My Little Stars
Family Day Care & Preschool

12 Pammer Road
Youngsville, NY 12791
845-594-4282
www.mylittlestars.org

2024 Child Care Contract

PARENT AGREEMENTS:

Please read, initial, and then sign below.

_____ I have read the Family Handbook and agree to comply with all provisions contained therein.

_____ A non-refundable deposit equal to my first week's tuition is required to reserve my spot and that my spot is not guaranteed until this deposit is paid. This deposit will pay my first week's tuition.

_____The $50 registration fee, and the enrollment packet must be received a minimum of 3 days before my child's scheduled start date.

_____ I understand the "NO PAY, NO PLAY POLICY". (My childcare tuition is due on FRIDAYS for the upcoming week of care and if my tuition is not paid on time my child may not attend.)

_____ I understand that My Little Stars is enrollment based, and that my tuition is due every week regardless of any absences or closings.

_____ I agree to follow my schedule of care as described in this contract. I agree to notify My Little Stars before my scheduled drop-off time if my child will be late or absent.

_____I understand that there will be a $25 fee per child if I drop off or pick up my child more than 5 minutes outside my approved schedule of care.

_____ I will provide a ready-to-serve lunch for my child every day. Lunches must be packed in a lunch box or bag. Your child's full name must be written on the lunch box and all non-disposable containers including bottles and sippy cups. We do not prepare, cook, or reheat foods.

_____ I have reviewed the closing calendar and snow day policy. I understand that it is my responsibility to know when the daycare is closed and to have backup care in place.

_____ I have reviewed and read the Sick Policy and understand that if my child is sick, they may not attend daycare until they have been symptom-free for a minimum of 24 HOURS without medication or have a doctor's note clearing them to return. I understand that if my child is sent home sick from daycare, they may not return for a minimum of 72 hours and must be symptom-free for a minimum of 24 hours without medication.

_____ I understand that the Child Care Assistance Program (CCAP) may reduce my childcare costs but that it does not cover all of my tuition. I understand that I am responsible for any fees not covered. I am aware that CCAP WILL NOT PAY for any daycare closings. You will be billed accordingly for these days and expected to pay your full tuition on time. Please plan for our extended closings. Ask us about our payment plan.

_____ I understand that a staff member will greet us on the front porch each day for drop-off and pick-up. I agree to complete the daily health screening and check my child in and out every day on the Brightwheel App.

_____

Parent Signature Date

Tuition Policy Agreement

As an enrollment-based program, we do not offer discounts, credits, or refunds for closings, holidays, or absences. Our rates are all-inclusive, with no hidden fees. We have a "No Pay, No Play Tuition Policy". Tuition is due at the end of the business day on Fridays for the upcoming week of care. If tuition is not paid as agreed, your child will not be able to attend, and your spot may be forfeited.

- **Infant & Toddler Rate (Age 0 to Age 2)**
  - Full Time Rate (Enrolled 4 or 5 days weekly): $275/week/per child.
  - No part time enrollment offered for infants due to demand.
  - Parents supply all food, diapers, and extra clothing.
- **Preschool Rate (Age 3 to Age 5)**
  - Full Time Rate (Enrolled 4 or 5 days per week): $250/week/per child.
  - Part Time Rate (Enrolled 2 or 3 days per week): $200/week/per child.
  - Parents supply lunch & extra clothes.
- **Before & After School Program Rates: (Age 5+ and registered for K-6)**
  - Full Time Rate (Enrolled 4 or 5 days weekly for up to 2.5 hours per day): $150/weekly
  - Part Time Rate (Enrolled 2 or 3 days weekly up to 2.5 hours per day): $100/weekly
  - 2 Hour Delays: Additional $20/day/child.
  - Early Dismissals: Additional $20/day/child.

We do charge a $25 fee per child for early drop-offs or late pick-ups that exceed 7 minutes outside of your schedule of care. This fee will be charged for every additional hour your child remains in care past their scheduled pick-up time. Repeated disregard for our hours of operation, including dropping off or picking up your child outside of your scheduled time more than three times per month, may result in the termination of our services.

A yearly calendar is available on our website and includes all scheduled closings for the upcoming year. A monthly calendar is posted each month on our Brightwheel App. We also have a Bulletin Board on the porch with 2 monthly calendars posted. It is your responsibility to utilize our resources to know when we are closed.

