Parma Kids

Preschool & Child Care Center

39 Hovey Street
PO Box 57 ~ Hilton, NY 14468
(585) 392-5792

For Office Use Only:
Non-Refundable
Registration Fee $ ____
Check # _____
Date Paid _____
Medical Form Rec'd _____

2021-2022 School Year Preschool Registration Form

Child's Full Name _____
First Middle Last

Home Address _____
Street City State Zip

Home Phone _____ Cell _____ Date of Birth ___/___/___ Gender: M F

Parents' Marital Status: ____ Married ____ Divorced ____ Separated ____ Other

Parent's Email Address _____ Church You Attend _____

Mother's Name _____ Phone _____ Occupation _____ Hours _____

Father's Name _____ Phone _____ Occupation _____ Hours _____

Names and ages of other children in your family _____

Allergies or any medical conditions we should be aware of: _____

Frequent ear infections? ____ ____ Tubes in ears? ____ Tubes in ears now

Is your child toilet trained? ____ yes ____ no ____ needs assistance

Is your child ____ right handed ____ left handed ____ undetermined

Does your child have any unusual habits? _____

Unusual words _____ Fears _____ Dislikes _____

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:
_____

Please circle day(s) & write the time(s) you need: **Child's Age_____**

Daycare:	**Mon Tues Wed Thurs Fri** **Start Time:_____ Pick-Up Time:_____**	
Start Date: _____	**Preschool Only 9:15am-11:45am** Mon Tue Wed Thurs Fri	**Preschool Class (circle one)** **2's 3's 4's**
Suggest other options, comments and/ or second choices: _____		

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: Child's Nickname:	Date Of Birth:
	Child's home Address:	
	Name of person Enrolling Child:	Relationship to child:
Phone number(s) of person enrolling child: [ ] ok to text Email:	Address of person enrolling child:	

Emergency contact /Addresses	**Pick up?**	**Primary phone**	**Other phone number**
Primary contact:	[ ] Yes [ ] No	[ ] ok to text	[ ] ok to text
Emergency contact:	[ ] Yes [ ] No	[ ] ok to text	[ ] ok to text
Emergency contact:	[ ] Yes [ ] No	[ ] ok to text	[ ] ok to text
For program use only Date of enrollment:		*For program use only* Date of disenrollment:	

Child's Full Name:	Date Of Birth:

Check boxes below to indicate if your child has any special needs/services:
[ ] Early Intervention [ ] Special Education [ ] Occupational Therapy [ ] Speech/Language [ ] Physical Therapy

[ ] None [ ] Allergies, please list: _____

[ ] 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

- I consent to emergency medical treatment for my child ……..…[ ] Yes [ ] 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……..…… [ ] Yes [ ] No
- I understand the [program may need additional permissions for situations such as transportation, medication, release of information, and field trips……..…….[ ] 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 legally responsible:	Date: