

Kids Connection Parent Checklist:

As a parent of a Kids Connection child, you should receive:

_____ KC Handbook

_____ KC Calendar

The following must be completed and turned into the JCC
PRIOR to your child's start date.

_____ Kids Connection Contract

_____ OCFS (Blue) Registration Card

_____ Emergency Child Information Sheet

_____ Transportation Permission Form

_____ Authorization for Pick-up Form

_____ Vestal Hill's Pickup Permission Slip (if applicable)

_____ Medical Form

(not a copy of any existing form, filled out by your medical care provider)

_____ CACFP Form

_____ KC Swimming Consent Form

_____ DSS Supported Family Addendum (if applicable)

Please call the JCC at 724-2417 ext. 421 with any questions

Harry Cohen & Willa Cohen – JCC Co-Youth Directors

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 your 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 Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

Would you like information on Child Health Plus? Yes No

EMERGENCY DATA	RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other
				<input type="checkbox"/> Pager <input type="checkbox"/> Cell <input type="checkbox"/> Other

Provider/Day Care Facility Name and Address:	CHILD'S FULL NAME:		SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
	CHILD'S HOME ADDRESS:		DATE OF BIRTH:
			HOME TELEPHONE NUMBER:
	DATE OF ACCEPTANCE:	DATE OF DISCHARGE:	
	NAME OF PERSON APPLYING FOR CHILD:	<input type="checkbox"/> Parent <input type="checkbox"/> Guardian	HOME TELEPHONE NUMBER:
		<input type="checkbox"/> Caretaker <input type="checkbox"/> Relative <input type="checkbox"/> Other _____	DAYTIME TELEPHONE 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 the 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No			
I agree to review and update this information whenever a change occurs and at least once every six months. <input type="checkbox"/> Yes <input type="checkbox"/> No			
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE		DATE:	

Date: _____/_____/_____

KIDS CONNECTION EMERGENCY CHILD INFORMATION

Child's Name _____ Age _____

Permanent Address _____ Home Phone # _____

Date of Birth _____ Grade as of September 2023 _____

Mother/Guardian #1: _____ Primary Number _____

Where Employed _____

Father/Guardian #2: _____ Primary Number _____

Where Employed _____

Other Members in Household (include age/relationship) _____

MEDICAL INFORMATION

Emergency Hospital Preference _____

Child's Physician _____

Child's Dentist _____ Other Medical Specialist _____

If we are not able to contact the child's mother or father, we will contact the persons listed on your child release form

Does your child have any allergies? If so please list (examples: bee stings, colors, foods, etc)?

Does your child take any medication regularly? If so, please indicate dosage, time and purpose?

Other information about the child that we should be aware of?

HEALTH HISTORY OF THE CHILD

Does the child have: frequent colds [] vomit easily [] ear aches [] run high fevers []

Does the child wear: glasses/contact lenses [] hearing aids [] corrective shoes [] prosthesis []

STATUS OF PARENTS/GUARDIANS

Married [] Separated [] Divorced [] Step-Father/Mother [] Foster Parents []

Child lives primarily with: _____

Remarks: _____

It is legal for either parent to pick up a child unless we have a copy of a court order restrictions, custody and visitation arrangements.

KIDS CONNECTION TRANSPORTATION PERMISSION

I, _____ (parent/guardian) agree to allow my son/daughter _____, to participate in Kids Connection Trips through the JCC. This includes walking around the facility and crossing Clubhouse Rd.

I authorize the JCC staff to obtain the best available public medical care for my child in the event of an emergency at which time I cannot be reached; realizing that all reasonable means will be made to contact me prior to the rendering of any medical treatment, and that such medical treatment shall be on an emergency basis as decided by a qualified physician and I assume responsibility for such treatment.

Parent/Guardian Signature Emergency phone #1 Emergency phone #2

Insurance Policy Name _____

Policy Number _____

Allergies _____

PERMISSION TO PHOTOGRAPH

I, _____ (parent/guardian) agree to allow my son/daughter _____ to be photographed and for the photograph to be displayed, used in our brochure, put on our JCC Facebook page or placed in the local newspaper.

Parent/Guardian

I DO NOT want to my child to be photographed. _____
Parent/Guardian

Date: ____/____/____

Authorization for Pick-Up

The Kids Connection program will dismiss your child ONLY to persons you authorize. List the name and phone number(s) of anyone who has your permission to pick up your child. Please advise each of them that they will be required to show identification each time they pick up, as the staff on duty changes from day to day.

Be sure to list anyone that you feel could be of assistance in the case where we are unable to reach both parents. **It is a state requirement that at least one other person, in addition to the parents, is added to this list in case of emergencies.**

Additions or amendments to this list are made exclusively by the parent/guardian **IN PERSON**, with the Kids Connection staff. Phone calls or emails will not be accepted as the parent's permission. This is done to ensure the safety of your child and other children in the program.

Child's/Children's Name(s): _____

Pick-up Person's Name	Relationship to Child	Phone Number
1. Parent/Guardian 1		Cell: Work:
2. Parent/Guardian 2		Cell: Work:
3.		Cell: Work:
4.		Cell: Work:
5.		Cell: Work:
6.		Cell: Work:
7.		Cell: Work:
8.		Cell: Work:
9.		Cell: Work:
10.		Cell: Work:

Date: ____/____/____

Dear Vestal Hills Kids Connection Families,

Vestal provides all children attending Vestal Hills free bus transportation to the JCC. Please complete the bottom portion of this letter and return to the JCC with your paperwork to ensure your child's transportation from Vestal Hills to the JCC Kids Connection Program.

