



Cortelyou Early Childhood Center, Inc.

Main Office

1110 Cortelyou Road
Brooklyn, NY 11218

Phone: 718-282-6077

Fax: 718-282-2919

Annex

386 Marlborough Road
Brooklyn, NY 11226

Phone: 718-856-2880

Academy Building

2739 Bedford Avenue
Brooklyn, NY 11210

Phone: 718-421-9581

Fax: 718-421-2891

E-Mail: info@mycecc.com

Website: www.mycecc.com

Pre-School Tuition & Fees 2024-2025

Enrollment Fees

Enrollment and Textbook fees (*when applicable*) must be paid at the time of registration to secure your child's slot. This applies to all programs except certain 3-K and Pre-K for All programs. **These fees are paid annually, cannot be credited towards tuition payments and are non-refundable.** Please use this table at the bottom of this sheet to find the fees relevant for your program.

Tuition

Tuition is due on or before the fifth of each month. After the fifth, a late fee of \$50 will be added to your child's school fees. If school fees are not paid by the 15th of each month, we reserve the right to suspend your child's daycare service. If your child's service is suspended, there's a re-enrollment fee of \$100. Please use the table below to identify your child's program fees.

Program	Hours of Operation	Enrollment Fee	Textbook Fee	Monthly Tuition
Nursery* 2 Years Old	7:00am-6:00pm	\$300	\$0	\$1,800
3-K & Pre-K for All School Day ONLY	3-K: 8:30am-2:50pm Pre-K: 8:00am-2:20pm	\$0	\$0	FREE
3-K & Pre-K for All Extended Day	3-K: 7:00am-6:00pm Pre-K: 7:00am-6:00pm	\$200	3-K = \$0 Pre-K = \$115	3-K = \$600 Pre-K = \$500

*Our Nursery Program requires a down payment for the last month's tuition for your child (i.e. June 2025 for 2024-2025). The due date for this payment is one month from the date the application was submitted.

Parent Referral Program for Elementary School: Receive a \$500 credit for each child you refer to our Elementary School program (K-5th Grade). A referral form **MUST** be timely filled out to be eligible to receive the credit. For more info, call us @ 718-282-6077 or 718-421-9581.

*Updated as of 2/1/2024



Cortelyou Early Childhood Centers, Inc.

Application for Admission (Toddlers - Fifth Grade)

Attach
Child's
Photo



Student Information

Academic Year _____

First Name: _____ Last Name: _____ Male Female

Date of Birth _____ Place of Birth _____ Ethnicity: _____

Applicant for: **Pre-School** | 2's 3's **DOE** | 3-K for All Pre-K for All With Extended Day Services?

Elementary School | Kdg. Gr. 1 Gr. 2 Gr. 3 Gr. 4 Gr. 5 What school district do you reside in?

- Does your child have an **IEP** (Individual Education Plan) or receiving any special services? Yes No

If yes, please explain: _____

- Primary language(s) spoken at home: _____

Applicant's current/previous schools, if any:

Name	Address	Telephone
_____	_____	_____
_____	_____	_____

Parent/Guardian 1

Name: _____ Relationship to applicant _____

Address: _____ City _____ State _____ Zip _____

Contact Info: (H) _____ (C) _____ (W) _____

Email: _____ Occupation: _____

Employer: _____ Principal Contact: Both Mother Father

Parent/Guardian 2

Name: _____ Relationship to applicant _____

Address: _____ City _____ State _____ Zip _____

Contact Info: (H) _____ (C) _____ (W) _____

Email: _____ Occupation: _____

Employer: _____

Parent/Guardian Status: Single Married Divorced Separated Widowed Domestic

If Parent/Guardian contact cannot be reached, whom do we contact in case of an emergency?

Name: _____ Contact Number: _____



Cortelyou Early Childhood Centers, Inc.

Name of person(s) authorized to pick-up your child: _____

List any food allergies, medical conditions, and/or dietary restrictions: (e.g. lactose intolerance, peanuts, Asthma, etc.)

Is there anyone who is **NOT** allowed to have access to your child? (Please submit a copy of any supporting documentation.)

Trip Consent Form

I hereby give permission to allow my child, _____ to be taken on trips to points of interest throughout the New York City area, under the supervision of **Cortelyou Early Childhood Center**, via private means of transportation. I also grant permission for my child to be taken on walking trips throughout the neighborhood when accompanied by his/her teacher.

(Initial Here: _____)

Photograph & Video Release

I hereby give permission for images of my child, captured during regular and special school activities through video, photo and digital camera, to be used solely for **Cortelyou Early Childhood Center** promotional material and publication including websites, brochure, handbooks etc., and waive any rights of compensation or ownership thereto. (Initial Here: _____)

CECC Special Needs Policy

At CECC, we recognize the right of each child, including those with special needs, to have an appropriate early childhood engagement, which combines care and learning through purposeful play. We are very sensitive to the needs and feelings of children with special needs, as well as, that of their families. We are committed to assist families to seek appropriate help, to ensure that their child's individual needs are recognized and addressed. Parents, we are aware that you are your child's primary advocate and that all decision making relating to him/her are in your hands. Therefore, parents will be involved at every stage in any plan that is recommended to support a child's individual special needs.

If any child in our school is having trouble with language or speech, vision, motor skills, social/emotional and cognitive skills; or adapting to the physical, social and behavioral environment of our program, we will try our best effort to connect the parents to appropriate agencies to conduct an early childhood evaluation.

However, if parents choose to decline an evaluation to assess the possible developmental needs their child may require, CECC reserve the rights to discontinue childcare services since we do not hold the necessary licensing and certification required to work with children requiring special services. (Initial Here: _____)

I have read the policy and agree to comply with the forms as stated.

Parent/Guardian 1 Signature: _____ Date: _____

Parent/Guardian 2 Signature: _____ Date: _____

OFFICIAL USE ONLY

Accepted Not Accepted ACD HRA Co-Payment: \$ _____ Weekly

Registration Fee Paid Full Time Part-Time * Grades 1-5 Only: Plan _____ Option _____

Comments: _____ Date Rec'd _____ Rec'd by: _____



Cortelyou Early Childhood Center, Inc.

Parent Supplement for Day Care and Pre-School Students

Applicant's Name _____ Grade Applying to: _____

Parent(s) Name (s) _____

How did you learn about Cortelyou Early Childhood Center and how do you see our program meeting your family's needs?

Please tell us what you are looking for in a school.

Are there any particular strengths or areas of concern that you would like to bring to our attention?

What does your child enjoy doing? What is he/she like? Describe your child's social life (i.e. play dates, park, playground, family).

Parent #1 Signature _____ Date _____

Parent #2 Signature _____ Date _____

See INSTRUCTIONS on reverse.

CHILD CARE CENTER NAME: Cortelyou Early Childhood Center

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. Receives Food Stamps
2. Receives Temporary Assistance to Needy Families (TANF)
3. Participates in the Food Distribution Program on Indian Reservations (FDPIR)
4. Currently has a foster child enrolled in day care

SECTION A
Food Stamp Case Number _____
TANF Number _____
FDPIR Number _____
Foster Child's Name _____
Foster Child's Personal Monthly Income \$ _____
<p>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.</p> <p>I certify that the above information is true and correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.</p>
Signature: _____
Date: _____

FOR SPONSOR USE ONLY
Sponsor Agreement Number <u>3409</u>
Total Household Members _____
Total Income \$ _____
Free _____ Reduced _____ Paid _____
Signature of Determining Official _____
Date Determined ____ / ____ / ____

Complete SECTION B if SECTION A does not apply:

Sign, date and indicate the Social Security number of the adult signing the certification and return the completed form to the day care center.

SECTION B	
<p>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, welfare payments, child support and any other sources of income.</p>	
Name of Household Members	Monthly Gross Income
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
4. _____	\$ _____
5. _____	\$ _____
6. _____	\$ _____

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 correct and that all income is reported. I understand this information is being given for the receipt of Federal funds, that officials may verify the information on the application; and that deliberate misrepresentation of the information may subject me to prosecution under applicable State and Federal laws.

