



Parma Kids
Preschool & Child Care Center
PO Box 57 ~ Hilton, NY 14468
392-5792 Voice/Fax

For Office Use Only:

Non-Refundable
Registration Fee \$ _____
Check # _____
Date Paid _____

2020-2021 School Age WRAP Around Registration Form

Child's Full Name _____
First Middle Last

Home Address _____
Street City State Zip

Home Phone _____ Cell _____ Date of Birth ___/___/___ Sex of Child M F

Parents Marital Status: ___ Married ___ Divorced ___ Separated ___ Other

Parent's Email Address _____ Church You Attend _____

Mother's Name _____ Occupation _____ Phone _____ Hours _____

Father's Name _____ Occupation _____ Phone _____ Hours _____

Names and ages of other children in your family _____

Explain any emotional or learning problems your child might have _____

PHOTO AUTHORIZATION: I give permission for my child to be photographed and put on the school website or in newspaper. ___ YES ___ NO

SCHOOL DIRECTORY: I give permission for my child's address, parent's names, phone #, and email to be put in our school directory (Not our website). This is to stay connected with other parents and for staff usage.

___ YES ___ NO Please only list my:

Circle your choice of days and school AM Before School Care – Breakfast Provided 6-9 AM

Monday	Tuesday	Wednesday	Thursday	Friday	Quest	Village	Northwood
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What time will you drop off in the morning? _____

PM After School Care – Snacks and Program Provided 3-6 PM

Monday	Tuesday	Wednesday	Thursday	Friday	Quest	Village	Northwood
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What time will you pick up your child? _____

Comments of activities your child enjoys _____

Statement of Understanding

Please note that payment is due by the first of every month. No refunds will be given for missed days due to but not limited to; a sick child, personal vacations, or school vacations. Exceptions for refunds will be made at the discretion of the Board of Directors with the advisement of the School Director. Additional activities, meals, and days require advanced permission from the School Director and payment in full before the starting date of attendance. Failure to make payments on time will result in the assessment of late fees and possible dismissal from the program. Your signature confirms your understanding of the above stated conditions and agreement to fulfill your financial obligations to Parma Kids Preschool & Child Care Center around program.

Print name: _____ **Signature:** _____ **Date** ___/___/___

Photo of Child (optional)	New York State Office of Children and Family Services Day Care Enrollment		
	Child's Full Name:	Date Of Birth:	
	Child's Nickname:		
	Child's home Address:		
	Name of person Enrolling Child:	Relationship to child:	
Phone number(s) of person enrolling child: <input type="checkbox"/> ok to text	Address of person enrolling child:		
Email:			
Emergency contact /Addresses	Pick up?	Primary phone	Other phone number
Primary contact:	<input type="checkbox"/> Yes		
	<input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
Emergency contact:	<input type="checkbox"/> Yes		
	<input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
Emergency contact:	<input type="checkbox"/> Yes		
	<input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
<i>For program use only</i> Date of enrollment:		<i>For program use only</i> Date of disenrollment:	
Child's Full Name:			Date Of Birth:
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> Early Intervention <input type="checkbox"/> Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> None <input type="checkbox"/> Allergies, please list: _____ <input type="checkbox"/> Other: _____ Please provide information here AND discuss with your child care provider:			
Child's Primary Care Physicians' Name/Group:		Phone number:	
Preferred hospital:		Phone number:	
Child's Dental Care:		Phone number:	
Child health insurance information is available by calling toll free 1-800-698-4543 or the New York State Health Marketplace website: https://nystateofhealth.ny.gov/			
Agreements			
<ul style="list-style-type: none"> • I consent to emergency medical treatment for my child<input type="checkbox"/> Yes <input type="checkbox"/> No • I consent for my child to take part in neighborhood walking trips (i.e., library, park, playground, local businesses) away from the program under proper supervision..... <input type="checkbox"/> Yes <input type="checkbox"/> No • I understand the [program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....<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 year.....<input type="checkbox"/> Yes <input type="checkbox"/> No 			
Signature- Parent or person legally responsible:			Date: