Islander's Kids Learning Daycare Center
219 Jefferson Ave, Staten Island NY 10306
Phone: (718) 979-5331 Fax: (718) 979-5315
Email: islandersinfo04@gmail.com
Our fundamental program will ensure your child's prosperity.

Enrollment Application Form

Registration Fee and Security Deposit Paid on _____

Child Information: Child's name _____ **DOB:** _____

Gender: Male___ **Female**___ **Toilet Trained: Yes**___ **No**____

Primary Language: _____ **Secondary Language:** _____

Home Address: _____
Street City State Zip

Parent/Guardian Info: _____ _____
First Name Last Name

Phone#: Home: _____ Work: _____ Cell: _____

Place of Employment: _____ E-mail Address: _____

Parent/Guardian Info: _____ _____
First Name Last Name

Phone#: Home: _____ Work: _____ Cell: _____

Place of Employment: _____ E-mail Address: _____

Family Doctor: _____ **Phone #:** _____

Emergency Contact/Relationship _____ **Phone #:** _____

Emergency Contact/Relationship _____ **Phone #:** _____

Student's Allergies: _____

How did you learn about Islander's Kids Learning Daycare Center? _____

Please list what aspects you look for when searching for a daycare center: _____

_____

Your child's specific needs: _____

Rules and Regulations

1. Registration Fee: $100.00 per year for first child, $50.00 for addition child.
2. Islander's Kids Learning Daycare Center is not responsible for any lost articles.
3. In the event of dangerous weather conditions and/or all public schools will be closed, Islander's kids Learning Daycare Center will act accordingly with regard to the safety of our children/staff and will be closed.

Parent/ Guardian: _____
Signature Date Relationship to Student

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Tuition Agreement Form

Child's Name: _____ DOB _____

Parent/Guardian Name: _____

I agree to pay $_____ every month.

REGISTRATION: $100
Payment is due by the 5th of each month or $35.00 late fee will be charged.
I understand that my child is entitled for one week (5 consecutive school days) vacation per year at no charge and two sick weeks (5 consecutive school days) per year at which I will be responsible for 50% of the tuition for those weeks ONLY. All accounts with checks returned for non-sufficient funds will be charged a $25.00 returned check fee.
[ ] ACS/HRA: I understand that my child's co-pay is an ongoing weekly/monthly fee and I am responsible for my child's co-payment based on the ACS form. I am responsible for my child's weekly/monthly co-pay fee even if my child is absent for one or more days during the week.
I understand if I take my child for four consecutive weeks for vacation I am responsible for paying 50 % of the monthly tuition in order for Islander's Kids Learning Daycare Center to hold the spot in the classroom.

Tuition for the 2015/2016 School Year

Full Day Program (7 a.m. – 7 p.m.)	$950 a month
After School Program(2pm-7pm; full time attendance during winter and spring recess	$550 a month

Islander's Kids Pre-Kindergarten Program will focus on developing your child's reading, writing, and math skills. Our program also offers a personalized curriculum that has successfully prepared children for the Gifted and Talented (G&T) program in NYC.
Rates may be subject to change and ALL FEES ARE NONREFUNDABLE.

Registration is complete when Enrollment Application Form, Tuition Agreement Form and Daily Procedures Disciplinary Agreement Form are filled out and signed.

I understand and agree with all the aforementioned terms listed in the Tuition Agreement.

Parent/Guardian Name: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

ISLANDERS KIDS LEARNING DAYCARE CENTER ADMITS STUDENTS OF ALL RACE, RELIGION AND NATIONAL OR EHTNIC ORIGIN.

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Daily Procedures and Disciplinary Agreement

Child's Name: _____ DOB: _____

Parent/Guardian Name: _____

Islander's Kids is committed to ensure that our daycare is safe, secure and orderly environment in which teaching and learning takes place each day. Safe and supportive school environment depends on students, staff and parents demonstrating mutual respect.

Students, staff and parents – must know and understand the standards of behavior which all students are expected to live up to and the consequence if these standards are not met.

We hope that our parents will enforce our disciplinary rules and we will receive full cooperation from you to mold our children for today's world. These skills will help our children become responsible, and kind citizens in the future.

Please initial each item below:

_____ I agree to sign the school attendance log when my child arrives in the morning and again when he/she is picked up at the end of the day. No one under the age of 16 is allowed to sign my child in/out of the school.

_____**Illness**: I understand that I will be notified by school personnel if my child becomes ill during the day and I agree to make every effort to have my child picked up in a timely manner, as the health and safety of all children is of the utmost importance. If my child is exposed to contracts a contagious disease, I agree to notify the school and I will make certain that he/she does not return to school without written permission from the child's doctor,

_____**Withdrawal from Islander's Kids**: I have the right to withdraw my child from the program at any time. I also understand that I must provide a 2 week written notice of withdrawal. If this written notification is not received I agree to pay all the tuition for the 2 week period. I understand that if I then choose to re-enroll my child, she/he will only be readmitted based upon space availability and at the current rate of tuition.

_____ At the Director's discretion, Islander's Kids has the right to ask a child to withdraw from our program.

_____ **Inclement Weather/School Closings**: I understand that it is the Day Cares objective to be open during every regularly scheduled school day; however, there are some specific days during which the school will be closed. This will no affect my child's tuition in any way.

_____ I understand that I am late picking up my child on any given day, I will be charged a late fee of $1 a minute. **NO EXCEPTIONS.**

_____ I agree to pay for any property damage resulting from my child's actions.

NO TOYS FROM HOME are permitted inside the daycare unless it was asked by their classroom teacher.

NO:

1. spitting
2. hitting
3. kicking
4. pinching
5. biting
6. punching
7. lying
8. candy or gum brought from home
9. toys from home
10. fighting with teachers or peers
11. running (indoors or out)

I WILL:

1. be polite and respectful at all time
2. listen courteously
3. be friendly to all
4. be honest/tell truth
5. be prepared for class
6. do my best
7. use kind words
8. follow directions
9. share with others
10. pay attention
11. keep a positive attitude

1st Offense – Warning to the student
2nd Offense – Time Out
3rd Offense - A phone call home and a note to be signed by parent and return back the next day

All points mentioned above are considered as serious behavioral issues, and may be cause for immediate suspension and/or dismissal from the program is possible. Any other behavior which the Executive Director deems a threat to the safety or physical or emotional well-being of program participants or staff .Each child and each case will be considered individually. If there is no cooperation between our school and the child and parents then we are permitted to dismiss the students from Islander's Kids Learning Daycare Center.

_____ I understand and agree that violation of the Daily Procedures and Disciplinary Agreement may result in termination of student's enrollment.

Please sign below:

Parent/Guarding Name: _____

Parent Guarding Signature: _____ Date _____

ISLANDERS KIDS LEARNING DAYCARE CENTER ADMITS STUDENTS OF ALL RACE, RELIGION AND NATIONAL OR EHTNIC ORIGIN.

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY 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, Cell, Work

Health Insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER — If "yes" to any item, please explain (attach addendum, if needed)

Birth history (age 0-6 yrs)
☐ Uncomplicated ☐ Premature: _____ weeks gestation
☐ Complicated by _____

Allergies ☐ None ☐ Epi pen prescribed
☐ Drugs (list) _____
☐ Foods (list) _____
☐ Other (list) _____

Does the child/adolescent have a past or present medical history of the following?
☐ Asthma (check severity and attach MAF/Asthma Action Plan): ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent
If persistent, check all current medication(s): ☐ Inhaled corticosteriod ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes (attach MAF)
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis (latent infection or disease)
☐ Other (specify) _____

Explain all checked items above or on addendum

Medications (attach MAF if in-school medication needed) ☐ None ☐ Yes (list below) _____

Dietary Restrictions ☐ None ☐ Yes (list below) _____

PHYSICAL EXAMINATION

Height _____ cm (___ %ile)
Weight _____ kg (___ %ile)
BMI _____ kg/m² (___ %ile)
Head Circumference (age ≤2 yrs) _____ cm (___ %ile)
Blood Pressure (age ≥3 yrs) ___/___

General Appearance:

	NI	Abnl
HEENT	☐	☐
Dental	☐	☐
Neck	☐	☐
Lymph nodes	☐	☐
Lungs	☐	☐
Cardiovascular	☐	☐
Abdomen	☐	☐
Genitourinary	☐	☐
Extremities	☐	☐
Skin	☐	☐
Neurological	☐	☐
Back/spine	☐	☐
Psychosocial Development	☐	☐
Language	☐	☐
Behavioral	☐	☐

Describe abnormalities:

DEVELOPMENTAL (age 0-6 yrs) ☐ Within normal limits

If delay suspected, specify below
☐ Cognitive (e.g., play skills) _____
☐ Communication/Language _____
☐ Social/Emotional _____
☐ Adaptive/Self-Help _____
☐ Motor _____

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 (annually, age 6 mo-6 yrs)	___/___/___	☐ At risk (do BLL) ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	___/___/___	☐ Normal ☐ Abnormal
Head Start Only		
Hemoglobin or Hematocrit (age 9-12 mo)	___/___/___	_____ g/dL _____ %

	Date Done	Results
Tuberculosis	Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school	
PPD/Mantoux placed	___/___/___	Induration _____ mm
PPD/Mantoux read	___/___/___	☐ Neg ☐ Pos
Interferon Test	___/___/___	☐ Neg ☐ Pos
Chest x-ray (if PPD or interferon positive)	___/___/___	☐ NI ☐ Abnl ☐ Not Indicated
Vision (required for new school entrants and children age 4-7 yrs)	___/___/___ ☐ with glasses	Acuity Right ___/___ Left ___/___ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES

CIR Number of Child

Hep B ___/___/___ ___/___/___ ___/___/___ ___/___/___
Rotavirus
DTP/DTaP/DT ___/___/___ ___/___/___ ___/___/___ ___/___/___
___/___/___ ___/___/___ ___/___/___ ___/___/___
Hib
PCV ___/___/___ ___/___/___ ___/___/___ ___/___/___
Polio

Influenza
MMR ___/___/___ ___/___/___ ___/___/___
Varicella
Td ___/___/___ ___/___/___ ___/___/___
Tdap Hep A
Meningococcal ___/___/___ ___/___/___
HPV
Other, specify: _____ ___/___/___; _____ ___/___/___

RECOMMENDATIONS

☐ Full physical activity ☐ Full diet
☐ Restrictions (specify) _____
Follow-up Needed ☐ No ☐ Yes, for _____ Appt. date: ___/___/___
Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision
☐ Other _____

ASSESSMENT

☐ Well Child (V20.2) ☐ Diagnoses/Problems (list) ICD-9 Code

_____ ___.___
_____ ___.___
_____ ___.___

Health Care Provider Signature | Date ___/___/___

Health Care Provider Name and Degree (print) | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (___) ___-____ | Fax (___) ___-____

DOHMH ONLY PROVIDER ID

TYPE OF EXAM ☐ NAE current ☐ NAE Prior Years

Comments

Date Reviewed ___/___/___ ID NUMBER

REVIEWER

CH-205 (5/08)

Copies: White School/Child Care/Early Intervention/Camp, Canary Health Care Provider, Pink Parent/Guardian

CENTER

NAME:

ADDRESS:

BORO:

318K (REV. 8/02)

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF DAY CARE

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission ____/____/____

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

NAME: (Last) (First) (Middle)	SEX F ☐ M ☐	DATE OF BIRTH Country/State of Birth
ADDRESS: (No.) (Street) (City/Boro) (State) (Zip)		
MOTHER'S NAME: (First) (Last) FATHER'S NAME: (First) (Last)		TELEPHONE NO Home: Work:
FOSTER PARENT		
FOSTER AGENCY ADDRESS		TELEPHONE #
LANGUAGE SPOKEN IN HOME		

PERSON/S TO CONTACT IN CASE OF EMERGENCY (Other Than Parent)		
NAME	RELATIONSHIP TO CHILD	
ADDRESS		TELEPHONE NO. Home: Work:

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL

NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY		IS CHILD ALLERGIC TO ANY:
(____) Sickle Cell	(____) Heart Disease	(____) Medications (Specify)
(____) Diabetes	(____) Hypertension	(____) None
(____) Convulsive Disorder	(____) Tuberculosis	(____) Foods (Specify)
(____) Allergies (Specify)	(____) Vision	(____) Insect Bites
(____) OTHER (Specify)	(____) Hearing	(____) OTHER

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?			
Has child ever had a serious illness?			

SPECIAL HEALTH CONDITIONS (Long term or chronic)	AGE IT BEGAN	TREATMENT/MEDICATIONS
1.		
2.		
3.		
4.		
5.		

I, _____ hereby certify that information provided herein is complete and accurate.

CONSENT FOR EMERGENCY MEDICAL TREATMENT *(REQUIRED FOR ADMISSION TO DAY CARE)*

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED _____ DATE _____ RELATIONSHIP _____

Subscribed and sworn to before me this _____ day of _____ 19 _____

_____ _____

Notary Public or Commissioner of Deeds (OPTIONAL) County of

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CONSENT FORM

Student's Name: _____

I hereby consent to the participation of taking photographs, movies or video tapes of the student named above.

I grant Islander's Kids Daycare Center the right to edit, use, and reuse products of non profit purposes including use in print, on the internet, and all other forms of media.

I grant permission for my child to attend any Extra Curriculum Activities in the Gym Floor.

I grant permission for my child to go on local walking trips outside the daycare building.

Signature of Parent/Guardian _____

Date: _____

Thank you for your cooperation,

Administration