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Dear Parent/Guardian,

Included in this packet are the following:

Required Forms
Enrollment Packet
Medication Consent Form - OCFS-LDSS-7002 (if applicable)
Individualized Health Care Plan - OCFS-LDSS-7006 (if applicable)
COVID-19 Health Policy
DSS Approval Letter
Client Characteristic Form
Swimming Waiver
2 - Day Care Enrollment Blue Cards - OCFS-LDSS-0792
Child In Care Medical Statement - OCFS-LDSS-4433
Healthy Child Policy
Napping Agreement
Emergency Contact Form
Child & Adult Care Food Program Income Eligibility Form
Bus Information Sheet (if applicable)

Contract - The parent/guardian contract must be filled out completely before starting the program; The contract has the days and times your child(dren) will be attending, and the cost of care for family share and or private pay.

All completed applications must be returned to the administration side of The Belle Center. **DO NOT** return completed applications to the daycare.

Please feel free to reach out to 716-845-0485 if you have any questions.

Thank you,

Belle Center Daycare

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YEAR: _____

THE BELLE CENTER: DAYCARE ENROLLMENT FORM

PLEASE FILL OUT APPLICATION IN ITS ENTIRETY

DAYCARE (6 weeks - 5 years old):		
☐ **DAYCARE** 6:30 AM - 5:30 PM	**Days Needed**: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	
☐ **DAYCARE** **HOLIDAYS / RECESS ONLY** 6:30 AM - 5:30 PM	**Times Needed:** _____ _____	**Meals:** ☐ Breakfast ☐ Lunch ☐ Snack
Start Date: _____		

CHILD'S INFORMATION:

Name (First & Last): _____ Nickname: _____

Date of Birth: _____ / _____ / _____ Age: _____ Gender: ☐ Male ☐ Female

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). **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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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:** _____

FIELD TRIP ACKNOWLEDGMENT

Please read the following and sign. **Permission slips will be sent home prior to field trips.**	**Signature**
I give permission for my child to participate in field trips. 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 <u>DO NOT</u> give permission for my child to participate in field trips. I understand that I will be responsible for childcare on days there are field trips.	

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The Belle Center Infectious Disease / COVID-19 Health Policy

Our priority at The Belle Center is to ensure the health and safety of the children and staff that come to our center every day. We will not be successful without your help! Our new health guidelines are based on recommendations set forth by our local licensing agency, recommendations made by our Health Care Consultant, which were based on The Center for Disease control. The practices are subject to change as needed.

As COVID-19 is still around our community, we are asking each of our families to acknowledge and agree to the following procedures. *This form must be returned before your child can start/return to our program.*

Child's Name: _____ DOB: _____

I, _____, _____
Parent/Guardian Relationship to Child

Acknowledge that if my child or any person within my household shows any of the following symptoms, I agree to keep them home for 48 hours or until the child is fever free, without fever reducing medication.

- Fever over 100.0
- Excessive dry cough
- Shortness of breath
- Lethargic, overly tired, unusually calm or quiet
- Mild respiratory illness/issues

If my child experiences any of the above symptoms during childcare, I understand that either myself, or a person I have designated as an emergency pick up, will arrive within one hour.

Administration may request a physician's note to return to care.

I agree to inform the program if my child, or any family member, has tested positive for COVID-19 so that the program can take necessary mandated steps. Your child's identity will remain confidential.

Out of respect for the other children, families, and staff members, failure to abide by our policies or failure to disclose COVID-19 exposure or positive test of your child or family member may result in immediate termination from this program.

I certify and acknowledge that I have read and understand the COVID-19 Health Policy and agree to the terms listed above.

Signature: _____ Date: _____

Print Name: _____

Director Signature: _____ Date: _____

THE BELLE CENTER - HOME OF ERIE REGIONAL HOUSING DEVELOPMENT CORPORATION
104 Maryland Street • Buffalo, New York 14201 • Phone 716-845-0485 • Fax 716-845-0486 • www.thebellecenter.org
Connect With Us:

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Healthy Child Policy

It is our intention to promote the health and well-being of all children in the center. In order to maintain a healthy atmosphere and protect everyone from the risk of infection, children may not be brought to the center is they have the following symptoms:

- Fever of 100.0 or more
- Vomiting
- Diarrhea
- Undiagnosed Rash of any kind
- Red Eyes with Discharge
- Any Nasal Discharge that is not clear in color

If children develop these symptoms while at the center, parents **will be contacted** and **must pick up the child within the hour**.

Children must be symptom free for a full 24 hours before returning to the center

For example, if you are called to pick up a sick child on Monday afternoon, the child should not return to the center on Tuesday because the child has not been symptom free for 24 hours.

Exceptions to this policy require a doctor's note stating the child may return to school/daycare. Any contagious illness requires a doctor's note to return to school.

Thank you for your cooperation with these policies and keeping all children and staff healthy!

I have read the policy above and understand the Healthy Child Policy and agree to comply with it.

Parent Signature: _____ Date: _____

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Health Policies

(PER NYS HEALTH DEPARTMENT REGULATIONS)

CHILDREN WILL BE SENT HOME IF:

1. A temperature of 100.0 or more. **(NO MATTER WHAT THE CAUSE)**

2. Children are sick the night before or morning of school/daycare attendance. **DO NOT** give tylenol and send the child/children in.

3. Diarrhea (loose and smelly) stools x3.

4. Illness such as: Earache, Vomiting, Sore Throat, Red Running Eyes, Swollen Glands, Unusual Fatigue, Severe Cough. **(MUST SEE DOCTOR)**

5. **Communicable Diseases** such as:
   - Chicken Pox
   - Lice
   - Measles
   - Mumps
   - Roseola
   - Strep Throat
   - Scarlet Fever
   - Whooping Cough
   - Tonsillitis
   - Meningitis
   - Pink Eye
   - Impetigo
   - Ringworm
   - Pinworms
   - Otitis Media Infections (Ear)

6. Hand and Mouth Disease: **MUST STAY HOME** until blisters clear. Thrush: **MUST STAY HOME** until the coating inside the mouth clears.

7. **Must have a doctor's note for readmittance if absent for three (3) consecutive days or has had a contagious illness.**

8. **You must** alert staff to any medication given to the child whether non-prescription (over the counter) or prescription. If the child is taking an antibiotic, **they must stay at home** for one (1) full day or a full 24 hours after starting the medicine.

9. If any of the above symptoms of illness occur while the child is at The Belle Center Child Care Center, **we will send the child home**.

10. This is for the benefit of all our children, to prevent the spread of illness and infections.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD DAY CARE CENTER
SLEEPING AND NAPPING AGREEMENT

This form may be used to meet the regulatory requirement that, other than for school-age children, sleeping and napping arrangements must be made in writing between the parent and the program.

Name of Child in Care:	**Date of Birth** / /

Name of Parent/Guardian:	
Name of Program: Erie Regional Housing Development Corp.	Facility ID# 416503

Area of program where child will nap or sleep: In Child's Classroom
Napping or sleeping surface (Check all that apply): ☐ Mat ☑ Cot ☐ Bed ☑ Crib
How will the child be supervised? Children will be supervised by staff at all times during nap or sleep times. Staff will circulate the sleep area and check on the children throughout nap or sleep times.

All applicable regulations must be followed, including, but not limited to, those listed below. Contact your regulator with any questions.

- In a child day care center, children may not sleep or nap in car seats, baby swings, strollers, infant seats, or bouncy seats, unless otherwise prescribed by a health care provider. Should a child fall asleep in one of these devices, they must be moved to an approved sleeping surface.
- Sleeping arrangements for infants through 12 months of age require that the infant be placed flat on their back to sleep, unless medical information from the child's health care provider is presented to the program by the parent that shows that arrangement is inappropriate for that child.
- Cribs, bassinets, and other sleeping areas for infants through 12 months of age must include an appropriately sized fitted sheet and must not have bumper pads, toys, stuffed animals, blankets, pillows, wedges, or infant positioners. Wedges or infant positioners will be permitted with medical documentation from the child's health care provider.
- The resting/napping places must be located in approved day care space; be located in safe areas of the program; be located in a draft-free area; be where children will not be stepped on; be in a location where safe egress is not blocked; allow a person to move freely and safely within the napping area in order to check on or meet the needs of children; and be at least two feet apart from each other.
- Children unable to sleep during nap time shall not be confined to a sleeping surface (cot, crib, etc.) but instead must be offered a supervised place for quiet play.
- A copy of this agreement must be kept on file at the program and accessible for review.

Signature of Parent/Guardian	Signature of Program Staff
/ /	/ /
Date	Date

ESTADO DE NUEVA YORK
OFICINA DE SERVICIOS PARA NIÑOS Y FAMILIAS

CENTRO DIURNO DE CUIDADO INFANTIL
ACUERDO DE DESCANSO Y SIESTA

Este formulario puede usarse para cumplir con el requisito regulatorio de que, excepto para niños en edad escolar, los acuerdos de descanso y siesta deben hacerse por escrito entre el padre/madre/tutor y el programa.

Nombre del niño bajo cuidado:	**Fecha de nacimiento** / /

Nombre del padre/madre/tutor:	
Nombre del programa: Corporación Regional de Desarrollo de Vivienda de Erie	N.° de id. de la instalación 416503

Lugar del programa donde el niño dormirá: En el aula del niño
Superficie para dormir (Marque todas las que apliquen): ☐ Esterilla ☑ Catre ☐ Cama ☑ Cuna
¿Cómo se supervisará al niño? Los niños serán supervisados por el personal en todo momento durante la siesta o la hora de dormir. El personal circulará por el área de dormir y se supervisarán a los niños durante la siesta o la hora de dormir.

Deben respetarse todas las normas vigentes que incluyen, entre otras, las que se enumeran a continuación. Comuníquese con su regulador si tiene preguntas.

- En un centro diurno de cuidado infantil, los niños no dormirán en asientos para automóvil, hamacas para bebés, cochecitos, asientos infantiles o sillas brincadoras, a menos que un proveedor de atención médica indique lo contrario. En caso de que un niño se duerma en uno de estos dispositivos, debe ser trasladarlo a una superficie para dormir aprobada.
- Los planes para dormir para bebés de hasta 12 meses de edad exigen que se coloque al bebé con la espalda sobre una superficie para dormir, a menos que el padre/madre/tutor presente información médica del proveedor de atención médica del niño ante el programa donde se indique que la disposición no es apropiada para ese niño.
- Las cunas, moisés y otras zonas de descanso para bebés de hasta 12 meses de edad deben incluir una sábana ajustable de un tamaño apropiado y no deben tener almohadillas, juguetes, peluches, mantas, almohadas, cojines de cuña o posicionadores para bebés. Se permitirán los cojines de cuña o posicionadores para bebé con documentación médica del proveedor de atención médica del niño.
- Los lugares de descanso/siesta deben encontrarse en zonas apropiadas de cuidado; encontrarse en zonas seguras del programa; encontrarse en una zona sin corrientes de aire; encontrarse donde no se pisará a los niños; encontrarse en una ubicación donde no se bloquee una salida segura; y deben permitir que una persona se mueva de forma libre y segura por la zona de siesta para controlar a los niños o satisfacer sus necesidades; y estar a un mínimo de dos pies de distancia entre sí.
- Los niños que no puedan dormir durante el tiempo de siesta no se confinarán en una superficie de descanso (cuna, catre, etc.) sino que se les ofrecerá un lugar supervisado para jugar en silencio.
- Debe conservarse una copia de este acuerdo en el expediente del programa y debe poder accederse para su revisión.

Firma del padre/madre/tutor	Firma del personal del programa
/ /	/ /
Fecha	Fecha

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

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). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd 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)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

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

/ /

Date

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:	FACILITY ID NUMBER:	PROGRAM TELEPHONE NUMBER:
The Belle Center	416503	(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: / /

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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.

