The Children's Corner of West Essex, Inc.

40 Freeman St., Roseland, NJ 07068-1336
Telephone 973-226-7300

PLEASE CHECK NUMBER OF DAYS & TIME(S) YOU WANT:	A.M.	P.M.
5 DAY M-F		
3 DAY		
2 DAY		

ENROLLMENT APPLICATION

DESIRED START DATE _____/_____/_____

Child's Name: _____ Application Date:_____/_____/_____

Child's Nickname:_____ Date of Birth:_____/_____/_____

Parent/Guardian Name:_____ Home Phone: (_____) _____

Home Address:_____
Address City St Zip

Occupation:_____ E-Mail:_____

Business Phone:(_____)_____ Cell Phone: (_____)_____ Pager: (_____)_____

Business Name:_____ Pager Pin: _____

Business Address:_____
Address City St Zip

Parent/Guardian Name:_____ Home Phone: (_____) _____

Home Address:_____
Address City St Zip

Occupation:_____ E-Mail:_____

Business Phone:(_____)_____ Cell Phone: (_____)_____ Pager: (_____)_____

Business Name:_____ Pager Pin: _____

Business Address:_____
Address City St Zip

Does your child have any medical conditions or allergies that require immediate treatment? ___Yes ___No

If yes, please describe:_____

_____

Does your child have any special learning needs, if so please describe: _____

_____

How did you learn about us: _____

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ENROLLMENT APPLICATION – pg. 2

If I have not arrived at The Children's Corner nor called by 6:00 PM and the people listed on my Emergency Information Form cannot be contacted, I authorize the teaching staff to do the following in numbered order:

_____ Take my child to West Orange Police Department

_____ Call NJ Division of Youth and Family Services for emergency care

_____ Other plan (please outline below)

Signature: _____ Date: ____/____/_____

If a non-custodial parent is not included among those persons authorized by the custodial parent to pick up the child please explain below and attach a copy of appropriate court order.

Signature: _____ Date: ____/____/_____

I give permission for my child _____ to participate in all school-scheduled health screenings, including but not limited to dental, vision and hearing;

Signature: _____ Date: ____/____/_____

I have received and reviewed the Information to Parents/Guardians, Policy on Medical Conditions & Medication, Policy Guidelines on Positive Discipline, Policy on the Release of Children, Policy on Removal or Expulsion of Children, and the New Jersey Law on Discrimination as part of the Parent Teacher Handbook (pages 15 through 25) as required by the New Jersey Manual of Requirements for Child Care Centers;

Signature Parent/Guardian #1: _____ Date: ____/____/_____

Signature Parent/Guardian #2: _____ Date: ____/____/_____

I prefer to receive my Monthly Tuition Invoice by:

_____ E-Mail to _____

_____ Paper in my Child's Cubby Mailbox

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PRESCHOOL EMERGENCY CONTACT INFORMATION

Child's Name: _____ Birth Date: _____

Parent/Guardian Name #1: _____

Telephone Nbrs: Home (____) _____ Work: (____) _____ Cell: (____) _____

Parent/Guardian Name #2: _____

Telephone Nbrs: Home (____) _____ Work: (____) _____ Cell: (____) _____

Emergency contact to whom child may be released if parent/guardian is unavailable:

Name & Relationship #1: _____

Telephone Nbrs: Home (____) _____ Work: (____) _____ Cell: (____) _____

Name & Relationship #2: _____

Telephone Nbrs: Home (____) _____ Work: (____) _____ Cell: (____) _____

Child's Health Care Provider

Name: _____ Telephone: _____

Address: _____

Child's Health Insurance

Name of Insurance Plan: _____ ID# _____

Subscriber's Name on Insurance Card: _____

List special conditions, disabilities, allergies or medical information for emergency situations:

_____

_____

List Preference for transport arrangement in an emergency situation (Parents/Guardians are responsible for all emergency transportation charges.):

Hospital Preference: 1ST Choice: _____ 2nd Choice: _____

Parent/Guardian Consent and Agreement for Emergencies

As parent/guardian, I give consent to have m my child, _____, receive first aid by the preschool staff, and, if necessary, be transported to receive emergency care. I also authorize the Director or Director Designee to contact my child's health care provider to alert him/her to my child's situation. I understand that I will be responsible for all charges not covered by insurance. I give consent for the emergency contact person listed above **to act on my behalf** until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months. In the event of accidental poisoning, I agree that my child may receive Syrup of Ipecac if, and as, directed by the Poison Control Center.

Parent/Guardian Signature #1: _____ Date: _____

Parent/Guardian Signature #2: _____ Date: _____

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DISMISSAL INFORMATION FORM

My Child, _____, is to be dismissed to:

Parent/Guardian:_____

Parent/Guardian:_____

Other Persons: _____

_____

_____

_____

_____

_____

No Child will be dismissed to any person other than those listed unless we receive written permission.

Parent/Guardian Signature:

_____ Date: ____/____/_____

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ACTIVITIES PERMISSION FORM

Name of Child: _____

I hereby grant permission for my child to use all play equipment and to participate in all activities in the school;

Further, I hereby grant permission for my child to leave the school premises, under adequate supervision by the staff, for neighborhood walks or park play (by foot, stroller, or carriage);

Further, it is my understanding that these trips may be taken at any time without further consent from me.

Parent/Guardian Signature:

_____ Date: ____/____/_____

SCHOOL DIRECTORY PERMISSION

Name of Child: _____

The Children's Corner will maintain a Directory of Students for the purpose of parents contacting parents to arrange play dates, car pooling, etc. For child safety reasons this directory includes only the name of the child, the name of the parents, the city of residence and the home telephone number. Please indicate the following options:

_____ I agree to have the above information regarding my child included in this Directory of Students.

_____ I do not agree to have the above information regarding my child included in the Directory of Students.

Parent/Guardian Signature:

_____ Date: ____/____/_____

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AGREEMENT WITH POLICIES AND PROCEDURES

Name of Child: _____

We have read, understood, and agree to abide by the policies and procedures of The Children's Corner as found in the Parent Teacher Handbook; (All parents, guardians, or other responsible persons involved in the daily care of the child are required to sign):

Parent/Guardian _____ Date: ____/____/_____

Parent/Guardian _____ Date: ____/____/_____

Other Responsible Person_____ Date: ____/____/_____

Other Responsible Person_____ Date: ____/____/_____

Other Responsible Person_____ Date: ____/____/_____

PHOTOGRAPH CONSENT

Name of Child: _____

This will give permission for my child to be photographed under the following conditions while they are students at The Children's Corner:

1. Insertion in the school photograph album: ____Yes ____No
2. School projects to be sent home: ____Yes ____No
3. Possible use in Future School Brochures: ____Yes ____No
4. News Releases (i.e. graduation photos): ____Yes ____No

I understand that it is the policy of The Children's Corner that unless expressly permitted by a parent at the time a photograph is used or printed that names of children will never be associated with their photograph.

Parent/Guardian Signature:

_____ Date: ____/____/_____

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LIKES & DISLIKES

Name of Child: _____

We are interested in your child's needs and request that you provide the following information. Please include any fears your child may have, so that we may be able to understand your child.

	LIKES	DISLIKES
ACTIVITES		
FOODS		
BEVERAGES		
ANIMALS		
OTHER		

Other special needs:

Parent/Guardian Signature:

_____ Date: ____/____/_____

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Health Record Checklist

☐ **Complete Section I of the attached Universal Child Health Record.**

☐ **Have your child's Pediatrician complete Section II of the Universal Child Health Record.**

☐ **Obtain a current copy of your child's Immunization Record.**

☐ **Return the Universal Child Health Record & Immunization Record to the School.**

☐ **Read, Sign, and return the Medication Administration Policy and Procedures document.**

☐ **If your child requires medication of any kind your child's Health Care Provider and You must complete and return a Permission to Give Medication in PreSchool form for each medication. This form is required for both prescription and over the counter medications.**

UNIVERSAL
CHILD HEALTH RECORD

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

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 and Senior Services, Immunization Program at 609-588-7512.
   - 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.state.nj.us/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.

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Medication Administration Policy and Procedures

PURPOSE: This policy was written to encourage communication between the parent, the child's health care provider and the preschool provider to assure maximum safety in the giving of medication to the child who requires medication to be provided during the time the child is in preschool.

INTENT: Assuring the health and safety of all children in our Center is a team effort by the preschool provider, family, and health care provider. This is particularly true when medication is necessary to the child's participation in preschool. Therefore, an understanding of each of our responsibilities, policies and procedures concerning medication administration is critical to meeting that goal.

Guiding Principles and Procedures:

1. Whenever possible, it is best that medication be given at home. Dosing of medication can frequently be done so that the child receives medication prior to going to preschool, and again when returning home and/or at bedtime. The parent/guardian is encouraged to discuss this possibility with the child's health care provider.

2. The first dose of any medication should always be given at home and with sufficient time before the child returns to preschool to observe the child's response to the medication given. When a child is ill due to a communicable disease that requires medication as treatment, the health care provider may require that the child be on a particular medication for 24 hours before returning to preschool. This is for the protection of the child who is ill as well as the other children in preschool.

3. Medication will only be given when ordered by the child's health care provider and with written consent of the child's parent/legal guardian. A "Permission to Give Medication in PreSchool" form is available and will hereafter be referred to as Permission Form. All information on the Permission Form must be completed before the medication can be given. Copies of this form can be duplicated, requested from the preschool staff, or downloaded from the school's website.

4. "As needed" medications may be given only when the child's health care provider completes a Permission Form that lists specific reasons and times when such medication can be given.

5. Medications given in the School will be administered by a staff member designated by the School Director and will have been informed of the child's health needs related to the medication and will have had training in the safe administration of medication.

6. Any prescription or over-the-counter medication brought to the preschool must be specific to the child who is to receive the medication, in its original container, have a child-resistant safety cap, and be labeled with the appropriate information as follows:
   - ✓ Prescription medication must have the original pharmacist label that includes the pharmacists phone number, the child's full name, name of the health care provider prescribing the medication, name and expiration date of the medication, the date it was prescribed or updated, and dosage, route, frequency, and any special instructions for it administration and/or storage. It is suggested that the parent/guardian ask the pharmacist to provide the medication in two containers, one for home and one for use in child care.
   - ✓ Over-the-counter (OTC) medication must have the child's full name on the container, and the manufacturer's original label with dosage, route, frequency, and any special instructions for administration and storage, and expiration date must be clearly visible.
   - ✓ Any OTC without instructions for administration specific to the age of the child receiving the medication must have a completed Permission Form from the health care provider prior to being given in the child care center.

7. Examples of over-the-counter medications that may be given include:
   - ✓ Antihistamines
   - ✓ Decongestants
   - ✓ Non-aspirin fever reducers/pain relievers
   - ✓ Cough suppressants
   - ✓ Topical ointments, such as diaper cream or sunscreen

8. All medications will be stored:
   - ✓ Inaccessible to children
   - ✓ Separate from staff or household medications
   - ✓ Under proper temperature control
   - ✓ A small lock box will be used in the refrigerator to hold medications requiring refrigeration.

9. For the child who receives a particular medication on a long-term daily basis, the staff will advise the parent/guardian one week prior to the medication needing to be refilled so that needed doses of medication are not missed.

10. Unused or expired medication will be returned to the parent/guardian when it is no longer needed or be able to be used by the child.

11. Records of all medication given to a child are completed in ink and are signed by the staff designated to give the medication. These records are maintained in the School. Samples of the forms used are attached to this policy and include:
    - ✓ Permission to Give Medication in PreSchool
    - ✓ Universal Child Health Record
    - ✓ Emergency Contact Sheet
    - ✓ Medication Administration Log
    - ✓ Medication Incident/Error Report

12. Information exchange between the parent/guardian and preschool provider about medication that a child is receiving should be shared when the child is brought to and pick-up from the Center. Parents/guardians should share with the staff any problems, observations, or suggestions that they may have in giving medication to their child at home, and likewise with the staff from the center to the parent/guardian.

13. Confidentiality related to medications and their administration will be safeguarded by the School Director and staff. Parents/guardians may request to see/review their child's medication records maintained at the School at any time.

14. Parent/guardian will sign all necessary medication related forms that require their signature, and particularly in the case of the emergency contact form, will update the information as necessary to safeguard the health and safety of their child.

15. Parent/guardian will authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about the medication the child is receiving, and will also authorize the health care provider to speak with the Director or Director's designee in the event that a situation arises that requires immediate attention to the child's health and safety particularly is the parent/guardian cannot be reached.

16. Parent/guardian will read and have an opportunity to discuss the content of this policy with the Director or Director's designee. The parent signature on this policy is an indication that the parent accepts the guidelines and procedures listed in this policy, and will follow them to safeguard the health and safety of their child. Parent/guardian will receive a copy of the signed policy including single copies of the records referenced in this policy.

17. The Medication Administration in Child Care Policy will be reviewed annually by the following:
    - School Director
    - Licensing Consultant
    - Child Care Health Consultant
    - Parent/guardian

Child's Name: _____

Parent/Guardian Signature #1 _____Date_____

Parent/Guardian Signature #2 _____Date_____

School Director Signature _____Date_____

REFERENCES: Information for the Medication Administration in PreSchool Policy was derived from the current **Manual of Requirements for Child Care Centers** in New Jersey and **Caring For Our Children—The National Health and Safety Performance Standards for Out-of-Home Child Care Programs**, second edition.

Effective date of this policy August 1, 2007

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Permission to Give Medication in PreSchool

(Please use one form per medication.)

The following information is to be completed by the child's health care provider:

Child's Name: _____ Birth Date: _____ Wt: _____

Medication: _____ Allergies: _____

Include food and/or medication allergies

Dosage: _____ Route: _____

Time of day medication is to be given: _____

Purpose of medication: _____

Special Instructions: _____

Possible side effects: _____

Start Date: _____/_____/_____ End Date: _____/_____/_____

_____ _____ _____

Signature of Health Care Provider | Telephone Number | Date

The following information is to be completed by parent or guardian:

I hereby give permission for my child, _____, to receive the above medication, according to the listed directions and cautions, from the School Director, or the School Director Designee. I confirm that I have given at least one dose of the medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container and labeled with my child's full name. I am also to supply the appropriate measuring device needed to give the accurate dose of the medicine.

I authorize the Director or Director Designee to contact the pharmacist or health care provider for more information about this drug, if necessary. I also authorize the Director or Director's Designee to contact the health care provider regarding my child's health, if necessary.

I usually do the following to make giving medication to my child easier: _____

_____

Amount of medication brought to the PreSchool: _____

_____ Date: _____/_____/_____

Signature of Parent/Guardian

Date & amount of medication returned to Parent/Guardian: _____

_____ _____

Signature of Director/Director Designee | Signature of Parent/Guardian