FOR OFFICE USE ONLY: BC__M __ AP___ M_ T__ W__ Th__ F __ DSS __ NEW__

THE GOAL PROGRAM

Contact: Kirk - 914-481-7415 | Fax: 914-963-4140
Email: Goalprogram@live.com
Website: www.mygoalprogram.com

APPLICATION

(Please Print)

Child's Last Name: _____ First Name:_____ M.I. ___ DOB _____

Child Teachers Name: _____ Child Grade: ____Age: ____ Gender: M__ F__ School: _____

Mother's Full Name/Guardian_____ Cell: _____

Personal Email: _____

Address_____ apt # ____City _____State____ Zip _____

Job Location & Address: _____ City _____ State ____ Zip _____

Work Phone: _____ ext _____ Work Email:_____

Father's Full Name/Guardian_____ Cell: _____

Personal Email: _____

Address_____ apt # ____City _____State____ Zip _____

Job Location & Address: _____ City _____ State ____ Zip _____

Work Phone: _____ ext _____ Work Email:_____

Emergency Contact List:

Name:_____Phone:_____Cell_____

Name:_____Phone:_____Cell_____

Does your child have any allergies? _____, If YES, must complete additional forms.

Does your child have any medical conditions or taking any medications? _____

Primary care Physician's name _____ Phone#:_____

A COPY OF YOUR CHILD'S MEDICAL FORM IS NEEDED TO COMPLETE THIS APPLICATION!

I agree for my child's picture to be taken for the After-School bulletin board, flyer, and website. **Yes ___** or **No ____**

AFTER-SCHOOL PROGRAM

We agree to provide After-School programs for your child (ren), during the hours of 2/3:00 pm to 6:00pm, Monday through Friday.

AFTER-SCHOOL FEES

Payment is due every week on Monday or first school day of that week. Registration is a one time fee of $25. Late fee is $15 per 15 minutes after 6pm.We provide sibling discount please ask After-School Director for further details.

HOLIDAY & SCHOOL CLOSINGS:

After-School Program will follow Yonkers Public School calendar. ***AFTER-SCHOOL PROGRAM WILL BE CLOSED, WHEN SCHOOL IS CLOSED, AND CLOSED FOR HALF SCHOOL DAYS AS WELL.*** Weekly after-school fees will be adjusted for weeks when school is closed for two or more consecutive days per week (due to emergency closings).

SICKNESS:

If your child becomes sick during After-School programs, a Parent/Guardian will be called immediately. If any child is hurt or severely injured, After-School Program will follow the NYS Office of Children and Family Services guidelines. *Additional information will be provided in the GOAL Program Parent Guide.*

We reserve the right to exclude any child (ren) from attending our After-School Program who is clearly physically aggressive, as well as poses a physical threat to themselves or the safety of the other children in our care.

My child will attend Afterschool at: School 31____ School 29_____ School 22_____ Pearls_____

Option 1 - For After-School Programs 4-5 days a week is $135 per week (Children attending Pearls, fee is $150 per week). Please check following days your child will attend. M____ T ____W _____ Th _____ F_____

Option 2 – For After-School Programs 2-3 days per week is $110 per week (Children attending Pearls, fee is $125 per week). Please check following days your child will attend, M _____ T _____W _____ Th _____ F _____

ALL AFTER-SCHOOL FEES ARE NON-REFUNDABLE. ALL FEES ARE PAID USING THE GOAL PROGRAM AUTOMATIC PAYMENT FORM. THANK YOU FOR CHOOSING THE GOAL PROGRAM! ***PLEASE ASK ABOUT OUR SUMMER PROGRAM!***

_____ _____

Parent/Guardian Signature Date

OCFS-LDSS-0792 (1/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE REGISTRATION

PHOTO OF CHILD (Optional)

Child's Full Name:

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

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

Child's Source of Medical Care/Primary Care Physician's Name:	Telephone Number:
Child's Source of Dental Care/Dentist's Name:	Telephone Number:
Name Of Medical Care Facility/Hospital:	Telephone Number:

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

EMERGENCY DATA

RELATIONSHIP	CONTACT NAME	TELEPHONE NUMBER DURING CHILD CARE	OTHER TELEPHONE NUMBER (Check type)
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other
			☐ Pager ☐ Cell ☐ Other

CHILD'S FULL NAME: | SEX: ☐ Male ☐ Female

CHILD'S HOME ADDRESS: | DATE OF BIRTH: | HOME TELEPHONE NUMBER:

DATE OF ACCEPTANCE: | DATE OF DISCHARGE:

NAME OF PERSON APPLYING FOR CHILD: | ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative ☐ Other ____ | HOME TELEPHONE NUMBER: | DAYTIME TELEPHONE NUMBER:

ADDRESS OF PERSON LISTED ABOVE: (IF DIFFERENT FROM CHILD'S):

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. ☐ 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 on the other side of this card) 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 agree to review and update this information whenever a change occurs and at least once every six months. ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE | DATE:

Provider/Day Care Facility Name and Address:

2018-2019

Recurring Payment Authorization Form

Schedule your payments to be automatically deducted from your bank account, or charged to your Visa, MasterCard, American Express or Discover Card. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- ❖ It's convenient (saving you time and postage)
- ❖ Your payment is always on time (even if you're out of town), eliminating late charges

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged each billing period for the total amount due for that period. A receipt will be emailed to you and the charge will appear on your bank or credit card statement.

Please complete the information below:

Child(ren) Names: _____ **After-School attending:** _____

I _____ authorize The Goal Program to charge/debit my account
(full name)
indicated below on the **MONDAY of each week** for payment of my Afterschool Service.

Total Due: $_____ **Payment Frequency:**_____

Start Date: _____ **End Date:** _____

Billing Address _____ **Phone#**_____

City, State, Zip _____ **(required)Email**_____

Checking/ Savings Account

☐ **Checking** ☐ **Savings**

Name on Acct _____

Bank Name _____

Account Number _____

Bank Routing # _____

Bank City/State _____

Credit Card

☐ **Visa** ☐ **MasterCard**
☐ **Amex** ☐ **Discover**

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card) _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify The Goal Program in writing of any changes in my account information or termination of this authorization at least 7 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Nonsufficient Funds (NSF) I understand that The Goal Program will process the charge again within 2 business days, and agree to an additional $10 charge for each attempt returned NSF which will be added to the current bill. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute the scheduled transactions with my bank or credit card Company; provided the transactions correspond to the terms indicated in this authorization form.

Medical Statement of Child in Childcare

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 day care 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):
/ / 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.

ADDITIONAL INFORMATION ON REVERSE SIDE→

Medical Statement of Child in Childcare

(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 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 day care. ☐ 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 day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.