

# The LADYBUG PLAYHOUSE NURSERY SCHOOL

## Infant Important Reminders/Supplies Needed

**Children in carriers must be taken out and handed to the teacher. No child will be accepted in a child carrier. You must take the carrier back to your car, we cannot store carriers on site.**

### Diaper bag:

- Diapers & Wipes
- Diaper Cream: Must be supplied by you. A Diaper Cream form must be completed and on file for us to use. When supplying the diaper cream please make sure the cream is the same as the one you listed on this form. If cream changes a new form will need to be filled out and filed.
- Change of Clothes. All clothes will be kept in a diaper bag.
- Weather appropriate jacket, hat, gloves, socks, shoes
- Bibs
- Binks/Pacifier
- Burp Cloths

### Feeding:

- Completed Feeding Schedule Form
- All bottles must be pre-made (We can fill with water) & Labeled with your child's name. Will be stored in fridge when necessary.
- Bottles will be warmed up in a bottle warmer only if specified on feeding form.
- Baby bottles will be rinsed and sent home but will not be sterilized. Please make sure to run through the dishwasher before reusing.
- All Baby Food and Snacks must be supplied by you labeled with your child's name and listed on the feeding schedule form.
- We will not supply any food in the infant room.

### Bedding:

- Please supply 2 sheets (pack and play size, 27x39) or regular crib sheet
- Crib Sheets will be sent home weekly for laundering.
- Sleep Sack: No blankets or toys allowed in crib when children nap. Thermostat must be set to 68 degrees so gets a little chilly during naptime.

### Medical Form:

- Must be completed and handed in prior to starting (Child cannot attend without completed medical form)

### For children with EPI Pens:

- **EPI pens** must be given to us in their original package (box) with the pharmacy label on it and **MUST NOT EXPIRE** during your child's enrollment period. You must also have an emergency medicine medical form completed by yourself and your child's doctor. No exceptions!

**Please make sure everything that belongs to your child is labeled with their first and last name.**

# The LADYBUG PLAYHOUSE NURSERY SCHOOL

## Drop Off & Pick Up Schedule

### **Early Drop Off (7:00 am-8:45 am):**

Ladybugs: Classroom Door

Caterpillars, Dragonflies & Butterflies Back Door Gym Entrance

### **AM Arrival (8:45am-9:10am)**

Ladybugs: Classroom Door

Caterpillars: Back Door Gym Entrance

Dragonflies: Back Door, Gym Entrance

Butterflies: Front Door, Main Entrance

**After 9:10 am all drop offs must be done in front main entrance, Teachers are told not to let anyone in after this time. We thank you for your cooperation with this matter.**

### **½ Day PM Dismissal (12pm)**

Ladybugs: Classroom Door

Caterpillars: Back Door Gym Entrance

Dragonflies: Front Door, Main Entrance

### **Mini Day Dismissal (2pm):**

Ladybugs: Classroom Door

Caterpillars: Back Door, Gym Entrance

Dragonflies: Front Door, Main Entrance

Butterflies: Back Door, Gym Entrance

### **Full Day Dismissal (4pm)**

Ladybugs: Classroom Door

Caterpillars: Back Door, Main Entrance

Dragonflies: Back Door, Gym Entrance

Butterflies: Back Door, Gym Entrance

### **After School Pick up (4:00pm -6:00pm):**

Ladybugs: Classroom Door

Caterpillars, Dragonflies & Butterflies: Back Door, Gym Entrance

**\*Note: All children must be dropped off at the door. No parents allowed in the classrooms. Thank you for your cooperation.**

# The LADYBUG PLAYHOUSE




Nursery School  
School Year: \_\_\_\_\_

## Enrollment Form

Child's Name: \_\_\_\_\_ Male or Female \_\_\_\_\_ Date of Birth \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Contact Information:	
Mothers Name	Fathers Name
Address	Address
Phone	Phone
Cell	Cell
Email	Email
Work#	Work#
Occupation	Occupation
Employer	Employer
Employ Address	Employ Address
Single      Married      Divorced      Widowed	Single      Married      Divorced      Widowed
Step Parent Name	Step Parent Name

Medical Information:	
Physician	Phone #
Date of Last Physical	
Medications:	
Allergies: <b>Yes or No</b> ; List of Allergies:	
Special Needs:	
Disabilities:	
Dentist:	Phone #
Date of Last Dental Visit:	

Emergency Contacts/Authorized Pick Ups:		
Name	Relationship	Phone

**OVER →**

**Enrollment Form Continued:**

**Signature & Authorization**

(a) I consent to the enrollment of the child listed on this form in this facility and have been advised of the policies regarding the administration of medication, fees, transportation and the services provided by the facility, and the OCFS Regulations under which it operates. **Yes or No**

(b) In case of accident or injury, I authorize any and all emergency medical, dental, and/or surgical care and hospitalization advised by the physicians, surgeons or hospital, (listed on this form) necessary for the proper health and well-being of my child. **Yes or No**

(c) 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. **Yes or No**

(d) I agree to review and update this information whenever a change occurs. **Yes or No**

(e) I give permission for my child to be photographed and videoed in the classroom. I understand that the photos and video may be used for our website, our school's Facebook page, in newsletters, newspaper advertising/publicity, and/or on our bulletin boards. ***We will never reference your child by name or provide any specific information regarding your child.*** **Yes or No**

(f) I have received The Ladybug Playhouse Handbook and agree to abide by these policies. **Yes or No**

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**CHILD IN CARE MEDICAL STATEMENT**

**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 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	5 <sup>th</sup> Date
Polio (IPV or OPV)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Haemophilus influenzae type B (Hib)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date <b>OR</b> 1 <sup>st</sup> Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	
Hepatitis B	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date		
Measles, Mumps and Rubella (MMR)	1 <sup>st</sup> Date	2 <sup>nd</sup> Date			
Varicella (also known as Chicken Pox)	1 <sup>st</sup> Date	2 <sup>nd</sup> 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. Acceptable tests include Mantoux or other federally approved test.  
 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.

*(Continued on reverse side)*

## CHILD IN CARE MEDICAL STATEMENT *(continued)*

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

### Summary of Physical Exam

Include special recommendations to child day care providers

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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 child day care.

Yes  No

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	(      ) Phone <span style="float: right;">Date</span>

### 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.

**Infant Developmental History**

Today's Date \_\_\_\_\_ Child's Full Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Nickname \_\_\_\_\_ Gender: M F

**Health Information**

1. Is your child taking any medications now? (Including aspirin, laxatives, vitamins, etc.) Yes No

If yes, what? \_\_\_\_\_

Why? \_\_\_\_\_

2. What arrangements have you made for the care of your child should he/she become ill at the center?

\_\_\_\_\_  
\_\_\_\_\_

3. Does your child have any special needs or disabilities? Yes No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

4. Has your child ever been hospitalized? Yes No

If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

5. Does your child chew on unusual things such as cribs, window ledges or hair? Yes No

If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

6. Has your child had any of the following? (Please Circle.)

Premature birth      Birth Injury/Defect      Convulsions/Seizures      Trouble Breathing at birth  
Head Injury      Allergies (including eczema, hives, drug, food intolerance, hay fever, wheezing,  
asthma, insect stings)

If yes, please describe:

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### **Development**

7. At what age did your child begin to walk? \_\_\_\_\_

8. How do you comfort your child? \_\_\_\_\_

9. What are your child's favorite toys? \_\_\_\_\_

10. What are your child's favorite activities? \_\_\_\_\_

11. What is the primary language(s) spoken in your home? \_\_\_\_\_

12. Has your child previously been in a group childcare setting? \_\_\_\_\_

### **Sleeping**

Please describe any specific ways in which you help your child to fall asleep:

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What is your child's current sleeping schedule?

Morning Nap:      Begin \_\_\_\_\_ End \_\_\_\_\_

Afternoon Nap:      Begin \_\_\_\_\_ End \_\_\_\_\_

Nighttime:      Begin \_\_\_\_\_ End \_\_\_\_\_

Does your child use a pacifier at naptime? Yes No

Does your child use a special toy at naptime? Yes No

Does your child use a blanket at naptime? Yes No

## Feeding

Is your child breast-fed? Yes No

Bottle fed? Yes No

Type of bottle: \_\_\_\_\_ Nipple Size: \_\_\_\_\_

Brand of Formula: \_\_\_\_\_

Is the bottle warmed? Yes No

Are there any special instructions for bottle feeding your child? Yes No

If yes, please explain.

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Does your child have any problems with feeding such as choking or spitting up? Yes No

If yes, please explain.

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What is your child's present eating schedule? (Please specify approximate amounts.)

Breakfast	Morning Snack	Lunch	Afternoon Snack	After Care
<b><u>Time:</u></b>	<b><u>Time:</u></b>	<b><u>Time:</u></b>	<b><u>Time:</u></b>	<b><u>Time:</u></b>
<b><u>Food Type/Amount:</u></b>	<b><u>Food Type/Amount:</u></b>	<b><u>Food Type/Amount:</u></b>	<b><u>Food Type/Amount:</u></b>	<b><u>Food Type/Amount:</u></b>

Do have any concerns regarding your child's eating habits? Yes No

If yes, what are they?

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Solid Food Introduction:

\*\* We encourage parents to try new foods with children at home before we introduce them at Ladybug in case of allergies or food sensitivities. If your child is eating table food, please make sure to supply all food including snacks in an insulated lunch box cut into appropriate sizes to avoid choking and please include heating instructions as necessary.

