room or there is other information that you think we might need.

SECTION 3. OTHER HOUSEHOLD INFORMATION

DO ANY OF THESE APPLY TO YOU OR YOUR SPOUSE/THE OTHER PARENT IF THEY LIVE IN THE HOME? For each of the following, answer YES or NO:		
	☐ YES ☐ NO	Need child care to **work**.
	☐ YES ☐ NO	Need child care for **another reason**. Give reason:
	☐ YES ☐ NO	**Homeless** (no fixed, regular, and adequate place to stay at night).
	☐ YES ☐ NO	A parent is on active duty (serving full-time) in the **U.S. Military.**
	☐ YES ☐ NO	A parent is a member of a **National Guard or Military Reserve unit**.
	☐ YES ☐ NO	Receiving or applying for **Public Assistance** through a different application.
	☐ YES ☐ NO	Receiving or applying for **other child care funding.** Agency Name:
	☐ YES ☐ NO	**Pregnant.** Due date: / /

SECTION 4. ABSENT PARENT INFORMATION. *List children in need of child care whose parent does not live in the household.*

NAMES OF CHILDREN UNDER 19	ABSENT PARENT'S NAME AND ADDRESS	Is absent parent available to provide care?	If No provide reason.
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

SECTION 5. APPLICANT'S EMPLOYMENT INFORMATION

EMPLOYER'S NAME		WORK PHONE ( ) -	START DATE OF JOB / /
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

Does the job have rotating or variable shifts? ☐ YES ☐ NO Does the job require overtime (O/T)? ☐ YES ☐ NO

Hourly Wage: $	What is a typical work schedule?	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO

SECTION 6. OTHER EMPLOYMENT INFORMATION. *Use this section for an applicant's second job or a spouse's/other parent's job (if they live in the home).*

Whose job information (check one)? ☐ Applicant's job ☐ Spouse's job ☐ Other Parent's job

EMPLOYER'S NAME		WORK PHONE ( ) -	START DATE OF JOB / /
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

Does the job have rotating or variable shifts? ☐ YES ☐ NO Does the job require overtime (O/T)? ☐ YES ☐ NO

Hourly Wage: $	What is a typical work schedule?	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO

SECTION 7. INCOME INFORMATION

Indicate if you or anyone who is applying with you receives money from:	YES	NO	WHO?	GROSS AMOUNT	PERIOD (week, month, etc.)	WHO?	GROSS AMOUNT	PERIOD (week, month, etc.)
Income from work (including wages/salary, overtime, commissions, training programs, tips)	☐	☐						
Net Self-Employment Income	☐	☐						
Child Support Payments (received)	☐	☐						
Alimony/Spousal Support (received)	☐	☐						
Unemployment Insurance Benefits, Workers' Comp	☐	☐						
Social Security Benefits (including SSI)	☐	☐						
Disability Benefits (NYS, VA, Private)	☐	☐						
Rental/Boarder/Lodger Income (received)	☐	☐						
Dividends/Interest - Stocks, Bonds, Savings	☐	☐						
Pensions/Annuities	☐	☐						
Public Assistance (PA) Grant, Safety Net Benefits	☐	☐						
Other (Please specify.)	☐	☐						

SECTION 8. TRAVEL TIME BETWEEN CHILD CARE PROVIDER AND WORK/EDUCATIONAL/OTHER APPROVED ACTIVITY.

DROP-OFF	**Travel time from the child care provider to work/activity?**		**Public Transportation?** ☐ YES ☐ NO
PICKUP	**Travel time from work/activity to the child care provider?**		**Public Transportation?** ☐ YES ☐ NO

SECTION 9. CHILD CARE PROVIDER INFORMATION

PROVIDER NAME AND ADDRESS	NAMES OF CHILDREN	ALREADY ENROLLED?	
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No

SECTION 10. CHILD'S SCHOOL INFORMATION. *List all children enrolled in school*

SCHOOL NAME AND ADDRESS	NAMES OF CHILDREN	ATTENDANCE HOURS	
		START TIME	END TIME

SECTION 11. NOTICES. READ THE IMPORTANT CERTIFICATIONS AND CONSENTS BELOW.

CHANGE REPORTING – I understand that by signing this application form I agree to inform the agency **immediately** of any change in my needs, income, living arrangement, or address to the best of my knowledge or belief. I agree to inform the agency immediately of any change in child care arrangements, including where child care is provided, who is providing care, provider's fees, and hours for which child care is needed.

JURISDICTION – I understand that if I move out of the originating district that authorized my Child Care Assistance eligibility, the information about myself, my child(ren), and any other persons residing in my household, may be disclosed to any local district I move to within New York State. By signing this application, I authorize the release of the information in my child care case file to the new district that I move to, for my continued eligibility.

