EMAIL: ____________________ START DATE ____________

APPLICATION

WEEK 1 ☐ WEEK 2 ☐ WEEK 3 ☐ — 8:00 - 5:00 ☐ or 8:00 - 5:30 ☐

WEEK 4 ☐ WEEK 5 ☐ WEEK 6 ☐ — 8:00 - 5:00 ☐ or 8:00 - 5:30 ☐

☐ MALE
☐ FEMALE

CHILD'S NAME: ____________________ D.O.B. __________ AGE: __________

PARENT'S/GUARDIAN'S NAME: ____________________

ADDRESS: ____________________

CITY: ____________________ STATE: __________ ZIP __________

HOME PHONE: __________ WORK PHONE: __________ CELL PHONE: __________

EMERGENCY CONTACT: ____________________ TEL #: __________

PHYSICIAN OR MEDICAL SERVICES ____________________ TEL#: __________

MEDICAL INFORMATION

DOES YOUR CHILD NEED ANY MEDICATION? ☐ YES ☐ NO

DOES YOUR CHILD HAVE ANY ALLERGIES? ☐ YES ☐ NO

IF YES, PLEASE EXPLAIN: ____________________

AGREEMENT

I CONSENT TO THE ENROLLMENT OF THE CHILD LISTED ABOVE I THIS FACILITY AND HAVE BEEN ADVISED OF THE POLICIES REGARDING FEES, TRANSPORTATION AND THE SERVICES PROVIDED BY THE FACILITY UNDER WHEICH IT OPERATES. I UNDERSTAND THAT THERE IS A $20 LATE PICK UP FEE FOR THE FIRST 15 MINUTES AND EVERY 15 MINUTES THERE AFTER.

I GIVE CONSENT FOR THIS CHILD TO TAKE PART IN FIELD TRIPS OR EXCERSIONS AWAY FROM THE FACILITY UNDER PROPER SUPERVISION. I AGREE THAT IN CASE OF ACCIDENT OR INJURY, EMERGENCY MEDICAL CARE MAY BE GIVEN IN THE EVENT THAT I OR PERSON(S) DESIGNATED ABOVE CANNOT BE REACHED.

I ALLOW ☐ I DO NOT ALLOW ☐ MY SON/DAUGHTER TO BE PHOTOGRAPHED/VIDEOTAPED FOR THE SMILEY FACES WEBSITE.

SIGNATURE OF PARENT/GUARDIAN: ____________________ DATE: __________

Smiley Faces

SUMMER FUN
at
Montessori Academy

(near Cross County, Central Park Ave., Yonkers Ave., McLean Ave. & Bronx River Rd.)

99 Wakefield Avenue
Yonkers, NY 10704
Tel: (914) 424-3993
or (914) 830-3532

Visit us at: smileyfacesdc.com

Ages 4 – 14 Years
(must be turning 5 by 12/31/19)

"A Summer full of Fun and Smiles"

OVER 20 YEARS OF EXPERIENCE
"Bringing Smiles to Every Child's Face"

ACTIVITIES:

All activities are age appropriate; Activities include, but are not limited to:

- Weekly Field Trips
- Swimming (Lifeguards on staff)
- Outdoor water sprinklers to keep cool
- Talent shows
- Non-Instructional music/dance
- Non-Instructional Sports: Baseball, Basketball, Flag Football, Soccer, Kickball . . . and much more
- Arts and crafts, boardgames

*** NO FLIP FLOPS ALLOWED!**

FIELD TRIPS:

Must be paid separately at time of registration

- Swimming - (FREE) (Included in Camp Cost)
- Funplex - ($35.00) (Not included in camp fees) **NO REFUND**
- Sportime USA - ($30.00) Not included in camp fees **NO REFUND**
- Splashdown - ($35.00) (Not included in camp fees) **NO REFUND**
- Medieval Times - ($50.00) (Not included in camp fees) **NO REFUND**

***If outdoor trips are cancelled due to inclement weather, indoor activities will be in session. Field trips are part of the activities.**

DETAILS:

Meals:
Free breakfast and lunch
(only if provided through Yonkers Food Department)
*** No breakfast provided on July 1,2019 ***

Certification:
We are CPR, AED and First Aid certified.