If you have any questions, please contact Harry Cohen & Willa Cohen, JCC Co-Youth Directors at 724-2417 ext. 421 or Harryc@binghamtonjcc.org & willac@binghamtonjcc.org.

Harry Cohen & Willa Cohen
JCC Co-Youth Directors



Vestal Hills Transportation Permission Slip

I, _____ give my consent for my child
_____ to ride the Vestal School bus
from Vestal Hills Elementary to the JCC in order to attend Kids Connection.

Parent/Guardian Signature

Date

BOTH SIDES OF FORM MUST BE COMPLETED AND RETURNED

OCFS-LDSS-4433 (Rev. 4/2008) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES



Medical Statement of Child in Childcare

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

Name of Child:	Date of Birth:	Date of Examination:
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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)	1 st Date	2 nd Date	3 rd Date	4 th Date	5 th Date
Polio (IPV or OPV)	1 st Date	2 nd Date	3 rd Date	4 th Date	
Haemophilus influenzae type B (Hib)	1 st Date	2 nd Date	3 rd Date	4 th Date OR 1 st Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08	1 st Date	2 nd Date	3 rd Date	4 th Date	
Hepatitis B	1 st Date	2 nd Date	3 rd Date		
Measles, Mumps and Rubella (MMR)	1 st Date	2 nd Date			
Varicella (also known as Chicken Pox)	1 st Date	2 nd 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.

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.

ADDITIONAL INFORMATION ON REVERSE SIDE



JCC Fax: (607) 724-2418

BOTH SIDES OF FORM MUST BE COMPLETED AND RETURNED

OCFS-LDSS-4433 (Rev. 4/2008) REVERSE



Medical Statement of Child in Childcare
(continued)

JCC Fax: (607) 724-2418

Health Specifics

Comments

Are there allergies? (Specify) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is medication regularly taken? (Specify drug and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is a special diet required? (Specify diet and condition) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any hearing, visual or dental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are there any medical or developmental conditions requiring special attention? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Summary of Physical Exam

Include special recommendations to 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 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.

ADDITIONAL INFORMATION ON REVERSE SIDE





CACFP Information Form

Child's Name _____

Day's Attending (please circle) M T W Th F

Approximate daily schedule Arrival _____ Departure _____

Meals Received (please circle) am snack lunch pm snack

Parent Signature _____

Date _____

Dear Kids Connection Parents/Guardians,

Although our snack and hot lunch program is very successful, it costs more to run than we charge. The JCC qualifies for a subsidy through the NYS Department of Health called CACFP - Child and Adult Care Food Program. We are currently receiving this monthly subsidy and will continue to do so, contingent upon periodic review of our records.

It is imperative that this form is completed and returned by **ALL** of our KC families. For our program to continue with the additional funding it requires we greatly need your cooperation. By filling out the application the JCC will get the subsidy it needs whether you are within or beyond our financial guidelines.

Please fill out the attached "Income Eligibility Guidelines" form and return it to the JCC Office with your other camp paperwork. We need to have this form returned to us no matter what your income is. Your confidentiality will, of course, be respected. Thank you

Sincerely,

Harry Cohen & Willa Cohen

Youth Director

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. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

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	
CACFP Agreement # _____	
Total Number of Household Members _____ <small>(INCLUDING FOSTER CHILDREN, IF APPLICABLE)</small>	
Total Household Income \$ _____	
Free _____ Reduced _____ Paid _____	
Date of Determination _____	
Signature of Center Staff _____	

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

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.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____
7. _____	\$ _____

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 _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER

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 DATE _____

USDA is an equal opportunity provider and employer.

KC Swimming Consent Form

One of the great assets the Jewish Community Center has to offer our families and students is our pool. Kids Connection swims Tuesdays & Thursdays (subject to change) from 4pm-5pm and during all days off from school including half days, long days and snow days. Flotation belts are available to be used by the children if needed. Kids Connection staff is always stationed around the pool as extra eyes in addition to the lifeguard on duty in the high lifeguard chair.

As of **June 1, 2015** the New York State Office of Family and Children requires a permission slip signed by the parents for each child. Please sign this form as permission for your child to swim with Kids Connection.

Child's Name: _____

Child's Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Date: _____



ONLY For Families Supported by DSS

Parent/Guardian must initial each statement:

_____ I understand that the JCC does not accept DSS as payment in full for Kids Connection Contracts.

_____ I understand that if my child attends Kids Connection on days or times that I am not working or hours beyond what DSS allows, I am responsible for the balance of Kids Connection tuition.

_____ I understand that if my child's attendance exceeds the hours that DSS has designated, I am responsible for any fees/balances.

_____ I understand that I am solely responsible for the annual registration fees

_____ I understand that my DSS stated co-pay may not satisfy the weekly KC tuition fee and I am responsible for the balance.

_____ I understand that DSS will not pay for times that I am not working

_____ I understand that I am expected to adhere to the KC payment policies and that I will be subject to late fees for failure to pay timely.

Please refer to Kids Connection Contract for tuition costs and your DSS contract for the portion of support provided by DSS.

Parent/Guardian Signature

____/____/____

Date

Parent/Guardian Name

Contracted Child Name(s)