PENALTIES – Federal and state laws provide for penalties, including fines, imprisonment, or both if you do not tell the truth when you apply for Child Care Assistance or when you are questioned about your eligibility, or if you cause someone else not to tell the truth regarding your application or continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial or continuing eligibility for Child Care Assistance; or if you conceal or fail to disclose facts that would affect the right of someone, for whom you have applied, to obtain or continue to receive Child Care Assistance. If you are the authorized representative applying on behalf of someone else, Child Care Assistance must be used for that person and not yourself. It is unlawful to obtain Child Care Assistance by concealing information or providing false information.

CITIZENSHIP – By signing this application, I swear and/or affirm that all the children needing Child Care Assistance are United States citizens or nationals, or persons with satisfactory immigration status. I understand that this information will only be shared to make decisions about the Child Care Assistance Program, and that the United States Citizenship and Immigration Services may be contacted if more information is needed to verify the children's status.

CONSENT FOR INVESTIGATION – I understand that by signing this application form, I agree to cooperate fully with any investigation to verify or confirm the information I have given or any other investigation in connection with my request for Child Care Assistance. I will provide additional information if it is requested.

RESOURCES – I certify that my family resources do not exceed $1,000,000. Resources include, but are not limited to, cash, bank accounts, real estate, stocks, bonds, mutual funds, IRAs, 401(k) accounts, life insurance, trust accounts, annuities, burial funds/spaces.

NON-DISCRIMINATION – This application will be considered without regard to race, color, sex, gender identity, sexual orientation, disability, religious creed, national origin, political belief, or any other factors prohibited by law.

SECTION 12. CERTIFICATION AND SIGNATURE

CERTIFICATION: I swear and/or affirm under the penalties of perjury that all of the information I have given or will give to the local social services district relating to Child Care Assistance is correct. I have read and understand the notices above. I understand and agree to the consents.

APPLICANT'S/REPRESENTATIVE'S SIGNATURE	DATE SIGNED	SECOND APPLICANT'S/REPRESENTATIVE'S SIGNATURE	DATE SIGNED
X	/ /	X	/ /
PRINT NAME:		**PRINT NAME:**	

RETURN YOUR APPLICATION TO:
THE LOCAL SOCIAL SERVICES DISTRICT (LSSD)
OF THE COUNTY THAT YOU LIVE IN.

FOR AGENCY USE ONLY:

CASE NAME	CASE #	REGISTRY #	VERSION #	REUSE INDICATOR ☐	DISTRICT: CASE TYPE: 40	DATE / /

SERVICES TRANS TYPE: ☐ New Open ☐ Reopen ☐ Recert.	Disposition: ☐ Denial	Reason Code			☐ Withdrawal

ELIGIBILITY DETERMINED BY	DATE / /	ELIGIBILITY APPROVED BY	DATE / /

CHILD CARE AUTHORIZATION FROM DATE / /	CHILD CARE AUTHORIZATION TO DATE / /	COMMENTS:

L1 CIN:	L4 CIN:	L7 CIN:
L2 CIN:	L5 CIN:	L8 CIN:
	L6 CIN:	L9 CIN:

NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

- ☐ **YES** If you checked **YES**, please complete the **VOTER REGISTRATION APPLICATION** below
- ☐ **NO** because I choose not to register *OR*
- ☐ I am already registered at my current address *OR*
- ☐ I asked for and received a mail registration form

If you do not check any box, you will be considered to have decided not to register to vote at this time.

Signature _____ Date ___/___/___

Please Print Name _____

Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料：若您有興趣索取中文資料表格，請電： 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদিআপনিএইফর্মটিইংরেজীতেপেতেচানতাহলে 1-800-367-8683 নম্বরে ফোন করুন

VOTER REGISTRATION APPLICATION (instructions on back)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1	**Are you a U.S. citizen?** ☐ YES ☐ NO If you answered **NO**, do not complete this form	2	**A) Will you be 18 years old on or before election day?** ☐ YES ☐ NO **B) Are you at least 16 years of age and understand that you must be 18years of age on or before election day to vote, and that until you will be 18 years of age at the time of such election your registration will be marked "pending" and you will be unable to cast a ballot in any election?** ☐ YES ☐ NO If you answered **NO** to both of the prior questions, you cannot register to vote.	**For Board Use Only**
3	Last Name	First Name	Middle Initial	Suffix
4	Address where you live (do not give P.O. box)	Apt. No.	City/Town/Village	Zip Code / County
5	Address where you get your mail (if different than above)	P.O. Box, Star Route, etc.	Post Office	Zip Code
6	Date of Birth	7 Gender (optional)	8 Telephone (optional)	Email (optional)
10	The last year you voted / In county/state	Your address was (give house number, street and city) / Under the name (if different from your name now)	9	**ID Number** (Check the applicable box and provide your number) ☐ New York State DMV number ---------- ☐ Last four digits of your Social Security number ---------- ☐ I do not have a New York State DMV or Social Security number

11 Political Party

I wish to enroll in a political party

- ☐ Democratic party
- ☐ Republican party
- ☐ Conservative party
- ☐ Working Families party
- ☐ Other_____

I do not wish to enroll in any political party and wish to be an independent voter

- ☐ No party

12 Affidavit: I swear or affirm that

- I am a citizen of the United States.
- I will have lived in the county, city or village for at least 30 days before the election.
- I will meet all requirements to register to vote in New York State.
- This is my signature or mark on the line below.
- The above information is true, I understand that if it is not true, I can be convicted and fined up to $5,000 and/or jailed for up to four years.

Signature or Mark in ink _____ Date ___/___/___

(Optional) Register to donate your organs and tissues

Last Name		
First Name	Middle Initial	Suffix
Address		
Apt Number / City/Town/Village		Zip Code
Birth Date	Gender ☐ M ☐ F	
Eye Color	Height Ft. In.	
Email	DMV or ID NYC Number	

By signing below, you certify that you are:

- 16 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to NYS Donate Life Registry for enrollment;
- And authorizing the Registry to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and others approved by the NYS Commissioner of Health hospitals upon your death.

DONATE LIFE New York State

Signature _____ Date ___/___/___

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since youlast voted;
- enroll in a political party or change your enrollment;
- pre-register to vote if you are 16 or 17 years of age.

To Register You Must:

- be a U.S. citizen;
- be 18 years old (you may pre-register at 16 or 17 but cannot vote until youare 18);
- be a resident of the County, or of the City of New York at least 30 daysbefore an election;
- not be in prison for a felony conviction;
- not claim the right to vote elsewhere; and
- not found to be incompetent by a court.

Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections 40
North Pearl St, Suite 5
Albany, NY 12207-2729
Telephone: 1-800-469-6872;
TDD/TTY users contact the
New York State Relay at 711;
or visit our web site - **www.elections.ny.gov**

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/ or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Verifying your identity

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver IDnumber), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may includea copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a politicalparty, a voter must enroll in that political party, unless state party rules allow otherwise.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

APPLICATION FOR CHILD CARE ASSISTANCE

ATTENTION: This application is used to apply ONLY for Category 2 or 3 Child Care Assistance. To apply for Public Assistance or other benefits, including Category 1 Child Care Assistance, you must use the *New York State Application for Certain Benefits and Services* (**LDSS-2921**).

CASE NAME	CASE #	REGISTRY #	OFFICE	UNIT	WORKER	APP DATE / /

DISTRICT:	CASE TYPE: 40	Services Transaction Type: ☐ New Open ☐ Reopen ☐ Recert.	Disposition: ☐ Denial Reason Code	☐ Withdrawal

SECTION 1. APPLICANT'S INFORMATION

FIRST NAME	M.I.	LAST NAME (Please include any ALIASES or MAIDEN names in parentheses.)		PHONE NUMBER ( ) -

STREET ADDRESS	APT NO.	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	APT NO.	CITY	STATE	ZIP CODE

FORMER ADDRESS (IN PAST YEAR)	OTHER PHONE NUMBERS WHERE YOU CAN BE REACHED

Marital status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary language? ☐ English ☐ Spanish ☐ Other (specify)

Email (optional):

SECTION 2. LIST EVERYBODY WHO LIVES WITH YOU, EVEN IF THEY ARE NOT APPLYING WITH YOU. *LIST YOURSELF ON THE FIRST LINE.*

LN	First Name, Middle Initial, Last Name (Please include any ALIASES or MAIDEN names in parentheses)	DATE OF BIRTH (MM-DD-YY)	SEX (M/F)	RELATIONSHIP TO YOU	Gender Identity *Optional:* Male, Female, Non-Binary, X, Transgender, Different Identity [Please describe]	SOCIAL SECURITY NUMBER (SSN) *Optional*	Enter Y (Yes) or N (No) if Hispanic or Latinx (Optional) H	Enter Y (Yes) or N (No) for each Race*(Optional) I	A	B	P	W	Does this child need child care? (Y/N)	FOR EACH CHILD in need of child care, answer Yes/No: Child is U.S. Citizen/National or Has Satisfactory Immigration Status?	Does child have special needs?	Do both parents reside in the home?
1				SELF												
2																
3																
4																
5																
6																
7																
8																

* **Racial Affiliation Codes: I** – Native American or Alaskan Native, **A** – Asian, **B** – Black or African American, **P** – Native Hawaiian or Pacific Islander, **W** – White

You may use additional pages if you need more room or there is other information that you think we might need.

SECTION 3. OTHER HOUSEHOLD INFORMATION

DO ANY OF THESE APPLY TO YOU OR YOUR SPOUSE/THE OTHER PARENT IF THEY LIVE IN THE HOME? For each of the following, answer YES or NO:		
	☐ YES ☐ NO	Need child care to **work.**
	☐ YES ☐ NO	Need child care for **another reason**. Give reason:
	☐ YES ☐ NO	**Homeless** (no fixed, regular, and adequate place to stay at night).
	☐ YES ☐ NO	A parent is on active duty (serving full-time) in the **U.S. Military.**
	☐ YES ☐ NO	A parent is a member of a **National Guard or Military Reserve unit**.
	☐ YES ☐ NO	Receiving or applying for **Public Assistance** through a different application.
	☐ YES ☐ NO	Receiving or applying for **other child care funding.** Agency Name:
	☐ YES ☐ NO	**Pregnant.** Due date: / /

SECTION 4. ABSENT PARENT INFORMATION. *List children in need of child care whose parent does not live in the household.*

NAMES OF CHILDREN UNDER 19	ABSENT PARENT'S NAME AND ADDRESS	Is absent parent available to provide care?	If No provide reason.
		☐ Yes ☐ No	
		☐ Yes ☐ No	
		☐ Yes ☐ No	

SECTION 5. APPLICANT'S EMPLOYMENT INFORMATION

EMPLOYER'S NAME		WORK PHONE ( ) -	START DATE OF JOB / /
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

Does the job have rotating or variable shifts? ☐ YES ☐ NO Does the job require overtime (O/T)? ☐ YES ☐ NO

Hourly Wage: $	What is a typical work schedule?	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO

SECTION 6. OTHER EMPLOYMENT INFORMATION. *Use this section for an applicant's second job or a spouse's/other parent's job (if they live in the home).*

Whose job information (check one)? ☐ Applicant's job ☐ Spouse's job ☐ Other Parent's job

EMPLOYER'S NAME		WORK PHONE ( ) -	START DATE OF JOB / /
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

Does the job have rotating or variable shifts? ☐ YES ☐ NO Does the job require overtime (O/T)? ☐ YES ☐ NO

Hourly Wage: $	What is a typical work schedule?	SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO	FROM	TO

SECTION 7. INCOME INFORMATION

Indicate if you or anyone who is applying with you receives money from:	YES	NO	WHO?	GROSS AMOUNT	PERIOD (week, month, etc.)	WHO?	GROSS AMOUNT	PERIOD (week, month, etc.)
Income from work (including wages/salary, overtime, commissions, training programs, tips)	☐	☐						
Net Self-Employment Income	☐	☐						
Child Support Payments (received)	☐	☐						
Alimony/Spousal Support (received)	☐	☐						
Unemployment Insurance Benefits, Workers' Comp	☐	☐						
Social Security Benefits (including SSI)	☐	☐						
Disability Benefits (NYS, VA, Private)	☐	☐						
Rental/Boarder/Lodger Income (received)	☐	☐						
Dividends/Interest - Stocks, Bonds, Savings	☐	☐						
Pensions/Annuities	☐	☐						
Public Assistance (PA) Grant, Safety Net Benefits	☐	☐						
Other (Please specify.)	☐	☐						

SECTION 8. TRAVEL TIME BETWEEN CHILD CARE PROVIDER AND WORK/EDUCATIONAL/OTHER APPROVED ACTIVITY.

DROP-OFF	**Travel time from the child care provider to work/activity?**		**Public Transportation?** ☐ YES ☐ NO
PICKUP	**Travel time from work/activity to the child care provider?**		**Public Transportation?** ☐ YES ☐ NO

SECTION 9. CHILD CARE PROVIDER INFORMATION

PROVIDER NAME AND ADDRESS	NAMES OF CHILDREN	ALREADY ENROLLED?	
		☐ Yes	☐ No
		☐ Yes	☐ No
		☐ Yes	☐ No

SECTION 10. CHILD'S SCHOOL INFORMATION. *List all children enrolled in school*

SCHOOL NAME AND ADDRESS	NAMES OF CHILDREN	ATTENDANCE HOURS	
		START TIME	END TIME

SECTION 11. NOTICES. READ THE IMPORTANT CERTIFICATIONS AND CONSENTS BELOW.

CHANGE REPORTING – I understand that by signing this application form I agree to inform the agency **immediately** of any change in my needs, income, living arrangement, or address to the best of my knowledge or belief. I agree to inform the agency immediately of any change in child care arrangements, including where child care is provided, who is providing care, provider's fees, and hours for which child care is needed.

JURISDICTION – I understand that if I move out of the originating district that authorized my Child Care Assistance eligibility, the information about myself, my child(ren), and any other persons residing in my household, may be disclosed to any local district I move to within New York State. By signing this application, I authorize the release of the information in my child care case file to the new district that I move to, for my continued eligibility.

PENALTIES – Federal and state laws provide for penalties, including fines, imprisonment, or both if you do not tell the truth when you apply for Child Care Assistance or when you are questioned about your eligibility, or if you cause someone else not to tell the truth regarding your application or continuing eligibility. Penalties also apply if you conceal or fail to disclose facts regarding your initial or continuing eligibility for Child Care Assistance; or if you conceal or fail to disclose facts that would affect the right of someone, for whom you have applied, to obtain or continue to receive Child Care Assistance. If you are the authorized representative applying on behalf of someone else, Child Care Assistance must be used for that person and not yourself. It is unlawful to obtain Child Care Assistance by concealing information or providing false information.

CITIZENSHIP – By signing this application, I swear and/or affirm that all the children needing Child Care Assistance are United States citizens or nationals, or persons with satisfactory immigration status. I understand that this information will only be shared to make decisions about the Child Care Assistance Program, and that the United States Citizenship and Immigration Services may be contacted if more information is needed to verify the children's status.

CONSENT FOR INVESTIGATION – I understand that by signing this application form, I agree to cooperate fully with any investigation to verify or confirm the information I have given or any other investigation in connection with my request for Child Care Assistance. I will provide additional information if it is requested.

RESOURCES – I certify that my family resources do not exceed $1,000,000. Resources include, but are not limited to, cash, bank accounts, real estate, stocks, bonds, mutual funds, IRAs, 401(k) accounts, life insurance, trust accounts, annuities, burial funds/spaces.

NON-DISCRIMINATION – This application will be considered without regard to race, color, sex, gender identity, sexual orientation, disability, religious creed, national origin, political belief, or any other factors prohibited by law.

SECTION 12. CERTIFICATION AND SIGNATURE

CERTIFICATION: I swear and/or affirm under the penalties of perjury that all of the information I have given or will give to the local social services district relating to Child Care Assistance is correct. I have read and understand the notices above. I understand and agree to the consents.

APPLICANT'S/REPRESENTATIVE'S SIGNATURE	DATE SIGNED	SECOND APPLICANT'S/REPRESENTATIVE'S SIGNATURE	DATE SIGNED
X	/ /	X	/ /
PRINT NAME:		PRINT NAME:	

RETURN YOUR APPLICATION TO:
THE LOCAL SOCIAL SERVICES DISTRICT (LSSD)
OF THE COUNTY THAT YOU LIVE IN.

FOR AGENCY USE ONLY:

CASE NAME	CASE #	REGISTRY #	VERSION #	REUSE INDICATOR ☐	DISTRICT: CASE TYPE: 40	DATE / /

SERVICES TRANS TYPE: ☐ New Open ☐ Reopen ☐ Recert.	Disposition: ☐ Denial	Reason Code				☐ Withdrawal

ELIGIBILITY DETERMINED BY	DATE / /	ELIGIBILITY APPROVED BY	DATE / /

CHILD CARE AUTHORIZATION FROM DATE / /	CHILD CARE AUTHORIZATION TO DATE / /	COMMENTS:

L1 CIN:	L4 CIN:	L7 CIN:
L2 CIN:	L5 CIN:	L8 CIN:
	L6 CIN:	L9 CIN:

NYS Agency-Based Voter Registration Form

"If you are not registered to vote where you live now, would you like to apply to register here today?"

- ☐ **YES** If you checked **YES**, please complete the **VOTER REGISTRATION APPLICATION** below
- ☐ **NO** because I choose not to register *OR*
- ☐ I am already registered at my current address *OR*
- ☐ I asked for and received a mail registration form

If you do not check any box, you will be considered to have decided not to register to vote at this time.

Signature _____ Date / /

Please Print Name _____

Important!

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private.

Información en español: si le interesa obtener este formulario en español, llame al 1-800-367-8683

中文資料: 若您有興趣索取中文資料表格, 請電: 1-800-367-8683

한국어: 한국어 한국어 양식을 원하시면 1-800-367-8683 으로 전화 하십시오.

যদিআপনিএইফর্মটিইংরেজীতেপেতেচানতাহলে 1-800-367-8683 নম্বরে ফোন করুন

VOTER REGISTRATION APPLICATION (instructions on back)

☐ Yes, I need an application for an Absentee Ballot **Please print or type in blue or black ink** ☐ Yes, I would like to be an Election Day worker

1	**Are you a U.S. citizen?** ☐ YES ☐ NO If you answered **NO**, do not complete this form	2	**A) Will you be 18 years old on or before election day?** ☐ YES ☐ NO **B) Are you at least 16 years of age and understand that you must be 18years of age on or before election day to vote, and that until you will be 18 years of age at the time of such election your registration will be marked "pending" and you will be unable to cast a ballot in any election?** ☐ YES ☐ NO If you answered **NO** to both of the prior questions, you cannot register to vote.	**For Board Use Only**
3	Last Name	First Name	Middle Initial	Suffix
4	Address where you live (do not give P.O. box)	Apt. No.	City/Town/Village	Zip Code / County
5	Address where you get your mail (if different than above)	P.O. Box, Star Route, etc.	Post Office	Zip Code
6	Date of Birth	7 Gender (optional)	8 Telephone (optional)	Email (optional)
10	The last year you voted / In county/state	Your address was (give house number, street and city) / Under the name (if different from your name now)	9	**ID Number** (Check the applicable box and provide your number) ☐ New York State DMV number ---------- ☐ Last four digits of your Social Security number ---------- ☐ I do not have a New York State DMV or Social Security number
11	**Political Party** I wish to enroll in a political party ☐ Democratic party ☐ Republican party ☐ Conservative party ☐ Working Families party ☐ Other_____ I do not wish to enroll in any political party and wish to be an independent voter ☐ No party		12	**Affidavit: I swear or affirm that** • I am a citizen of the United States. • I will have lived in the county, city or village for at least 30 days before the election. • I will meet all requirements to register to vote in New York State. • This is my signature or mark on the line below. • The above information is true, I understand that if it is not true, I can be convicted and fined up to $5,000 and/or jailed for up to four years. Signature or Mark in ink _____ Date / /

(Optional) Register to donate your organs and tissues

Last Name		
First Name	Middle Initial	Suffix
Address		
Apt Number	City/Town/Village	Zip Code
Birth Date	Gender ☐ M ☐ F	
Eye Color	Height Ft. In.	
Email	DMV or ID NYC Number	

By signing below, you certify that you are:

- 16 years of age or older
- Consent to donate all of your organs and tissues for transplantation, research, or both;
- Authorizing the Board of Elections to provide your name and identifying information to NYS Donate Life Registry for enrollment;
- And authorizing the Registry to allow access to this information to federally regulated organ procurement organizations and NYS-licensed tissue and eye banks and others approved by the NYS Commissioner of Health hospitals upon your death.

DONATE LIFE New York State

Signature _____ Date / /

Qualifications for Registration

You Can Use This Form To:

- register to vote in New York State;
- change your name and/or address, if there is a change since you last voted;
- enroll in a political party or change your enrollment;
- pre-register to vote if you are 16 or 17 years of age.

To Register You Must:

- be a U.S. citizen;
- be 18 years old (you may pre-register at 16 or 17 but cannot vote until you are 18);
- be a resident of the County, or of the City of New York at least 30 days before an election;
- not be in prison for a felony conviction;
- not claim the right to vote elsewhere; and
- not found to be incompetent by a court.

Important!

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with:

NYS Board of Elections 40
North Pearl St, Suite 5
Albany, NY 12207-2729
Telephone: 1-800-469-6872;
TDD/TTY users contact the
New York State Relay at 711;
or visit our web site - **www.elections.ny.gov**

Your decision to register will remain confidential and will be used only for voter registration purposes. Anyone not choosing to register to vote and/ or information regarding the office to which the application was submitted will remain confidential, to be used only for voter registration purposes.

Verifying your identity

We will try to check your identity before Election Day, through the DMV number (driver's license number or non-driver ID number), or the last four digits of your social security number, which you will fill in Box 9.

If you do not have a DMV or Social Security number, you may use a valid photo ID, a current utility bill, bank statement, paycheck, government check or some other government document that shows your name and address. You may include a copy of one of those types of ID with this form.

If we are unable to verify your identity before Election Day, you will be asked for ID when you vote for the first time.

To complete this form:

It is a crime to procure a false registration or to furnish false information to the Board of Elections.

Box 9: You must make one selection. For questions refer to Verifying your identity above.

Box 10: If you have never voted before, write "None". If you can't remember when you last voted, put a question mark (?). If you voted before under a different name, put down that name. If not, write "Same".

Box 11: Check one box only. Political party enrollment is optional but that, in order to vote in a primary election of a political party, a voter must enroll in that political party, unless state party rules allow otherwise.

