2017-2018 HAYC3 REGISTRATION FORM

HAYC3 Armory, 80 Church Street, Hoosick Falls, NY I PO Box 492, Hoosick Falls, NY 12090
518-686-9050 I HAYC3.org I contactHAYC3@gmail.com

As an inclusive, nonprofit organization with the mission of serving our entire community, HAYC3 is not a membership organization and there is no "HAYC3 membership." Anyone may register for any class, workshop, or event without having to pay an organizational membership fee. Simply use the form below to register for programs. Please put the number of people you are registering for in the box on the far left. Total your fees at the bottom of the page. All information must be completed. Make your check payable to HAYC3 and drop off at the HAYC3 Armory or mail to HAYC3, PO Box 492, Hoosick Falls, NY 12090. You may also choose to pay online at **HAYC3.org/Register (**please clearly indicate your PayPal transaction number). Your spot will not be reserved until your payment has been received.

FULL NAME	AGE	GRADE	BIRTHDATE	M/F

Street Address ____________________ City ____________________ Zip __________

Primary Phone ____________________ Email ____________________

Emergency Contact Information

Full Name ____________________ Relationship __________ Phone ____________________

Full Name ____________________ Relationship __________ Phone ____________________

#	YOUTH PROGRAMS	FEES
	New York State After-School Program for Grades K-5 *(includes supervision and homework help)*	$130/month
	New York State Certified School Vacation Enrichment Programs ***Please check which weeks you are registering for:*** __ February Break __ June 25 – 29 __ July 16–20 __ July 30–August 43 __ August 13–17 __ April Break __ July 9 – 13 __ July 23–27 __ August 6–10 __ August 20–24	$120/week: 8am-4pm Extended hours: $5/hour (7-8am and 4-5pm) Non-resident: $140/week

#	OTHER PROGRAM	DATE	AMOUNT $
	Add a donation to support HAYC3 & our community:		$
	TOTAL DUE:		$

Please include your check payable to HAYC3. If you paid online, clearly indicate your PayPal transaction number:

____

Interested in volunteering for HAYC3? *We will be in touch.* YES, sign me up! ________

Sign up for our e-newsletter! **Email**: ____________________

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE REGISTRATION

PHOTO OF CHILD
(Optional)

Child's Full Name:

Does your child have any allergies? ___ YES ___ NO
If yes, what is your child allergic to?

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 you child does have special health care needs, please discuss these with your child-care provider.

Child's Source of Medical Care / Primary Care Physician's Name:	Telephone:
Child's Source of Dental Care / Dentist's Name:	Telephone:
Name of Medical Care Facility / Hospital:	Telephone:

Would you like information on Child Health Plus? ? __ YES __ NO

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	PHONE NUMBER DURING CARE	OTHER NUMBER (CHECK KIND)	ADDRESS
			_ HOME _ CELL _OTHER	
			_ HOME _ CELL _OTHER	
			_ HOME _ CELL _OTHER	
			_ HOME _ CELL _OTHER	

Provider / Day Care Facility Name and Address:

CHILD'S FULL NAME:	SEX: __ M __ F
CHILD'S HOME ADDRESS:	DATE OF BIRTH:
	HOME NUMBER:
DATE OF ACCEPTANCE:	DATE OF DISCHARGE:

NAME OF PERSON APPLYING FOR CHILD:	__ PARENT __ GUARDIAN __ CARETAKE __ RELATIVE __ OTHER: ________________	HOME NUMBER: DAYTIME NUMBER:

ADDRESS OF PERSON LISTED ABOVE (IF DIFFERENT FROM CHILD'S):

AGREEMENTS

I consent to the enrollment of the child listed above in this facility and have been advised of policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park, and playground) away from the facility under proper supervision. __ YES __ NO

In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeon or hospital (listed on the other side of this card) necessary for the proper health and well-being of my child. __ YES __ NO

I have provided information on my child's special needs (Allergies, Diet, Disabilities, and / or Medical Information) to the provider, as may be necessary to assist the facility in properly caring for my child in case of an emergency. __ YES __ NO

I agree to review and update this information whenever a change occurs and at least once every six months. __ YES __ NO

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE	**DATE:**

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may 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.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:

4. Name of Medication *(including strength):*	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: ______

OR

7B. Identify the symptoms that will necessitate administration of medication: *(signs and symptoms must be observable and, when possible, measurable parameters)*: ______

8A. Possible side effects: ☐ See package insert 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 ☐ Contact health care provider at phone number provided below

☐ Other *(describe)*: ______

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

10B. Additional special instructions: *(Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situation's when medication should not be administered.)* ______

11. Reason for medication *(unless confidential by law)*: ______

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /

16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: ______________________

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized: / /

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on **/ /** ______________________
(Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

____

____

____

____

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / / ______________________

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X