Registration Dates

Early Registration - April 22nd - June 14th

Late Registration - ongoing as of June 15th
(10% late charge will be added)

3 WAYS TO REGISTER:

Online:
www.smileyfacesdc.com
Pay online! A percentage will be donated to St. Jude Children's Research Hospital

In Person: Montessori Academy
99 Wakefield Avenue
Yonkers, NY 10704

Monday thru Friday 5:30 pm - 6:30 pm
Call for an appointment

By Mail:
Send application with payment to:
Smiley Faces
PO Box 483
Yonkers, NY 10704

SPACE IS LIMITED

SUMMER FUN DATES:
July 1st – August 9th

SUMMER FUN HOURS:
8am - 5pm
****(Additional fee after 5:00 pm)****

WEEKLY FEE:
$215 per Child
(Includes swimming, which is part of the activities)

Fee Total $ ________
(including trips)

FREE T-SHIRT WITH PAID REGISTRATION
(If Paid in Full by June 14, 2019)

Child's Shirt Size:

Child: S__ M__ L__ XL__
or
Adult: S__ M__ L__ XL__ XXL__

Extra T-Shirts can be purchased for $10 per shirt
XXL $12 per shirt

PAYMENT:

Payment is due in full **no later than June 14, 2019.** 10% will be added if NOT paid in full by June 14, 2019. If a child does not attend **there is NO REFUND!**
There is a $50.00 returned check fee.
Private payment, public assistance and all grants are accepted. **Grants are available, if you qualify.**

Bring us a referral and receive a discount

Dear Parents,

Thank you for your interest in Smiley Faces Summer Fun. Once again, we are getting ready for another summer full of fun and smiles. Please note the following important information:

*SUMMER FUN DATES: July 1, 2019 - August 9, 2019

*REGISTRATION DATES: April 22, 2019 - June 14, 2019

*LATE REGISTRATION: Starts June 15, 2019 - (10% late fee)

3 EASY WAYS TO REGISTER:

(1) ONLINE – smileyfacesdc.com

(2) IN PERSON – Mon. – Fri. 5:30 p.m. – 6:00 p.m.
(Call for an appointment (914) 424-3993 or (914) 830-3532)

Place: Montessori Academy
99 Wakefield Avenue
Yonkers, New York 10704

(3) By Mail – Smiley Faces
P.O. Box 483
Yonkers, New York 10704

-Medical Forms, Registration Forms, Payment (including trips) are due at time of registration.
-Children are not allowed to start without a current medical.
-Discount fees applies only if you send us a referral.
-T-Shirts are for children registered by 6/14/19. NO T-Shirts will be ordered for children registered after 6/14/19.
-NO FLIP FLOPS ALLOWED!
-Please note: there will be no breakfast served on 7/1/19

WE LOOK FORWARD TO SEEING YOU!!!!!

SUMMER FUN 2019 (RULES)

NO cell phones or electronic devices are allowed. Cell phones and electronic devices will be taken away from the child and returned to the parent at time of pick-up.

As of 7/1 (first day of camp):

PLEASE NOTE: There will be no breakfast served 7/1/19.

Please make sure your child brings a towel, bathing suit and water shoes for the sprinklers. **NO FLIP FLOPS ALLOWED!** All items can be kept on site until the end of the Summer Fun Program. Please make sure to label all items.

Suntan lotions, insect repellant sprays - will only be applied with a **Non-Medical Consent Form** fully completed by the parent. **NO EXCEPTIONS!!!** The form can be downloaded at smileyfacesdc.com.

EpiPen and Asthma medication – will be administered with a **"Medication Consent Form"** (2 page form). The form must be fully completed by both parent and licensed authorized prescriber. The form can be downloaded at smileyfacesdc.com. Children are not allowed to administer their own medications. **NO EXCEPTIONS!!!**

THANK YOU FOR YOUR COOPERATION

2019 TRIPS
6 Weeks of Fun and Smiles!!!!!

Thursday 7/11 -------------------------SWIMMING / PICNIC (Saxon Woods)

Thursday 7/18 -----------------------FUNPLEX WATER PARK (Rain or Shine)

Thursday 7/25 ……………………………….SPORTIME USA

Thursday 8/1 ----------------------------SPLASHDOWN WATER PARK
(Rain date is at the discretion of Splashdown)

Thursday 8 /8………………………MEDIEVAL TIMES "GRAND FINALE"
(Show / Tournament and Lunch)

*******Outdoor trips (Swimming/Picnic, Junior Olympics/Picnic, Funplex, Splashdown) are subject to change due to inclement weather. Outdoor trips are part of the scheduled activities. If outdoor trips are cancelled indoor activities will be in session. There is NO REFUND for Funplex, Sportime USA, Splashdown or Medieval Times.**
<u>NO</u> FLIP FLOPS ALLOWED! *****

Thank You For Your Cooperation

"SUMMER FUN TRIPS 2019"

I allow my child________________________________to attend the following trips:

______Thursday 7/11------SWIMMING / PICNIC (Saxon Woods) - Free

______Thursday 7/18 -------FUNPLEX WATER PARK (Rain or Shine) - $35

______Thursday 7/25 ----------SPORTIME USA - $30

______Thursday 8/1 -------SPLASHDOWN WATER PARK - $35
(Splashdown ……………Rain date is at the discretion of Splashdown)

______Thursday 8 /8-----MEDIEVAL TIMES "GRAND FINALE"- $50
(Show / Tournament and Lunch)

*******Outdoor trips (Swimming/Picnic, Junior Olympics/Picnic, Funplex, Splashdown) are subject to change due to inclement weather. Outdoor trips are part of the scheduled activities. If outdoor trips are cancelled indoor activities will be in session. There is NO REFUND for Funplex, Sportime USA, Splashdown or Medieval Times.**
NO FLIP FLOPS ALLOWED!*****

______________________________ ______________________
Parent's Signature **Date**

NEW YORK STATE

OFFICE OF CHILDREN AND FAMILY SERVICES

Medical Statement of Child in Smiley Faces

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

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

Immunizations required for entry into Smiley Faces ☐ 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)	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.

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):

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, Smiley Faces may not exclude the child from the program, 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.

Medical Statement of Child in Smiley Faces

(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 the Smiley Faces program

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 the Smiley Faces day program. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( )
Phone

Date

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 Smiley Faces program's Director operator or administrator who shall determine whether the statement of religious belief is acceptable.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NON-MEDICATION CONSENT FORM

Child Day Care Programs

- This form may be used when a parent consents to having over-the-counter products administered to their child in a child day care program. These products include, but are not limited to: topical ointments, lotions and creams, sprays, sunscreen products and topically applied insect repellant.
- This form should NOT 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. OCFS Form 7002 would meet the consent requirements for medications.
- One form must be completed for each over-the-counter product. Multiple products cannot be listed on one form.
- This form must be completed in a language in which the staff is literate.
- If parent's instructions differ from the instructions on the product's packaging, permission must be received from a health care provider or licensed authorized prescriber.

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1. Child's first and last name:	2. Date of birth:	3. Child's known allergies:

4. Name of product (including strength):	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: ______

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): ______

8A. Possible side effects: ☐ See product label 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 ______

Other (describe): ______

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

AND/OR

10B. Additional special instructions: ______

11. Reason(s) for use (unless confidential by law): ______

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

DAY CARE PROGRAM TO COMPLETE THIS SECTION (#15 - #21)

15. Program name:	16. Facility ID number:	17. Program telephone number:

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print):	20. Date received from parent:

21. Staff's signature:

X

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