Hostos Community College
Children's Center, Inc.
475 Grand Concourse, Bronx, NY 10451
718-518-4175

CONSENT FOR EMERGENCY MEDICAL CARE

Child's Name	Date of Birth

I am the parent or legal guardian of the above-named child. My child is enrolled at Hostos Community College Children's Center.

By signing this form, I authorize the 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 the New York City Department of Health is now requiring center-based child care 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).

(3) 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 the Authorization and Release, then the Center will follow my child's individual health care plan.

I hereby release and forever discharge Hostos Community College Children's Center, Hostos Community College, The City University of New York, The Research Foundation of the City University of New York, New York State, and New York City, and the directors, officers, employees and agents of each of them from any 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 THIS AUTHORIZATION AND RELEASE AND UNDERSTAND IT, AND I AM SIGNING IT VOLUNTARILY

Parent or Legal Guardian's Name (PRINT)	
Signature	Date

OCFS-6010 (5/2015)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect 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)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: _____

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

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

HEALTH DIETARY, & SPECIAL NEEDS FORM

475 GRAND CONCOURSE, RM 109A, BRONX, N.Y. 10451 TEL NO.: (718) 518-4176

PARENT/GUARDIAN NAME _____
FIRST NAME *LAST NAME*

CHILD'S NAME _____
FIRST NAME *LAST NAME*

CHILD'S DATE OF BIRTH ____/____/____ **SEX** ☐ Male ☐ Female

My child has a **MEDICAL CONDITION DIAGNOSED** such as Asthma, Congenital Heart Defect, Seizures, Diabetes, Sickle Cell Disease etc: ☐ No, my child has no medical conditions ☐ Yes, my child has the following conditions:

_____

My child has a **ROUTINE MEDICATION PRESCRIBED BY A DOCTOR SCHEDULED** during school hours 7 am-5 pm:
☐ No, my child has no routine medication
☐ Yes, my child takes the following routine medication(s): _____

_____

My child has an **EMERGENCY MEDICATION PRESCRIBED BY A DOCTOR** such as an Epi-Pen injector, Albuterol rescue inhaler, Diphenhydramine (Benadryl) etc: ☐ No, my child has no emergency medications
☐ Yes, my child takes the following medication(s): _____

_____

My child has a known allergic reaction to **FOOD**: ☐ No, my child has no known FOOD allergies:
☐ Yes, my child has allergic reactions to the following FOOD items: _____

_____

My child follows a **SPECIAL DIET** related to a medical condition, or personal preference such as dairy free, gluten free, no pork: ☐ No, my child has no limits to their diet ☐ Yes, my child has the following dietary restrictions:

_____

My child has allergic reactions to insect bites: ☐ No ☐ Yes *(please explain):* _____

_____

My child has allergic reactions to materials/fabrics/environmental allergens such as metal, latex, pollen, dust:
☐ No ☐ Yes *(please explain):* _____

_____

My child has allergic reactions to topicals such as soap, lotion, cream:
☐ No ☐ Yes *(please explain):* _____

_____

By signing below, I attest I have answered all questions truthfully. I understand it is my responsibility to immediately inform The Hostos Community College Children's Center, Inc. of any changes in my child's health, dietary, and/or special needs.

PARENT/GUARDIAN NAME _____

PARENT/GUARDIAN SIGNATURE _____

DATE _____

OFFICE USE ONLY: _____ *Date Received* _____ *Date Transferred* _____ *Initials*

NYC Health — Department of Health and Mental Hygiene | Department of Education | CHILD & ADOLESCENT HEALTH EXAMINATION FORM (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	District Number ___	Phone Numbers Home ______

Health insurance (including Medicaid)? ☐ Yes ☐ No	☐ Parent/Guardian ☐ Foster Parent Last Name	First Name	Email	Cell ______ Work ______

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 ☐ Seizure disorder
☐ Behavioral/mental health disorder ☐ Speech, hearing, or visual impairment
☐ Congenital or acquired heart disorder ☐ Tuberculosis *(latent infection or disease)*
☐ Developmental/learning problem ☐ Hospitalization
☐ Diabetes *(attach MAF)* ☐ Surgery
☐ Orthopedic injury/disability ☐ Other (specify) ______
Explain all checked items above. ☐ ***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

NI Abnl	NI Abnl	NI Abnl	NI Abnl	NI 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 *(at each well child exam, 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	___/___/___	☐NI ☐Abnl ☐Referred
OAE	___/___/___	☐NI ☐Abnl ☐Referred
≥ 4 yrs: pure tone audiometry	___/___/___	☐NI ☐Abnl ☐Referred