Signature: _____

Print Name: _____

SS# - - Date: _____

DAY CARE CENTER ENROLLMENT FORM

Center Name: CORTELYOU EARLY CHILDHOOD CENTER

Child's Name: _____

Male _____ Female _____ Date of Birth _____ Home Phone _____

Home Address _____

Mother/Guardian Name _____

Father/Guardian Name _____

Parent/Guardian Address and Phone, if different _____

In case of emergency, notify _____ Phone _____

Second person to notify _____ Phone _____

Physician's name _____ Phone _____

TIME MEALS SERVED

Breakfast _____ am to _____ am Lunch _____ am/pm and _____ pm Afternoon Snack _____ pm to _____ pm

If your child is in care during these times, he/she will receive the meal or snack that is being served.

What days will your child usually be at the center? M _____ Tu _____ W _____ Th _____ F _____ Sat _____ Su _____

What hours will your child usually be at the center? Arrive _____ am pm

Depart _____ am pm

Signature of a parent/guardian _____ Date _____



After 1 year of care

Is all the information above still correct? Yes _____ No _____

If no, what has changed? _____

Signature of a parent/guardian _____ Date _____

Section 9

Unless you list the Food Stamp, TANF or FDPIR number for the child or a household member or are applying for a foster child, Section 9 of the National School Lunch Act requires that you include the Social Security Number of the household member signing the application or indicate that the household member signing the application does not have a Social Security Number. You do not have to list a Social Security Number, but if a Social Security Number is not listed or an indication is not made that the adult household member signing the application does not have a Social Security Number, CACFP cannot approve the application. The Social Security Number may be used to verify the correctness of the information stated on the application. This may include program reviews, audits and investigations and may include contacting employers to determine income, contacting a Food Stamp, TANF or FDPIR office to determine current certification for Food Stamp, TANF or FDPIR benefits, contacting the State employment security office to determine the amount of benefits received and checking the documentation produced by the household member to prove the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported.

Definition of Income

Income means income before deductions for income taxes, social security taxes, insurance premiums, charitable contributions, and bonds, etc. It includes the following: (1) monetary compensation for services, including wages, salary, commissions or fees; (2) net income from non-farm self-employment; (3) net income from farm self-employment; (4) social security payments; (5) dividends or interest on savings or bonds, income from estates or trusts or net rental income; (6) public assistance or welfare payments; (7) unemployment compensation; (8) government civilian employee or military retirement, or pensions or veteran's payments; (9) private pensions or annuities; (10) alimony or child support payments; (11) regular contributions from persons not living in the household; (12) net royalties; (13) military benefits received in cash, such as housing allowance; and (14) any other cash income.

Definition of Household

Household means *family* as defined in Section 226.2. *Family* means a group of related or non-related individuals who are not residents of an institution or boarding house, but who are living as one economic unit.

INSTRUCTIONS FOR COMPLETING DOH-3688

Instructions for Parents or Guardians:

Write in the name of the child care center in the space provided.

Print the name of each child in your household who attends this child care center.

Section A: If anyone in your household receives Food Stamps, Temporary Assistance for Needy Families (TANF) or participates in the Food Distribution Program on Indian Reservations (FDPIR), complete Section A only. Write down the Food Stamp, TANF or FDPIR number (do not use your ACD or DSS child care subsidy number) and sign and date the form and return it to the day care center.

Foster children: If your household includes a foster child who is in child care, complete Section A only. Write in the foster child's name and any income that the child receives from social services for his or her personal use. Write in 0 if the foster child does not receive any income. A separate application must be completed for each foster child. The foster parent or an official who represents the child must sign and date the form and then return it to the child care center.

Section B: Write in the names of all the people living in your household, even if they do not have any income. Include yourself and all other adults and children in the household, including unrelated people. Do not include the children in child care who are listed at the top of the form.

Enter the amount of income each person received **last month**, before taxes or anything else was taken out. Refer to the Definition of Income and the Definition of Household, above. If any amount last month was more or less than the usual, write in that person's usual income. The signature and Social Security Number of the adult signing the certification is required. If you do not have a Social Security Number, write *none*.

Instructions for Centers and Sponsors:

The For Sponsor Use Only section is to be completed, signed and dated by child care center or sponsor staff.

The sponsor/center representative must review the income eligibility application and ensure that it is completed as indicated in the instructions above. Then indicate the following:

The sponsor agreement number.

Total household members – This item does not have to be completed if the parent completed Section A. Add those indicated in Section B (if completed) to the children enrolled in child care.

Total Income – This item does not need to be completed if the parent completed Section A. Indicate the total monthly income as calculated from Section B. If the parent chooses not to disclose income, the application must be categorized as *paid*.

Free, Reduced or Paid – Compare the total household income and the total number of household members with the current year's Income Eligibility Guidelines (CACFP-3687) to determine if the household should be categorized as **Free, Reduced or Paid**. Use the appropriate column on the CACFP-3687 to categorize their income. For example, if the parent indicated biweekly income, multiply this amount by 26 to determine yearly income.

Incomplete applications (missing signatures, income information, or Food Stamp, TANF or FDPIR numbers) are categorized in the paid category.

The income eligibility application is valid until the last day of the month one calendar year from the date of submission. For example, a form submitted on May 12, 2010 is valid until May 31, 2011.

CENTER

318K (REV. 8/02)

NAME:

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BUREAU OF DAY CARE

ADDRESS:

BORO: Brooklyn, NY

DAY CARE CUMULATIVE HEALTH RECORD

Date of Admission _____

TO BE COMPLETED BY PARENTS/GUARDIANS AND DAY CARE STAFF

NAME: (Last) (First) (Middle)			SEX F <input type="checkbox"/> M <input type="checkbox"/>	DATE OF BIRTH Country/State of Birth
ADDRESS: (No.) (Street)		(City/Boro)	(State)	(Zip)
MOTHER'S NAME: (First) (Last)	FATHER'S NAME: (First) (Last)		TELEPHONE NO Home: Work:	
FOSTER PARENT				
FOSTER AGENCY		ADDRESS	TELEPHONE #	
LANGUAGE SPOKEN IN HOME				

PERSON/S TO CONTACT IN CASE OF EMERGENCY (Other Than Parent)	
NAME	RELATIONSHIP TO CHILD
ADDRESS	
TELEPHONE NO. Home: Work:	

NAME OF MEDICAL PROVIDER, CLINIC OR HOSPITAL		
NAME	CONTACT PERSON	PATIENT NO.
ADDRESS		TELEPHONE NO.

SIGNIFICANT FAMILY HISTORY	IS CHILD ALLERGIC TO ANY:
() Sickle Cell	() Medications (Specify)
() Diabetes	() None
() Convulsive Disorder	() Foods (Specify)
() Allergies (Specify)	() Insect Bites
() OTHER (Specify)	() OTHER
() Heart Disease	
() Hypertension	
() Tuberculosis	
() Vision	
() Hearing	

HOSPITALIZATIONS AND ILLNESSES	YES	NO	EXPLAIN
Has child ever been hospitalized or operated on?			
Has child ever had a serious accident (broken bone, head injury, fall, burns, poisoning)?			
Has child ever had a serious illness?			

SPECIAL HEALTH CONDITIONS	AGE IT BEGAN	TREATMENT/MEDICATIONS
(Long term or chronic)		
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

I, _____ hereby certify that information provided herein is complete and accurate.

CONSENT FOR EMERGENCY MEDICAL TREATMENT (REQUIRED FOR ADMISSION TO DAY CARE)

I do hereby give authority to the day care program staff to obtain necessary emergency medical treatment for my child, with the understanding that the family will be notified as soon as possible.

SIGNED _____ DATE _____ RELATIONSHIP _____

Subscribed and sworn to before me this _____ day of _____ 19 _____

Notary Public or Commissioner of Deeds (OPTIONAL) _____ County of _____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

Please
Print Clearly

NYC ID (OSIS)

TO BE COMPLETED BY THE PARENT OR GUARDIAN

Child's Last Name	First Name	Middle Name	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth (Month/Day/Year) ____/____/____
Child's Address		Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	Race (Check ALL that apply) <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Other _____	
City/Borough	State	Zip Code	School/Center/Camp Name	District Number _____ Phone Numbers Home _____ Cell _____ Work _____
Health insurance <input type="checkbox"/> Yes (including Medicaid)? <input type="checkbox"/> No	<input type="checkbox"/> Parent/Guardian Last Name <input type="checkbox"/> Foster Parent	First Name	Email	

TO BE COMPLETED BY THE HEALTH CARE PRACTITIONER

Birth history (age 0-6 yrs) <input type="checkbox"/> Uncomplicated <input type="checkbox"/> Premature: _____ weeks gestation <input type="checkbox"/> Complicated by _____	Does the child/adolescent have a past or present medical history of the following? <input type="checkbox"/> Asthma (check severity and attach MAF): If persistent, check all current medication(s): Asthma Control Status <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Behavioral/mental health disorder <input type="checkbox"/> Congenital or acquired heart disorder <input type="checkbox"/> Developmental/learning problem <input type="checkbox"/> Diabetes (attach MAF) <input type="checkbox"/> Orthopedic injury/disability Explain all checked items above.	<input type="checkbox"/> Intermittent <input type="checkbox"/> Mild Persistent <input type="checkbox"/> Moderate Persistent <input type="checkbox"/> Severe Persistent <input type="checkbox"/> Quick Relief Medication <input type="checkbox"/> Inhaled Corticosteroid <input type="checkbox"/> Oral Steroid <input type="checkbox"/> Other Controller <input type="checkbox"/> None <input type="checkbox"/> Well-controlled <input type="checkbox"/> Poorly Controlled or Not Controlled <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Speech, hearing, or visual impairment <input type="checkbox"/> Tuberculosis (latent infection or disease) <input type="checkbox"/> Hospitalization <input type="checkbox"/> Surgery <input type="checkbox"/> Other (specify) _____ Addendum attached.	Medications (attach MAF if in-school medication needed) <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____ _____
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PHYSICAL EXAM Date of Exam: ____/____/____	General Appearance: <input type="checkbox"/> Physical Exam WNL <input type="checkbox"/> Psychosocial Development <input type="checkbox"/> Language <input type="checkbox"/> Behavioral	<input type="checkbox"/> HEENT <input type="checkbox"/> Dental <input type="checkbox"/> Neck	<input type="checkbox"/> Lymph nodes <input type="checkbox"/> Lungs <input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Abdomen <input type="checkbox"/> Genitourinary <input type="checkbox"/> Extremities	<input type="checkbox"/> Skin <input type="checkbox"/> Neurological <input type="checkbox"/> Back/spine
Height _____ cm (____ %ile) Weight _____ kg (____ %ile) BMI _____ kg/m ² (____ %ile) Head Circumference (age ≤2 yrs) _____ cm (____ %ile) Blood Pressure (age ≥3 yrs) _____ / _____	Describe abnormalities: _____				

DEVELOPMENTAL (age 0-6 yrs) Validated Screening Tool Used? _____ Date Screened ____/____/____ <input type="checkbox"/> Yes <input type="checkbox"/> No Screening Results: <input type="checkbox"/> WNL <input type="checkbox"/> Delay or Concern Suspected/Confirmed (specify area(s) below): <input type="checkbox"/> Cognitive/Problem Solving <input type="checkbox"/> Adaptive/Self-Help <input type="checkbox"/> Communication/Language <input type="checkbox"/> Gross Motor/Fine Motor <input type="checkbox"/> Social-Emotional or Personal-Social <input type="checkbox"/> Other Area of Concern: _____	Nutrition < 1 year <input type="checkbox"/> Breastfed <input type="checkbox"/> Formula <input type="checkbox"/> Both ≥ 1 year <input type="checkbox"/> Well-balanced <input type="checkbox"/> Needs guidance <input type="checkbox"/> Counseled <input type="checkbox"/> Referred Dietary Restrictions <input type="checkbox"/> None <input type="checkbox"/> Yes (list below) _____	Hearing Date Done ____/____/____ Results < 4 years: gross hearing _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred OAE _____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred ≥ 4 yrs: pure tone audiometry ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl <input type="checkbox"/> Referred	Vision Date Done ____/____/____ Results <3 years: Vision appears: ____/____/____ <input type="checkbox"/> NI <input type="checkbox"/> Abnl Acuity (required for new entrants and children age 3-7 years) Right ____/____/____ Left ____/____/____ <input type="checkbox"/> Unable to test
Describe Suspected Delay or Concern: _____	Lead Risk Assessment (annually, age 6 mo-6 yrs) _____ <input type="checkbox"/> At risk (do BLL) <input type="checkbox"/> Not at risk	Screened with Glasses? _____ Strabismus? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Visible Tooth Decay _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Urgent need for dental referral (pain, swelling, infection) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Dental Visit within the past 12 months _____ <input type="checkbox"/> Yes <input type="checkbox"/> No
Child Receives EI/CPSE/CSE services <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobin or Hematocrit _____ g/dL _____ %	Report only positive immunity: IgG Titers Date Hepatitis B _____ Measles _____ Mumps _____ Rubella _____ Varicella _____ Polio 1 _____ Polio 2 _____ Polio 3 _____	

CIR Number _____	Physician Confirmed History of Varicella Infection <input type="checkbox"/>	Report only positive immunity:
IMMUNIZATIONS - DATES		
DTP/DTaP/DT _____ Tdap _____	MMR _____	Hepatitis B _____
Td _____	Varicella _____	Measles _____
Polio _____	Mening ACWY _____	Mumps _____
Hep B _____	Hep A _____	Rubella _____
Hib _____	Rotavirus _____	Varicella _____
PCV _____	Mening B _____	Polio 1 _____
Influenza _____	Other _____	Polio 2 _____
HPV _____		Polio 3 _____

ASSESSMENT <input type="checkbox"/> Well Child (Z00.129) <input type="checkbox"/> Diagnoses/Problems (list) _____ ICD-10 Code _____	RECOMMENDATIONS <input type="checkbox"/> Full physical activity <input type="checkbox"/> Restrictions (specify) _____ Follow-up Needed <input type="checkbox"/> No <input type="checkbox"/> Yes, for _____ Appt. date: ____/____/____ Referral(s): <input type="checkbox"/> None <input type="checkbox"/> Early Intervention <input type="checkbox"/> IEP <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Other _____
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Health Care Practitioner Signature _____	Date Form Completed ____/____/____	DOHMH ONLY PRACTITIONER I.D. _____
Health Care Practitioner Name and Degree (print) _____	Practitioner License No. and State _____	TYPE OF EXAM: <input type="checkbox"/> NAE Current <input type="checkbox"/> NAE Prior Year(s) Comments: _____
Facility Name _____	National Provider Identifier (NPI) _____	Date Reviewed: ____/____/____ I.D. NUMBER _____
Address _____ City _____ State _____ Zip _____		REVIEWER: _____
Telephone _____ Fax _____ Email _____		FORM ID# _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

**CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS
HEALTH SCREENING ONE-TIME ATTESTATION**

Before entering a child care program, employees, volunteers, parents, children and essential visitors **must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers “Yes” to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are “Yes,” individuals **cannot** enter the program. If the answers are “No” to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer “No” to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing *ANY* of the following symptoms?
 - Cough (new or worsening)
 - Shortness of breath (new or worsening)
 - Trouble breathing (new or worsening)
 - Fever
 - Chills
 - Muscle pain (new or worsening)
 - Headache (new or worsening)
 - Sore throat (new or worsening)
 - New loss of taste
 - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered “NO” to all questions, you have passed and may enter the program.

If you have answered “YES” to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Signature

Date

Signature

Date

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.