

Daycare Registration Form
New York State Office of Children and Family Services

Child's Full Name: _____
 Sex: Male _____ Female _____
 D.O.B. _____
 Home Address: _____
 Date of Acceptance: _____
 Date of Discharge: _____
 Parent Name: _____
 Parent Daytime Telephone: _____

Does your Child have any allergies? Yes _____ No _____
 If Yes, what is your child allergic to? _____

Children who have special health care needs are those who have chronic physical, developmental, behavioral, and emotional conditions expected to last 12 months or more and who also require health and related services of a type beyond that required by children generally. If your child does have a special health care need please discuss these with your child care provider.

Child's Source of Medical Care/Primary Care Physician: _____
 Phone # _____

Child's Source of Dental Care/Dentist name: _____
 Phone # _____

Name of Medical Care/Facility/Hospital: _____
 Phone # _____

Would you like information on Child Health Plus? Yes _____ No _____

Emergency Contact Information (At least 3 needed)

Name	Relationship	Phone #	Additional Phone #

Parent Signature: _____

Date: _____