Vision	*Date Done*	*Results*
<3 years: Vision appears:	___/___/___	☐ NI ☐ 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 ___/___/___	DOHMH ONLY — PRACTITIONER I.D. ☐☐☐☐☐☐

Health Care Practitioner Name and Degree *(print)*	Practitioner License No. and State	**TYPE OF EXAM:** ☐ NAE Current ☐ NAE Prior Year(s) *Comments:*
Facility Name	National Provider Identifier (NPI)	
Address / City / State / Zip		Date Reviewed: ___/___/___ I.D. NUMBER ☐☐☐☐☐☐ REVIEWER:
Telephone / Fax / Email		**FORM ID#** ☐☐☐☐☐☐☐☐☐☐☐

Asthma Action Plan

[To be completed by Health Care Provider]

Medical Record #:	Updated On:

Name _____ Date of Birth _____

Address _____ Emergency Contact/Phone _____

Health Care Provider Name _____ Phone _____ Fax _____

Asthma Severity: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

Asthma Triggers: ☐Colds ☐Exercise ☐Animals ☐Dust ☐Smoke ☐Food ☐Weather ☐Other

If Feeling Well (Green Zone) — Take Every Day Long-Term Control Medicines

You have all of these:
- Breathing is good
- No cough or wheeze
- Can work / play
- Sleeps all night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

5-15 minutes before exercise use this medicine

If Not Feeling Well (Yellow Zone) — Take Every Day Medicines and Add these Quick-Relief Medicines

You have any of these:
- Cough
- Wheeze
- Tight chest
- Coughing at night

Peak flow in this area:
_____ to _____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

Call doctor if these medicines are used more than two days a week.

If Feeling Very Sick (Red Zone) — Take These Medicines and Get help from a Doctor NOW!

Your asthma is getting worse fast:
- Medicine is not helping
- Breathing is hard and fast
- Nose opens wide
- Can't walk or talk well
- Ribs show

Peak flow reading below:
_____

MEDICINE:	HOW MUCH:	WHEN TO TAKE IT:

SEEK EMERGENCY CARE or CALL 911 NOW if: Lips are blush. Getting worse fast. Hard to breathe. Can't talk or cry because of hard breathing or has passed out.

Make an appointment with your primary care provider within two days of an ER visit or hospitalization

Health Care Provider Signature _____ Date _____

Patient/Guardian Signature [I have read and understood these instructions] _____ Date _____

NYC Health
New York City Department of Health and Mental Hygiene
Michael R. Bloomberg, Mayor
Thomas.R Frieden, M.D., M.P.H., Commissioner
nyc.gov/health

New York City Asthma Initiative
Adapted from Finger Lakes Asthma Action Plan and NHLBI
Revised 06/04

WHITE - PATIENT COPY
YELLOW - SCHOOL/DAY CARE COPY
PINK - PROVIDER COPY

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

Instructions:

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

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

My child is reactive to the following allergens:

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

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

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

Date of Plan: / /

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

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

MEDICATION/DOSES

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

ADMINISTRATION AND SAFETY INFORMATION FOR EPINEPHRINE AUTO-INJECTORS

When administering an epinephrine auto-injector follow these guidelines:

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

STORAGE OF EPINEPHRINE AUTO-INJECTORS

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

MAT/EMAT CERTIFIED PROGRAMS ONLY

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

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

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

STORAGE OF INHALERS, ANTIHISTAMINES, BRONCHODILATOR

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

Explain here:

STRATEGIES TO REDUCE THE RISK OF EXPOSURE TO ALLERGIC TRIGGERS

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

Document plan here:

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

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

HOSTOS COMMUNITY COLLEGE CHILDREN'S CENTER INC.
475 GRAND CONCOURSE, ROOM A-109
BRONX, NY 10451
TEL: (718) 518 – 4176

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

PARENT/GUARDIAN NAME _____
FIRST NAME *LAST NAME*

CHILD'S NAME _____
FIRST NAME *LAST NAME*

CHILD'S DATE OF BIRTH ____/____/____

HOME ADDRESS _____
STREET

_____
CITY *STATE* *ZIP CODE*

TELEPHONE _____ **EMAIL** _____

The above listed parent authorizes the following child care facility to make record disclosures:

HOSTOS COMMUNITY COLLEGE CHILDREN'S CENTER INC.
475 GRAND CONCOURSE, ROOM A-109
BRONX, NY 10451
TEL: (718) 518 – 4176

RELEASE TO _____
NAME OF PERSON OR ORGANIZATION

ADDRESS _____
STREET

_____
CITY *STATE* *ZIP CODE*

PARENT SIGNATURE _____

PARENT PRINTED NAME _____ **DATE** _____