



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 _____

2022-2023 School Year Preschool Registration Form

Child's Full Name _____
First Middle Last

Home Address _____
Street City State Zip

Date of Birth ___/___/___ Gender: M F

Guardian's Marital Status ___ Married ___ Divorced ___ Separated ___ Other

Guardian's Email Address _____

Guardian 1's Name _____ Phone _____ Occupation _____

Guardian 2's Name _____ Phone _____ Occupation _____

Names and ages of other children in your family _____

Is your child toilet trained? ___ yes ___ no ___ needs assistance _____

Is your child ___ right handed ___ left handed ___ undetermined

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

Please circle the days you want to register your child for

Daycare: 6am-6pm	<table style="margin: 0 auto; border: none;"> <tr> <td style="padding: 0 15px;">Mon</td> <td style="padding: 0 15px;">Tues</td> <td style="padding: 0 15px;">Wed</td> <td style="padding: 0 15px;">Thurs</td> <td style="padding: 0 15px;">Fri</td> </tr> <tr> <td colspan="2" style="padding: 10px 0;">Start Time: _____</td> <td colspan="3" style="padding: 10px 0;">Pick-Up Time: _____</td> </tr> </table>	Mon	Tues	Wed	Thurs	Fri	Start Time: _____		Pick-Up Time: _____		
Mon	Tues	Wed	Thurs	Fri							
Start Time: _____		Pick-Up Time: _____									
Preschool: 9:15am-11:45am	<table style="margin: 0 auto; border: none;"> <tr> <td style="padding: 0 15px;">Mon/Wed</td> <td style="padding: 0 15px;">Tue/Thurs</td> <td style="padding: 0 15px;">Mon-Fri</td> </tr> <tr> <td style="padding: 0 15px;">Mon/Wed/Fri</td> <td style="padding: 0 15px;">Tue/Thurs/Fr</td> <td></td> </tr> </table>	Mon/Wed	Tue/Thurs	Mon-Fri	Mon/Wed/Fri	Tue/Thurs/Fr		Preschool Class (circle one) 2's 3's 4's/UPK			
Mon/Wed	Tue/Thurs	Mon-Fri									
Mon/Wed/Fri	Tue/Thurs/Fr										

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: