



**Welcome to  
Infant 1 at  
Merrick Avenue  
2024-2025**



Dear Parents,

Hi, my name is Janine Maniscalco. I have been part of the TLC family for eight years. I am CPR and First Aid certified and a mother of three daughters. I want to thank you for letting me have the privilege to care for your precious baby and do many fun and exciting things with them this school year.

I am very specific about how I care for your baby and welcome any information you can give such as their eating and sleeping schedule, likes and dislikes. Your baby is going to learn and grow so much in the next few months and I'm so happy to share this time with you!

My agenda for the day includes tummy time, reading and singing, as well as meeting your child's individual basic needs such as feeding, diaper changing, and napping.

I will have additional staff/floaters working beside me and help as needed.

If you have any questions, please feel free to text me at any time at 516-462-4397.

I am looking forward to a great year!

Sincerely,

Miss Janine



# Registration and Emergency Contact Form

**Child's Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_ Sex: Male or Female (please circle)

**Known Allergies (food/medicine)** \_\_\_\_\_

**Mother's Name** \_\_\_\_\_

Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Work Phone \_\_\_\_\_

**Father's Name** \_\_\_\_\_

Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Employer \_\_\_\_\_

Work Address \_\_\_\_\_

Work Phone \_\_\_\_\_

## Emergency Contacts that are ALSO ALLOWED TO PICK UP YOUR CHILD

**Name** \_\_\_\_\_

Relationship \_\_\_\_\_

Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

**Name** \_\_\_\_\_

Relationship \_\_\_\_\_

Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Home Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

## Days/Hours of Care

Days \_\_\_\_\_

Hours (ex: 8am-4pm, 9am-5pm, 7am-6pm) \_\_\_\_\_

## Doctor Information

**Name** \_\_\_\_\_ **Hospital** \_\_\_\_\_

Street Address \_\_\_\_\_

City, State & Zip \_\_\_\_\_

Phone \_\_\_\_\_

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Child's Full Name:		Date of Birth: / /	
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (list) _____ <input type="checkbox"/> 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 insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: <a href="https://nystateofhealth.ny.gov/">https://nystateofhealth.ny.gov/</a>			
<b>AGREEMENTS</b>			
● I consent to emergency medical treatment for my child.....		<input type="checkbox"/> Yes	<input type="checkbox"/> 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.....		<input type="checkbox"/> Yes	<input type="checkbox"/> No
● I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....		<input type="checkbox"/> Yes	<input type="checkbox"/> No
● I provided information on my child's special needs to the program to assist in caring for my child.....		<input type="checkbox"/> Yes	<input type="checkbox"/> No
● I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....		<input type="checkbox"/> Yes	<input type="checkbox"/> No
● I agree to review and update this information whenever a change occurs and at least once every year.....		<input type="checkbox"/> Yes	<input type="checkbox"/> No
SIGNATURE - PARENT OR PERSON(S) LEGALLY RESPONSIBLE:		DATE: / /	



# Merrick Avenue Infant 1 Supply List

Please Label the following with Sharpie- First and Last Name.

- ☐ 3- Changes of Clothes including Socks and Onesies
- ☐ 1- Portable Crib Sheet (to be sent home for cleaning on Fridays)
- ☐ 1- Light Blanket (**Muslin Only**- to be sent home for cleaning on Fridays)
- ☐ Sleeve of Diapers
- ☐ 2-Package of Wipes (one for diaper changes, one to wipe hands)
- ☐ Diaper Ointment- please complete the **Non-Medication Consent Form** located at [www.tlcmerrick.com/forms](http://www.tlcmerrick.com/forms)

Please Label the following with stickers- first and last name. (Mabels Labels or Daddy's Labels are good)

- ☐ Bottles/Sippy Cups (Sent Home Daily to Sterilize)
- ☐ Pacifiers if Needed (To be kept at TLC)

If on solid food:

- ☐ Spoons
- ☐ Bowls
- ☐ Cereal (Label and Date)
- ☐ Jar Food (Label and Date)

Additional Items:

- ☐ 1-Box of Tissues
- ☐ 1-Container of Disinfecting Wipes

- ☐ Suggested Items:
- ☐ Boppy Pillow (If needed- we also have one at TLC)
- ☐ Teethers

\*\*If your child takes formula, it must be already made with a label (masking tape/post-it) stating the **date** and your child's **first and last name**. As per Nassau County Health Department, we cannot mix powder formula. \*\*



# **TLC Daycare**

## **Napping Plan for Infants Under 1 Year**

Today's Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

How many hours does your child nap during the day? \_\_\_\_\_

How many times a day? \_\_\_\_\_

How many hours does your child sleep at night? \_\_\_\_\_

Does your child sleep in a crib? \_\_\_\_\_ Other? \_\_\_\_\_

Special Instructions or requests? \_\_\_\_\_

Does your child use a pacifier? \_\_\_\_\_

*For Babies Over 9 Months:*

I prefer my child to sleep in a (Circle One)                      Crib                      Pack-N-Play

Why? \_\_\_\_\_

**All Sheets and Blankets MUST be labeled with your child's first and last name and will be sent home every Friday for cleaning.**

*I will inform TLC if there are any changes that need to be made to this plan for my child.*

Parent Signature \_\_\_\_\_ TLC Staff \_\_\_\_\_



# TLC Daycare

## Feeding Plan for Infants Under 1 Year

Today's Date \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Bottles:

My child takes (Circle One)      Breast Milk      Formula

For formula: Type of formula \_\_\_\_\_

\_\_\_\_\_ oz bottles are given every \_\_\_\_\_ hours.

Comments: \_\_\_\_\_

### Mushy Foods (Please circle all that apply):

Not Applicable      Rice      Oatmeal      Barley      Mixed Cereal

Any reactions? \_\_\_\_\_

Applesauce    Pear    Peach    Carrot    Sweet Potato    Peas    Beans    Other: \_\_\_\_\_

Any reactions? \_\_\_\_\_

Please give an overview of your child's typical feeding schedule:

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Please list any dietary instructions/restrictions:

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All cups, bottles, and utensils must be labeled with your child's first and last name. Powdered formula must be mixed at home and ready to use. Please label all formula, milk, and juice with your child's name and the date.

*I will inform TLC if there are any changes that need to be made to this plan for my child.*

Parent Signature \_\_\_\_\_ TLC Staff \_\_\_\_\_