2020-2021

Cobleskill Campus Child Care Center
Medical Emergency Plan

Child's Name _____ **Home phone**	**Call this number:** **1st**_____ **2nd** _____	Teachers will place photo here
Birth Date _____/_____/_____ **Sex** **Male Female**	**Allergies** **No** ☐ **Yes** ☐ **Medical Condition** **No** ☐ **Yes** ☐ **Explain on back**	**E-mail Addresses** _____@_____ @
Name of Person Enrolling Child:	**Relationship to Child:**	**Child's Home Address:**
For Program Use Only **Date of Enrollment:**	***For Program Use Only*** **Date of Disenrollment:**	

Relationship	**Parent/Guardian**	**Address**	**Telephone** **C** **W** **H**
Relationship	**Parent/Guardian**	**Address**	**Telephone** **C** **W** **H**
Other Emergency Contact Persons / Persons authorized to pick up my child:			
Relationship	**Name**	**Telephone number during Child Care**	**Other Telephone #**
Relationship	**Name**	**Telephone number during Child Care**	**Other Telephone #**
Relationship	**Name**	**Telephone number during Child Care**	**Other Telephone #**
Relationship	**Name**	**Telephone number during Child Care**	**Other Telephone #**
Relationship	**Name**	**Telephone number during Child Care**	**Other Telephone #**

Child health insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website:
http://nystateofhealth.ny.gov/

Please finish on back.

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Child's Full Name: _____

Child's Source of Medical Care/Primary Care Physician's Name:	**Telephone**
Child's Source of Dental Care/Dentist's Name:	**Telephone**
Name of Preferred Medical Care Facility/Hospital:	**Telephone**
Check boxes to indicate if your child has any special needs/services: ☐ None ☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy ☐ Other	Children who have special health care needs are those who have chronic physical, developmental, behavioral or emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have special health care needs, please discuss these with your child-care provider.

Explanation of allergies or medical condition:

_____

_____

_____

_____

_____

_____

Agreements

- I consent to emergency medical treatment for my child…… ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision (CCCCC utilizes the campus community for trips) …….. ☐ Yes ☐ No
- I understand the program may need additional permission for situation such as transportation, medication, release of information, and field trips…… ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child…… ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation…….. ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year... ☐ Yes ☐ No

Signature – Parent or Person(s) Legally Responsible:	Date: / /

CACFP Program:

Time Meal Served

Breakfast: 8:30AM – 9:00Am Lunch: 11:30AM – 12:15PM Afternoon snack: 2:45PM – 3:45PM

If your child is in care during these times, he/she will receive the meal or snack that is being served.

What days will child usually be at the Center? M____ T____ W____ Th____ F____

What hours will your child usually be at the Center? Arrive: _____ ☐ AM ☐ PM

Depart: _____ ☐ AM ☐ PM