# The LADYBUG PLAYHOUSE

**Infant Feeding Agreement** Nursery School

Child's Name: \_\_\_\_\_ Date Of Birth \_\_\_\_\_

**As an early care and education provider, it is our responsibility to maintain a safe classroom environment for your child. As per OCFS guidelines, an agreement must be made outlining feeding procedures for your child. Please review the following statements, sign, and return it to your Center Director.**

- A schedule of your child's feeding/drinking routine must be provided by the family and updated as needed including times and types of fluids/foods offered.
- All containers or bottles of breast milk, formula or other individualized food items must be provided by the family and clearly marked with the child's complete name.
- Bottles should be prepared and provided by the family each day.
- Unused portions of bottles or containers from which children have eaten must be discarded after each feeding or placed in a securely tied bag and returned to parent at the end of the day. Please let us know your preference.
- Bottles and food items will be warmed using hot water. Microwave use is prohibited.
- Infants six months of age or younger will be held while being bottle fed. Infants older than six months will be held until the infant consistently demonstrates the capability of holding the bottle and ingesting an adequate portion of the contents. At that point, infants may sit in a highchair with their bottle.
- Age-appropriate solid foods will be introduced in consultation with families.

**Please sign below indicating your understanding and agreement. If you have questions about this agreement or questions about your individual needs, please let us know.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## **Toileting**

How frequently does your child have a bowel movement? \_\_\_\_\_

Does your child frequently have diaper rash? Yes No

If so, how is it treated? \_\_\_\_\_

Any Additional Information

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## **Social Emotional Development**

Please describe in detail your infants' "rhythms" of the day including awake times, "Fussy" periods, naps and rest periods, playtimes and how often you typically stimulate your baby through toys and music.

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Does your child...(Please circle all that apply)

Sleep through the night    Self sooth    Settle when held, worn in a sling/baby carrier, etc.

Turns their head    Sits in a bouncy seat    Burps after feedings    Uses a pacifier

Sucks their thumb    Sits in a high chair/support ring    Engages in/enjoys tummy time

Does your child have any allergies or suspected allergies? If yes, please describe in detail.

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What else would you like us to know about your little one or your family?

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NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**PARENT WRITTEN MEDICATION CONSENT FORM**

- This form must be completed in a language in which the child care provider is literate.
- One form must be completed for each medication. Multiple medications cannot be listed on one consent form.
- This form or an approved equivalent may be used when a parent consents to having an over-the-counter topical ointments, lotions and creams, sprays, including sunscreen products and topically applied insect repellent administered to their child in a child day care program.

**PARENT MUST COMPLETE THIS SECTION**

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:
4. Name of medication (including strength): (Diaper Cream)	5. Amount/dosage to be given:	6. Route of administration:
7A. Frequency to be administered, include times of day if appropriate: _____ <i>OR</i>		
7B. Identify the symptoms that will necessitate administration of medication: (signs and symptoms must be observable and, when possible, measurable parameters) _____		
8A. Possible side effects: <input type="checkbox"/> See package insert for complete list of possible side effects (parent must supply) <b>AND/OR</b>		
8B. Additional side effects: _____		
9. What action should the child care provider take if side effects are noted: <input type="checkbox"/> Contact parent _____ Other (describe): _____		
10A. Special instructions: <input type="checkbox"/> See package insert for complete list of special instructions (parent must supply) <b>AND/OR</b>		
10B. Additional special instructions: (Include any concerns related to possible interactions with other medication the child is receiving or concerns regarding the use of the medication as it relates to the child's age, allergies or any pre-existing conditions. Also describe situations when this medication should not be administered.) _____		
11. Reason for the medication: (unless confidential by law): _____		
12. I, the parent, authorize the day care program to administer the medication as specified herein.		
13. Parent name (please print):	14. Date authorized:	
15. Parent signature: <b>X</b>		

**DAY CARE PROGRAM TO COMPLETE THIS SECTION (#16 - #22)**

16. Program name: The Ladybug Playhouse	17. License/Registration number: 548610	18. Program telephone number: 516-252-7207
19. I have verified that #1-#15 are complete. My signature indicates that all information needed to give this medication has been given to the day care program.		
20. Caregiver's name (please print): Andrea Costa-Rothstock	21. Date received from parent:	
22. Caregiver's signature: <b>X</b>		

# The LADYBUG PLAYHOUSE NURSERY SCHOOL

## Parent Class List Authorization

Please fill out the following with information that you would like to be placed on a school parent list. This list will be distributed to the parents of the children enrolled at the Ladybug Playhouse.

Childs Name: \_\_\_\_\_

Parents Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_

Street Address: \_\_\_\_\_

\_\_\_\_\_

I \_\_\_\_\_ give permission to the Ladybug Playhouse Nursery School to place all information stated above on a parent class list that will be distributed to all parents enrolled at The Ladybug Playhouse.

Parent Signature \_\_\_\_\_ Date: \_\_\_\_\_