- We are closed for ALL FEDERAL HOLIDAYS.
- We are closed for MOST Sullivan West School District closings. This includes SNOW DAYS & both WINTER & SPRING BREAKS.
- We may be closed for up to 5 PROFESSIONAL DEVELOPMENT or WELLNESS DAYS.
- We may be closed for up to 15 days of VACATION time each year.
- Occasionally, we have days that we may need to close for SICK or PERSONAL reasons. Just like everyone else we need the occasional day for doctor appointments or family events. We will give as much notice as possible in these situations.

I acknowledge that I have read and understand the tuition rates, payment policy and late fee policy and agree to the terms therein.

_____

Parent Signature Date

SCHEDULE OF CARE

Your schedule of care describes the days and times you want to put your child in care each day. It should accurately reflect what time you will be dropping off and picking up your child. This schedule does not reflect your cost of tuition. This schedule is how we ensure appropriate staff coverage is available at all times. Frequent changes in your schedule of care will depend on availability of staff, so please make it as accurate as possible.

PLEASE NOTE:

- You must follow your schedule of care. If you need to make changes let us know ASAP.
- You must notify us if your child will be late, or absent.
- There will be a $25 fee per child if drop off or pickup falls outside your approved schedule of care.

Childs Name		**Childs Age**	**Childs DOB**	**Term**
				[ ] All Year [ ] Summer
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
____ to ____	____ to ____	____ to ____	____ to ____	____ to ____
Childs Name		**Childs Age**	**Childs DOB**	**Term**
				[ ] All Year [ ] Summer
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
____ to ____	____ to ____	____ to ____	____ to ____	____ to ____
Childs Name		**Childs Age**	**Childs DOB**	**Term**
				[ ] All Year [ ] Summer
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**
____ to ____	____ to ____	____ to ____	____ to ____	____ to ____

Your weekly tuition rate is _____ per child.

_____

Parent Signature Date

CHILD RELEASE FORM

I give the following people permission to pick up my child from Little Stars Family Day Care. I understand that if the person picking your child up is not on this form, my child will not be released to that person.

Name:	Phone:	Relationship to Child:

** Please advise anyone picking up your child that they must present a valid NYS ID.

MISCELLANEOUS PERMISSION SLIPS:

The following permission slips are required by NYS. Please check the appropriate response and initial.

1. _____ I **give Little Stars permission to photograph my child. [ ] Yes [ ] No**
   I understand that such pictures are the sole property of My Little Stars Family Day Care and that these pictures may be used for both personal and business use.
2. _____ **I give Little Stars permission to apply sunscreen to my child. [ ] Yes [ ] No**
   - I will provide sunscreen with a sun protection factor (SPF) of 30 or higher.

   I will apply sunscreen before bringing my child during the summer months.
3. _____ **I give Little Stars permission to allow my child to play outside without direct supervision. [ ] Yes [ ] No**
   - Child must be school-aged.
   - My Little Stars will check on my child every 15 minutes.
4. _____ **My child will nap/rest: [ ] On a cot [ ] In a playpen**
   - Nap time occurs after lunch in the playroom.
   - Children will be in direct visual contact of the provider during naptime.
5. _____ **Formula/ Breast Milk Feeding Schedule:**
   A. Please feed my child _____ oz bottles of
      [ ] Breast Milk [ ] Formula
      [ ] Whenever he/she is hungry [ ] Every_____ hours.
   B. Bottle Preparation:
      [ ] I give My Little Stars permission to make the formula I supply into _____ oz bottles (1 Scoop formula to every 2 oz water) and to be given to my child.
      [ ] I will supply ready-made bottles.

_____

Parent Signature Date

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER: ( ) -

CHILD'S FULL NAME: PREFERRED NAME/NICKNAME:	DATE OF BIRTH: / /	GENDER:

CHILD'S HOME ADDRESS:

NAME OF PERSON ENROLLING CHILD:	RELATIONSHIP TO CHILD: ☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____ ☐ Other _____

PHONE NUMBER(S) OF PERSON ENROLLING CHILD: ( ) - ☐ ok to text **EMAIL ADDRESS:**	ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY DATE OF ENROLLMENT: / /	***FOR PROGRAM USE ONLY*** DATE OF DISENROLLMENT: / /

CHILD'S FULL NAME:	DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child…… ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision…… ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips…… ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child…… ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation…… ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year…… ☐ Yes ☐ No

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

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