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THE BELLE CENTER - SUMMER CAMP ENROLLMENT FORM - 2026

PLEASE FILL OUT APPLICATION IN ITS ENTIRETY

SUMMER CAMP (5 - 12 years old):	
☐ **Early Drop Off**: 6:30 AM - 8:00 AM	**Days Needed**: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday
☐ **Belle Center Summer Camp**: 8:00 AM - 5:30 PM	**Check All That Apply**: ☐ **Breakfast** (8:00-8:30 AM) ☐ **Lunch** (11:30 - 12:00 PM) ☐ **Dinner**
☐ **SAY YES**: 8:00 AM - 12:00 PM	**Start Date:** _____

CHILD'S INFORMATION:

Name (First & Last): _____ Nickname: _____ ☐ Male ☐ Female

Date of Birth: _____ / _____ / _____ Age: _____ Grade in Fall: _____ School: _____

Race: _____ Ethnicity: _____ Primary Language: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Swimming Ability: (0 = Never Swam; 10 Excellent): 0 1 2 3 4 5 6 7 8 9 10

APPLICANT/HOUSEHOLD INFORMATION:

Please Check: ☐ BMHA Housing Resident ☐ Subsidized Housing Resident

Participant Lives With: ☐ Mom ☐ Dad ☐ Grandparents ☐ Aunt ☐ Uncle ☐ Foster Parent ☐ Legal Guardian

Parent/Guardian Name (First & Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____ Occupation: _____

Is the current head of household… ☐ Male ☐ Female …a single parent? ☐ Yes ☐ No

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LIABILITY WAIVER/MEDICAL TREATMENT CONSENT:

In consideration for my and/or my family members participation in The Belle Center's program that I wish to register for, I voluntarily RELEASE Erie Regional Housing Development Corporation and the officers, agents, employees, and volunteers, (hereinafter referred to as "releases") from any and all liability for injuries or death or property damage to me and/or my family members resulting from, arising out of, or in any way connected with my and/or any of my family members participation in The Belle Center's recreation programs or use of The Belle Center's facilities in connection with this/these program(s). I understand that this waiver and release is applicable even though the negligent activities of the releases may have contributed to the injury or death or property damage suffered by me or any family members participating in this/these program(s). I further agree to identify and hold harmless the releases from and against any and all liability, claims, causes of action, and/or loss of any kind (including litigation-related expenses such as attorney and expert witness fees) results from participation in this/these program(s) whether caused by any neglect act or omission of the releases.

I further understand that serious accidents may occur in The Belle Center program(s) that I am registering for, that participants in this/these program(s) may sustain mortal or serious personal injuries, and/or property damage, as a consequence of their participation in this/these program(s). Knowing the risk of said events, nevertheless, I hereby agree to assume those risks and to release and hold harmless to the fullest extent allowed by law all of those persons mentioned above who through passive or active negligence or carelessness might otherwise be liable to me for damages.
It is further understood and agreed that this waiver, release, hold harmless, and identification agreement is to be binding on me, any of my participating family members, and all of our heirs, representatives, and assigns.

I hereby authorize qualified physicians to render medical treatment of care that they deem necessary for me or my family members in case of illness or accident during such program(s). In the event of injury of a child participant, and if parent cannot be reached, emergency services and/or the Buffalo Fire Department will be contacted to transport the injured to a nearby local hospital.

Initials: _____

AGREEMENT:

Please read the following and sign.

- **County Child Care Assistance:** I ☐ **expect** or ☐ **do not expect** to be eligible for County Child Care Assistance (DSS) this summer. **Receipt of approval letter is required before start date.** Payments will only be charged in the event that Erie County DSS determines that there is a "Family Share" cost to be paid to The Belle Center.
- **Enrollment**: I consent to the enrollment of the child listed above at The Belle Center and have been advised of the policies regarding fees (**late pick-up fee $20.00/child**) and the New York State Department of Social Services regulations under which it operates. I understand that my child care may be suspended if my account is not current within two weeks.
- **Financial Information Release**: Financial information will only be released to those who sign below. Anyone not named below will obtain information from those signed.
- I understand that this is a **Contract for Services**.
- To Complete Registration: Return Registration Form to ERHDC, The Belle Center, 104 Maryland Street, Buffalo, NY 14201.

Signature of Parent/Guardian: _____ **Date:** _____

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RELEASE OF STUDENT ACADEMIC RECORDS AUTHORIZATION

As a parent/guardian of (Child's Name) _____, I, (Parent/Guardian Name) _____, do hereby give permission for release of my child's academic records to The Belle Center's Out of School Summer Program.

Name of School: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of Child's Most Recent Teacher: _____

Specific information to be released should include the following:

- Most current report card or progress report
- Report cards and standardized testing results from previous year
- Teacher evaluation
- Other: _____

Your timely return of the requested information is appreciated.

- Scan and email to: zsmith@thebellecenter.org
- Fax: 716-845-0486, Attention: School Age Program
- Mail: The Belle Center, Attention: School Age Program, 104 Maryland Street, Buffalo, NY 14201

Signature of Parent/Guardian: _____ **Date:** _____

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EMERGENCY CONTACT FORM		
Child's Full Name:	**Gender:** ☐ Female ☐ Male	**Date of Birth: (MM/DD/YYYY)**
Child's Home Address:	**Name of Person Applying for Child:**	
Does your child have health insurance?: ☐ Yes ☐ No **Insurance Carrier:** _____ **Policy #:** _____ **Group #:** _____	**Daytime Telephone #:** ☐ Parent ☐ Guardian ☐Other _____	
Does your child have any allergies? ☐ Yes ☐ No	**If yes, what is your child allergic to and what is the reaction?**	
Children who have special health care needs are those who have chronic physical, developmental, behavioral, or 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 special health care needs, please discuss these with your child care provider.		
Medications: Medications require a separate form. Please contact the youth director for more information.		
Child's Primary Care Physician's Name:	**Primary Care Physician's Telephone #:**	
Child's Source of Dental Care/Dentist's Name:	**Dental Care/Dentist's Telephone #:**	
Name of Medical Care Facility/Hospital:	**Medical Care Facility/Hospital Telephone #:**	

	CONTACT NAME	RELATIONSHIP TO CHILD	TELEPHONE NUMBER	AUTHORIZED TO PICK UP?
Emergency Data				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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Agreements: I consent to the enrollment of the child listed above in this facility and have been advised of the policies regarding administration of medications, fees, transportation and the services provided by the facility, and the Office of Children and Family Services regulations under which it operates.

I give consent for my child to take part in neighborhood trips (i.e. library, park and playground) away from the facility under proper supervision, including transportation provided by or arranged for The Belle Center's Out of School Program. ☐ **Yes** ☐ **No**

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

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** ☐ **No**

I understand and agree that photographs, videos, or other images may be taken during recreation programs and that I hereby give permission to have my child's photo taken and authorize the use and reproduction of said photos by The Belle Center. All negatives and prints shall become the sole property of The Belle Center. ☐ **Yes** ☐ **No**

I give permission for The Belle Center staff to apply sunscreen and insect repellent to my child. ☐ **Yes** ☐ **No**

My child is allowed to participate in swimming activities at The Belle Center. ☐ **Yes** ☐ **No**

I agree to review & update this information whenever a change occurs and at least once every six months. ☐ **Yes** ☐ **No**

Signature of Parent/Guardian: _____ **Date:** _____

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Field Trip Information	
Date/Time	**July 6, 2026 - August 24, 2026**
Destination/Transportation	**ALL SAY YES/BELLE CENTER SUMMER FIELD TRIPS AND OUTINGS**
Participation Costs/Fees	**$ 0.00**
Important Notes/Supplies	

Student Information	
Full Name	
Emergency Contact 1 Name/Phone	
Emergency Contact 2 Name/Phone	
Medical Considerations	

Parent/Guardian Signature	
Full Name	
Signature	
Date	

Participation Permissions	Initials
I give permission for my child to participate in this field trip. As such, I acknowledge I am aware of: • Risks including but not limited to slips, falls, pinches, scrapes, twists, jolts, scratches, bruises, sprains, lacerations, fractures, concussions, or even more severe injuries. • Potential hazards associated with travel to and from the field trip site. • Possible contact with plants, animals, or insects that could result in stings, allergic reactions, and associated diseases. Further, I confirm I have provided: • Appropriate and available emergency contact information for the duration of all field trips and travel hours. • All necessary medical information, including a list of allergies, instructions, and medications to the appropriate school staff to ensure adequate care is available while my student is under their supervision.	
I **DO NOT** give permission for my student to participate in this field trip.	

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Swimming Pool Waiver and Release of Liability Form

Release of Liability, Waiver of Claims, Assumption of Risk, and Indemnity Agreement

PLEASE READ CAREFULLY. BY SIGNING THIS DOCUMENT, YOU CHOOSE TO WAIVE CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE.

To: Parents and Guardians of the Belle Center

I wish to swim at the Center's pool during Daycare and SACC hours. In swimming at the Center's pool during this time, I recognize and fully understand certain things, including:

- During swim sessions a lifeguard will be on duty at all times.
- The swimmer has to take a swimming test, if not passed then has to wear a flotation device and not go past the deep end line. If passed, the swimmer has the option to take the deep end test, if passed both tests they will receive a bracelet and lifeguard will keep track of who has successfully tested.
- The pool is divided into two sections: a shallow end (depth of shallow end varies from 3ft to 5ft) and deep end (depth of deep end varies from 5ft to 11.5ft)
- My use of the Center's pool during these swim sessions involves certain risks, including:
    - The risk of injury resulting from possible malfunction of the pool equipment;
    - The risk of injuries resulting from tripping or falling over obstacles in the pool area;
    - The risk of injuries resulting from unsupervised divers and swimmers colliding;
    - The risk of other injuries resulting from participating in the swim session.
- I recognize and fully understand that the above list is not a complete or exhaustive list of all possible risks; the list only provides examples of types of risks that I am assuming.

In exchange for the Center allowing me to participate in the swim sessions, I hereby agree to the conditions below. I fully intend and choose to give up the legal rights, as stated below:

1. TO WAIVE ALL CLAIMS that I have or may have in the future against the Owner, its directors, officers, employees, agents, or representatives (hereinafter referred to as the "Releases") Relating to my use of the pool and pool area;
2. TO RELEASE THE RELEASES from any and all liability for any loss, damage, injury, expense, or other cost that I may suffer or that my next of kin may suffer in connection with my use of the Releases pool or pool area to any cause whatsoever, INCLUDING NEGLIGENCE ON THE PART OF THE RELEASES;
3. TO HOLD HARMLESS AND INDEMNIFY THE RELEASES from any and all liability to property, or personal injury to, any third party, resulting from the use of the pool or pool area.
4. That I am over 18 and that I am responsible and will adhere to all the rules of the property.

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5. That this Waiver, Release, and Agreement is fully effective and shall be effective and binding upon me, and my heirs, next of kin, executors, administrators, and assigns, or anyone else authorized to act on my behalf or on behalf of my estate

I have read and understood this document. I am aware that by signing this document, I am waiving certain legal rights that I may have against the Releases, and I fully agree that I am over eighteen (or have my adult parent's or guardian's signature below).

Name of Child: _____
Age and Gender of Child: _____

Name and signature of Parent or Guardian:

_____

Date: _____

NEW YORK STATE DEPARTMENT OF HEALTH
Child and Adult Care Food Program

Income Eligibility Form
for Child Care Centers

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME _____

Print the name of the child(ren) enrolled in this child care center

1. _____ 2. _____ 3. _____

DIRECTIONS

Complete SECTION A if anyone in your household
1. Participates in the Supplemental Nutrition Assistance Program (SNAP)
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR) OR
4. Is a foster child

SECTION A

SNAP Case # _____

TANF # _____

FDPIR # _____

Names of Foster Children _____

_____

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true. I understand that the center will get Federal funds based on the information I give.

Signature _____

Date _____

FOR SPONSOR USE ONLY

CACFP Agreement # _____

Total Number of Household Members _____
(INCLUDING FOSTER CHILDREN, IF APPLICABLE)

Total Household Income $ _____

Free _____ Reduced _____ Paid _____

Date of Determination _____

Signature of Center Staff _____

Complete SECTION B if no one in your household participates in SNAP, receives TANF, participates in FDPIR or if none of the children enrolled in the child care center is a foster child.

SECTION B

List all household members below. Include yourself and all adults and children NOT listed above, even if they do not receive income. Then list all income received **last month** in your household in the column to the right. Gross income includes: earnings from work, pensions, retirement, Social Security, child support, foster child's personal income and any other sources of income.

HOUSEHOLD MEMBER NAME	MONTHLY GROSS SALARY
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$
7.	$

An adult household member must sign the application before it can be approved. After reading the following statement and the statement on the back, sign below.

I certify that the above information is true and that all income is reported. I understand that the center will get Federal funds based on the information I give.

Signature _____

Print Name _____

LAST FOUR (4) DIGITS OF SOCIAL SECURITY NUMBER [ ][ ][ ][ ]

DATE _____

USDA is an equal opportunity provider and employer.

Agency: _____
Activity:

CLIENT CHARACTERISTIC FORM - CDBG 51

Public Services - Limited Clientele Activities

Staff Reviewed Initial _____
Issue Date: **10/1/25**

PARTICIPANTS MUST FILL AND COMPLETE ENTIRE FORM FOR ELIGIBILITY. THIS INFORMATION IS FOR RECORD KEEPING ONLY AND WILL NOT BE PUBLICLY SHARED.

Home Address: _____ City: _____ Zip: _____

1. Individual Age: Please check **one** from the below based on your (the participant) age.

◯ Under 5 years	◯ 10-15 years	◯ 21-24 years	◯ 45-54 years	◯ 62 years and older
◯ 5-9 years	◯ 16-20 years	◯ 25-44 years	◯ 55-61 years	

2. Gender: Please check **one** from the below based on your (the participant) gender.

◯ Male	◯ Female	◯ Other: _____

3. Please check **one** from the below for your (the participant) ethnicity. Ethnicity and Race are separate, please answer #4 as well.

◯ Hispanic	◯ Non-Hispanic

4. Please check **one** from the below which best describes your (the participant) race.

◯ White	◯ Asian and Black or African American
◯ Black or African American	◯ American Indian or Alaskan Native and White
◯ Asian	◯ American Indian or Alaskan Native and Black or African American
◯ American Indian or Alaskan Native	◯ Native Hawaiian or other Pacific Islander and White
◯ Native Hawaiian or other Pacific Islander	◯ Native Hawaiian or other Pacific Islander and Black or African American
◯ Black or African American and White	◯ Other/Multi Racial
◯ Asian and White	

5. Is your (the participant) family type defined as an **adult female head of household** (no male significant other with dependents)?

◯ Yes	◯ No	◯ Not Applicable

6. Are you (the participant) severely disabled?

◯ Yes	◯ No

7. Household Income: Please check **one** from the below based on your income and the number of members living in your household. **You may skip this section if you are over the age of 62, severely disabled or meet any other criteria for Presumed Benefit.**

Income Limits	1 Person Household	2 Person Household	3 Person Household	4 Person Household
30% median (XL)	◯ $21,250 or less	◯ $24,250 or less	◯ $27,300 or less	◯ $32,150 or less
50% median (VL)	◯ $35,350 or less	◯ $40,400 or less	◯ $45,450 or less	◯ $50,500 or less
80% median (LI)	◯ $56,600 or less	◯ $64,650 or less	◯ $72,750 or less	◯ $80,800 or less
81%+ median	◯ $56,601 or more	◯ $64,651 or more	◯ $72,751 or more	◯ $80,801 or more
Income Limits	**5 Person Household**	**6 Person Household**	**7 Person Household**	**8 Person Household**
30% median (XL)	◯ $37,650 or less	◯ $43,150 or less	◯ $48,650 or less	◯ $54,150 or less
50% median (VL)	◯ $54,550 or less	◯ $58,600 or less	◯ $62,650 or less	◯ $66,700 or less
80% median (LI)	◯ $87,300 or less	◯ $93,750 or less	◯ $100,200 or less	◯ $106,700 or less
81%+ median	◯ $87,301 or more	◯ $93,751 or more	◯ $100,201 or more	◯ $106,701 or more

Certification (If participant is under the age of 18, this form must be completed and signed by a parent or guardian): *I acknowledge that this information as submitted above has been examined by myself and is true and correct.*

Name: _____ Participant Name (if applicable): _____

Signature: _____ Date: _____

THIS DOCUMENT FOR HUD CDBG ELIGIBILITY MUST BE KEPT ON RECORD FOR A PERIOD OF 4 YEARS (CFR 24 §570.490).

DEFINITION FOR REPORTING TABLE RACE AND ETHNICITY

Racial Categories:

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, of the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Ethnic Categories:

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, " Spanish origin," can be used in addition to "Hispanic or Latino."

Not Hispanic of Latino: A person not of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Data Collection Information for Race and Ethnicity:

All Public Services Subrecipients must use a two-question format, meaning that separate questions for race and ethnicity should be used. Race and ethnicity are not the same thing. Both questions must be answered. The ethnicity question should precede the race question. Self-reporting or self-identification, rather than observer identification is the preferred method for collecting race and ethnicity data. Self-identification for race and ethnicity means that responses are based on self-perception.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

- This form may be used to meet the consent requirements for the administration of the following: prescription medications, oral over-the-counter medications, medicated patches, and eye, ear, or nasal drops or sprays.
- Only those staff certified to administer medications to day care children are permitted to do so.
- One form must be completed for each medication. Multiple medications cannot be listed on one form.
- Consent forms must be reauthorized at least once every six months for children under 5 years of age and at least once every 12 months for children 5 years of age and older.

LICENSED AUTHORIZED PRESCRIBER COMPLETE THIS SECTION (#1 - #18) AND AS NEEDED (#33 - 35).

1. Child's First and Last Name:	2. Date of Birth: / /	3. Child's Known Allergies:
4. Name of Medication *(including strength)*:	5. Amount/Dosage to be Given:	6. Route of Administration:

7A. Frequency to be administered: _____

OR

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: ☐ See package insert for complete list of possible side effects *(parent must supply)*

AND/OR

8B: Additional side effects:

9. What action should the child care provider take if side effects are noted:

☐ Contact parent ☐ Contact health care provider at phone number provided below

☐ Other *(describe)*: _____

10A. Special instructions: ☐ See package insert for complete list of special instructions *(parent must supply)*

AND/OR

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 situation's when medication should not be administered.)* _____

11. Reason for medication *(unless confidential by law)*: _____

12. Does the above named child have a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and requires health and related services of a type or amount beyond that required by children generally?

☐ No ☐ Yes If you checked yes, complete (#33 and #35) on the back of this form.

13. Are the instructions on this consent form a change in a previous medication order as it relates to the dose, time or frequency the medication is to be administered?

☐ No ☐ Yes If you checked yes, complete (#34 -#35) on the back of this form.

14. Date Health Care Provider Authorized: / /	15. Date to be Discontinued or Length of Time in Days to be Given: / /
16. Licensed Authorized Prescriber's Name (please print):	17. Licensed Authorized Prescriber's Telephone Number:

18. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

MEDICATION CONSENT FORM

CHILD DAY CARE PROGRAMS

PARENT COMPLETE THIS SECTION (#19 - #23)

19. If Section #7A is completed, do the instructions indicate a specific time to administer the medication? *(For example, did the licensed authorized prescriber write 12pm?)* ☐ Yes ☐ N/A ☐ No

Write the specific time(s) the child day care program is to administer the medication *(i.e.: 12 pm)*: _____

20. I, parent, authorize the day care program to administer the medication, as specified on the front of this form, to *(child's name):*

21. Parent's Name *(please print)*:	22. Date Authorized: / /

23. Parent's Signature:

X

CHILD DAY CARE PROGRAM COMPLETE THIS SECTION (#24 - #30)

24. Program Name:	25. Facility ID Number:	26. Program Telephone Number:

27. I have verified that (#1 - #23) and if applicable,(#33 - #36) are complete. My signature indicates that all information needed to give this medication has been given to the day care program.

28. Staff's Name *(please print)*:	29. Date Received from Parent: / /

30. Staff Signature:

X

ONLY COMPLETE THIS SECTION (#31 - #32) IF THE PARENT REQUESTS TO DISCONTINUE THE MEDICATION PRIOR TO THE DATE INDICATED IN (#15)

31. I, parent, request that the medication indicated on this consent form be discontinued on / / _____ (Date)

Once the medication has been discontinued, I understand that if my child requires this medication in the future, a new written medication consent form must be completed.

32. Parent Signature:

X

LICENSED AUTHORIZED PRESCRIBER TO COMPLETE, AS NEEDED (#33 - #35)

33. Describe any additional training, procedures or competencies the day care program staff will need to care for this child.

34. Since there may be instances where the pharmacy will not fill a new prescription for changes in a prescription related to dose, time or frequency until the medication from the previous prescription is completely used, please indicate the date you are ordering the change in the administration of the prescription to take place.

DATE: / / _____

By completing this section, the day care program will follow the written instruction on this form and *not* follow the pharmacy label until the new prescription has been filled.

35. Licensed Authorized Prescriber's Signature:

X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

You may use this form or an approved equivalent to document an individual health care plan developed for a child with special health care needs.

A child with a special health care need means a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally.

Working in collaboration with the child's parent and child's health care provider, the program has developed the following health care plan to meet the individual needs of:

CHILD NAME:	CHILD DATE OF BIRTH: / /
NAME OF THE CHILD'S HEALTH CARE PROVIDER:	☐ Physician ☐ Physician Assistant ☐ Nurse Practitioner

Describe the special health care needs of this child and the plan of care as identified by the parent and the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment.

Identify the caregiver(s) who will provide care to this child with special health care needs:

Caregiver's Name	Credentials or Professional License Information (if applicable)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

INDIVIDUAL HEALTH CARE PLAN FOR A CHILD WITH SPECIAL HEALTH CARE NEEDS

Describe any additional training, procedures or competencies the caregiver identified will need to carry out the health care plan for the child with special health care needs as identified by the child's parent and/or the child's health care provider. This should include information completed on the medical statement at the time of enrollment or information shared post enrollment. In addition, describe how this additional training and competency will be achieved including who will provide this training.

This plan was developed in close collaboration with the child's parent and the child's health care provider. The caregivers identified to provide all treatments and administer medication to the child listed in the specialized individual health care plan are familiar with the child care regulations and have received any additional training needed and have demonstrated competency to administer such treatment and medication in accordance with the plan identified.

PROGRAM NAME: The Belle Center	FACILITY ID NUMBER: 637203	PROGRAM TELEPHONE NUMBER: (716) 845-0485
CHILD CARE PROVIDER'S NAME (PLEASE PRINT):		DATE: / /
CHILD CARE PROVIDER'S SIGNATURE: X		

I agree this Individual Health Care Plan meets the needs of my child. Yes ☐ No ☐

I give consent to share information about my child's allergy with all program caregivers in a non-discreet way. I support the strategies the program implements to keep my child from being exposed to known allergen(s). I acknowledge these strategies may include visual reminders that may result in the disclosure of my child's confidential allergy information to non-child care staff. Yes ☐ No ☐

Signature of Parent:

X	DATE: / /