Shining Stars Childcare Center
"Where Kids Shine Like Stars"
20 Northpointe Parkway, Suite 190
Amherst, New York 14228
Phone (716) 568-1040 Fax (716) 568-1042

Child's Full Name: _____

Child's Preferred Name:

Complete Address: _____

Home Phone: _____ Cell Phone: _____

Birthday: _____ Age: _____

School Name: _____ Grade Level: _____

Parent/Guardian Full Name: _____

Occupation: _____ Employer: _____

Business Address: _____

Business Phone: _____ Other: _____

Parent/Guardian Full Name: _____

Occupation: _____ Employer: _____

Business Address: _____

Business Phone: _____ Other: _____

Is Mother Living: *YIN* Is Father Living: *YIN* Separated: *YIN* Divorced: *YIN*

Other Family Members Living at Home

Full Name	Age	Relationship to Child

Other Family Members living in the community

Full Name	Age	Relationship to child	Name used by child

Please List anyone who is authorized to pick up your child

Full Name	Relationship to child	Phone Number

Is there anyone who you do not wish to pick up your child

First Name	Relationship to Child

Has your child had any previous school experience

Name of School	Type of School

How many hours does your child typically sleep at night?_____

Is your child toilet trained?_____

Does your child have any special wording for bathroom_____

Describe your child's appetite (Check for yes)

- Always hungry
- Eats at mealtimes
- Snacks all day
- Never hungry
- Needs to be coaxed to eat
- Picky eater

Are there any foods your child may not eat due to allergies or religious beliefs? Y/N

If yes, please list food and the reason why:_____

_____

Are there any foods your child dislikes?_____

_____

Please list some of your child's favorite activities:_____

_____

_____

Please check the following that accurately describe your child:

- o Cooperative
- o Shy
- o Competitive
- o Aggressive
- o Sensitive
- o Submissive
- o Angry
- o Happy
- o Sad
- o Usually does what is asked
- o Seldom does what is asked
- o Whiny

Please list any other characteristics or behaviors of your child:_____

_____

_____

_____

Any other information that you feel would be useful in taking care of your child?_____

_____

_____

_____

Health History

PROVIDED BY PARENTS

Name:_____

Birth Date: ___/___/___ Sex:_____

Medical History

Diseases

	Age		Age
Asthma	_____	Pneumonia	_____
Chicken Pox	_____	Whooping Cough	_____
Heart Disorder	_____	Diphtheria	_____
Rubella	_____	Mumps	_____
Measles	_____	Other	_____

Congenital Malformations:_____

Allergies (drug, food, etc.):_____

Drug Sensitivities:_____

Seizures:_____

Comments:_____

_____

Parents Signature:_____ Date:_____

Address:_____ Phone #_____

Allergies History Form

Name of Child:_____ Date:_____

Allergies (please specify)

Foods	Reactions

Drugs	Reactions

Environment	Reactions

Treatment

Prevention:_____

_____

Medications_____

Special Circumstances (specify):_____

What to do if severe reaction occurs:_____

Adrenalin Kit required: YES NO

Signature:_____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date	2nd Date	3rd Date	4th Date	5th Date
Polio (IPV or OPV)	1st Date	2nd Date	3rd Date	4th Date	
Haemophilus influenzae type B (Hib)	1st Date	2nd Date	3rd Date	4th Date OR 1st Date (if given on or after 15 months of age)	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
Measles, Mumps and Rubella (MMR)	1st Date	2nd Date			
Varicella (also known as Chicken Pox)	1st Date	2nd Date			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: __/__/__ Mantoux Results: ☐ Positive ☐ Negative ____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: __/__/__

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year __/__/__ Result: ____ mcg/dL ☐ Venous ☐ Capillary

2 years __/__/__ Result: ____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

__/__/__ Result: ____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) Phone

Date

Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.

CACFP
Child and Adult Care Food Program
New York State Department of Health

LETTER TO HOUSEHOLDS

Dear Parent, Guardian or CACFP Participant:

This center participates in the Child and Adult Care Food Program (CACFP) and serves nutritious meals each operating day. The information requested on the attached Income Eligibility Form for Child Care or Adult Day Care Centers determines how much reimbursement this center will receive from CACFP for these meals and snacks, based on the United States Department of Agriculture (USDA) family income criteria listed below.

We encourage you to complete the form promptly so your center can maximize its reimbursement for healthy meals and snacks. One form needs to be completed for each household every year except for children enrolled in Head Start or At-Risk Only programs. All information on the form will be confidential and used only for the purpose of determining CACFP reimbursement for meals and snacks served at this center.

Foster children are automatically eligible for the highest rate of reimbursement from CACFP. Households with both foster and non-foster children in day care may complete one form, including the foster child as a household member. Eligibility determination for the non-foster children will be based on the information reported on the form by the household.

INCOME ELIGIBILITY GUIDELINES
(Effective July 1, 2014 until June 30, 2015)

HOUSEHOLD SIZE	REDUCED-PRICE MEALS		
	YEAR	MONTH	WEEK
1	21,590	1,800	416
2	29,101	2,426	560
3	36,612	3,051	705
4	44,123	3,677	849
5	51,634	4,303	993
6	59,145	4,929	1,138
7	66,656	5,555	1,282
8	74,167	6,181	1,427
FOR EACH ADDITIONAL FAMILY MEMBER	+7,511	+626	+145

SPONSOR/CENTER OFFICIAL _____ SPONSORING ORGANIZATION _____ DATE _____

USDA is an equal opportunity provider and employer.

CACFP
Child and Adult Care Food Program
New York State Department of Health

INCOME ELIGIBILITY FORM
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: _____

Print the name of the child(ren) enrolled in this child care center:

1. _____ 2. _____ 3. _____

DIRECTIONS:

Complete SECTION A if anyone in your household:

1. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. If any of the children enrolled in this child care center are foster children

Complete SECTION B if no one in your household receives Food Stamps, TANF, FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION A

Food Stamp Case Number _____

TANF Number _____

FDPIR Number _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Date: _____

FOR SPONSOR USE ONLY

Sponsor Agreement Number _____

Total Household Members _____
(including foster children, if applicable)

Total Income $_____

Free _____ Reduced _____ Paid _____

Date Determined ____/____/____

Signature of Center Staff _____

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

Name of Household Members	Monthly Gross Income
1. _____	$ _____
2. _____	$ _____
3. _____	$ _____
4. _____	$ _____
5. _____	$ _____
6. _____	$ _____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature: _____

Print Name: _____

SS# XXX-XX-____ ____ ____ ____ Date: _____

Shining Stars Childcare Center

Food Program Enrollment Form

Child's Name_____ Birth Date__/__/___

Enrollment Date_____

Any food allergies_____

Time	Monday	Tuesday	Wednesday	Thursday	Friday
In					
Out					
In					
Out					

Name of Parent/Guardian_____

Meals (Check all that apply)

Breakfast___ Lunch___ PM Snack___ Dinner___

Signature of Parent/Guardian_____

Dear Parents/Guardians

We have a Facebook page for Shining Stars Daycare. We would like to "friend" parents so parents can see what their children do while they are here. In order to post pictures on Facebook page, we need permission. IT IS OK TO DECLINE PERMISSION. We respect the privacy of our families here and understand that some people do not want any pictures of their child posted. Either way, please return the slip to your child's teacher so we know if we have or do not have permission.

- YES, I give Shining Stars permission to post pictures of my child on the daycare Facebook page.
- NO, I do not want any pictures of my child posted.

Child's Name

Signature of Parent/Guardian Date