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: _____

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Formulario de exención de piscina y liberación de responsabilidad

Liberación de responsabilidad, renuncia a reclamaciones, asunción de riesgos y acuerdo de indemnización

POR FAVOR, LEA ATENTAMENTE. AL FIRMAR ESTE DOCUMENTO, USTED ELIGE RENUNCIAR A CIERTOS DERECHOS LEGALES, INCLUIDO EL DERECHO A DEMANDAR.

Para: Padres y tutores del Belle Center

Deseo nadar en la piscina del Centro durante las horas de guardería y SACC. Al nadar en la piscina del Centro durante este tiempo, reconozco y entiendo completamente ciertas cosas, que incluyen:

- Durante las sesiones de natación una socorrista estará de guardia en todo momento
- El nadador tiene que tomar una prueba de natación, si no se aprueba, entonces tiene que usar un dispositivo de flotación y no ir más allá de la línea de extremo profundo. Si se aprueba, el nadador tiene la opción de tomar la prueba de extremo profundo, si pasa ambas pruebas recibirá un brazalete y el salvavidas hará un seguimiento de quién ha probado o no.
- La piscina está dividida en dos secciones: un extremo poco profundo (la profundidad del extremo poco profundo varía de 3 pies a 5 pies) y un extremo profundo (la profundidad del extremo profundo varía de 5 pies a 11.5 pies)
- Mi uso de la piscina del Centro durante estas sesiones de natación implica ciertos riesgos, que incluyen:
    - El riesgo de lesiones resultantes de un posible mal funcionamiento del equipo de la piscina;
    - El riesgo de lesiones resultantes de tropezar o caer sobre obstáculos en el área de la piscina;
    - El riesgo de lesiones resultantes de buzos y nadadores sin supervisión que colisionan;
    - El riesgo de otras lesiones resultantes de participar en la sesión de natación.
- Reconozco y entiendo plenamente que la lista anterior no es una lista completa o exhaustiva de todos los riesgos posibles; la lista solo proporciona ejemplos de tipos de riesgos que estoy asumiendo.

A cambio de que el Centro me permita participar en las sesiones de natación, acepto las siguientes condiciones. Tengo la intención y elijo renunciar a los derechos legales, como se indica a continuación:

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1. RENUNCIAR A TODAS LAS RECLAMACIONES que tenga o pueda tener en el futuro contra el Propietario, sus directores, funcionarios, empleados, agentes o representantes (en adelante, las "Liberaciones") relacionadas con mi uso de la piscina y el área de la piscina;
2. PARA LIBERAR A LOS EXONERADOS de toda responsabilidad por cualquier pérdida, daño, lesión, gasto u otro costo que pueda sufrir o que mis familiares más cercanos puedan sufrir en relación con mi uso de la piscina de Liberaciones o el área de la piscina por cualquier causa, INCLUIDA LA NEGLIGENCIA POR PARTE DE LAS LIBERACIONES;
3. EXIMIR DE RESPONSABILIDAD E INDEMNIZAR A LAS LIBERACIONES de cualquier y toda responsabilidad a la propiedad, o lesiones personales a terceros, resultantes del uso de la piscina o el área de la piscina
4. Que soy mayor de 18 años y que soy responsable y me adheriré a todas las reglas de la propiedad.
5. Que esta renuncia, liberación y acuerdo es plenamente efectiva y será efectiva y vinculante para mí, y mis herederos, parientes más cercanos, albaceas, administradores y cesionarios, o cualquier otra persona autorizada para actuar en mi nombre o en nombre de mi patrimonio.

He leído y entendido este documento. Soy consciente de que al firmar este documento, estoy renunciando a ciertos derechos legales que pueda tener contra las Liberaciones, y estoy totalmente de acuerdo en hacerlo.

Nombre del niño:_____
Edad y sexo del niño:_____

Nombre y firma del padre o tutor:

_____

Fecha: _____

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).