Enrollment Application

PART A:

START DATE:	CAMPUS LOCATION:
CASE/ID #	PROGRAM: ☐ INFANT/ TODDLER ☐ PRE-K ☐ BEFORE & AFTER ☐ Camp
CASE WORKER:	ARRIVAL TIME: DEPARTURE TIME:

STUDENT INFORMATION			
NAME:	DOB	AGE	SEX
Address City, State, Zip			

PARENT/GAURDIAN INFORMATION	
Primary Guardian	Secondary
Address	Address
City State Zip	City State Zip
Cell Phone	Cell Phone
E-Mail	E-Mail
Employer	Employer
Address	Address
Work Phone	Work Phone

EMERGENCY CONTACT/ PICK –UP		
Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

SIGN HERE

Parent Signature: Date:

PARENT-PROVIDER CHILD CARE CONTRACT

I. The following contract is between _____ and
(Parents of child(ren) in care)

_____ located at _____
(Child Care Provider) (Address of Child Care Facility)

Children listed below:

Child's Name_____ Date of Birth _____
Child's Name_____ Date of Birth _____
Child's Name_____ Date of Birth _____
Child's Name_____ Date of Birth _____
Child's Name_____ Date of Birth _____

II. Standard Rates and Payment Policies:

1. A deposit of $_____ is required. The deposit will be applied to the last week's payment or to the termination notice period if proper notice is not given (see V. Termination procedure).

2. The fee will be $_____ per hour per day per week (circle one)
Days and hours of care provided will be: PT / FT (Circle One)
Check All that Apply: ☐M ☐T ☐W ☐TH ☐F
From _____ to _____

3. **Special Notes:**

4. Payment is to be given: ☐Weekly ☐Bi-Weekly ☐Other _____ on _____
(Day of week/month)

5. The child care provider will provide (check all that apply):
X Breakfast __ Morning Snack X Lunch X Afternoon Snack ___ Dinner

6. The parent(s)/guardian(s) will provide the following (check all that apply):

☐ Change of Clothes/ Face Mask ___ Formula/ Breast Milk ___Bottles ___ Diapers ___ Infant Food ___Fitted Sheet/Light Blanket

7. Other special arrangements include:
_____

III. Rates for holidays, absences, vacations, overtime:

1. Care will not be provided holidays or scheduled days of professional development, etc. Payment is due on the day the child(ren) is/are regularly scheduled for care, prior to the holiday or closing date. If payment is not received a $10 late fee will be applied to the bill.

2. Return checks are subject to a $25.00 services charge and payment must be made cash, visa debit or money order for that payment.

3. The parent will notify the center if the child(ren) will be absent for the day.

4. **Policy for payment of absences:** Tuition payments will be made to the center regardless of student absence. If the student is absent for more than two consecutive days, the parent will supply a doctor's statement or case manger's statement concerning the child's absenteeism.

5. **Fees and policies for provider's vacation:** Tuition payments will be prorated to reflect the days of operation during the billing week. Any discounted tuition rates, promotions or co-payments will not be prorated.

6. **Fees and policies for parent/guardian's vacation:** The Parent(s) guardian(s) will provide the center with a written letter stating the vacation beginning and ending dates, including students return to school date. Tuition payment for vacation will be waived for two weeks throughout each school year.

7. If the provider is unable to provide care because of illness or emergency, the policy is that the tuition will be prorated to reflect the days of operation. Any discounted tuition rates, promotions or co-payments will not be prorated.

8. If the parent/guardian drops off the child earlier or picks up later than the times specified above, the following overtime rate will be charged: $25 per 15 minutes or portion thereof and should be made no later than the following business day.

IV. Damages:

The policy on damage caused by the child(ren) while in the provider's care unless caused by the negligence of the provider is that parent(s) guardian(s) are responsible for property destruction or defacement of property. (This does not apply to normal wear and tear on toys or furniture, only to damage.)

V. Termination Procedure:

This contract begins on the following date: _____ and may be terminated by either parent/guardian or provider by giving ***two weeks' written notice***. The provider may terminate the contract without notice if the parent/guardian is **over one week late** with scheduled payments or in instances of expulsion. Parent/guardian may terminate the contract without notice if the provider does not comply with NJ child care regulations/laws. Changes to the contract, desired by either provider or parent/guardian, must be made in writing and acknowledged in writing by the other parties at least 2 weeks before the desired change takes effect. A new contract may be signed at that time to reflect the changes.

VI. ***In Enrolling my child at _____, I also agree to:***

- Inform the provider of any and all changes to work, home addresses and telephone numbers
- Arrange for a readily available person to pick up my child in the event I cannot be reached.
- Notify the provider if my child cannot be picked up or dropped off at the regular time
- Inform the provider if someone other than the parents will pick up the child(ren)
- Give the provider an up-to-date immunization record and physician's examination statement
- Inform the provider if the child contracts a contagious disease
- Pick up my child immediately if notified that he/she is ill
- Maintain the following articles of clothing in the center at all times. (under garments, shirt, pants, socks)

2. The Provider also agrees to:

- Discuss your child's daily activities and routines with you
- Provide a safe, healthy, stimulating environment for your child(ren)
- Permit the parent to visit at any time the enrolled child(ren) are present
- Provide information to parents regarding policies of admission of sick children to the center and policies regarding administration of medication to children.
- Notify the parent immediately if the child(ren) is seriously injured, or by the end of the day if the injury is not serious. The center will provide the parent with a written accident report by the end of the next working day.
- Obtain your written permission before permitting your school- aged child(ren) to leave the center
- Obtain written permission before transporting your child(ren)
- Provide parent with a copy of the Information to Parents Statement provided by the State of NJ
- Provide the parent with documentation documenting incidents and the Expulsion Policy

VII. Signatures:

By signing this contract, all parties agree to all of the above terms and policies, including financial responsibility for child care provided. The provider is responsible for providing all parties a copy of the signed contract.

Provider's Signature: _____ Date:_____

Parent/Gaurdian Signature: _____ Date:_____

Parent/Gaurdian Signature: _____ Date:_____

UNIVERSAL
CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

10:122-7.3 Health and immunization requirements for children
May be completed by parents when school-age child is enrolled

MEDICAL DECLARATION STATEMENT FOR SCHOOL-AGE CHILD CARE

Child's Name: type here

Date of Birth: type here Grade in September type here

Is your child under any medical/physical restrictions? Select Yes Select No
If yes, check all that apply:
Select Asthma Select Hearing Loss Select Diabetes Select Convulsions

Select Other: type here

Is your child taking any medication? Select Yes Select No
If yes, please list:
type here...

Has your child been under a doctor's care or hospitalized within the last three years? Select Yes Select No
If yes, please explain:
Type here

Is your child allergic to any medications/foods/insect stings? Select Yes Select No
If yes, please list:
Type here

Family Health care provider's Name: Type here

Telephone Number: (_____) Enter here

Address: Type here

As a parent/guardian of the above participating child, I certify that he/she is in good physical health, has no special needs, and may participate in all of the activities of the Center's program, except as noted above.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____