*(For Office Use Only)*

**Children’s Record Checklist**

The following must be kept on file for each enrolled child:

1. NEW STUDENT FORM ………………………………………………………………………. page 2
2. ENROLLMENT APPLICATION ………………………………………………………………. page 3
	1. Child’s information
	2. Parents’ (guardian’s) information
	3. Persons authorized to pick child up
	4. Parents’ (guardian’s) signature
3. AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT …………………………. page 4
	1. Emergency information
	2. Any know allergies and medical condition
	3. Physician’s information
	4. Emergency Authorization
4. PHYSICIAN’S REPORT ……………………………………………………………………….... page 5
	1. Section I – to be completed by parent(s)
	2. Section II – to be completed by health care provider
5. PERMISSION TO DISPENSE MEDICATION …………………………………………………. page 6
	1. Parent’s (guardian’s) permission
	2. Parent’s (guardian’s) signature
6. ENROLLMENT AGREEMENT …………………………………………………………………. page 7
	1. Calendar, hours, fees, tuition, withdrawal and vacation
	2. Parent’s (guardian’s) signature
7. DEVELOPMENTAL HISTORY ………………………………………………………………. page 9
	1. Completed information
8. STATEMENT OF RIGHT TO VISIT AND OBSERVE ………………………………………. page 12
	1. Parent’s (guardian’s) signature

 *(For Office Use Only)*

**1. New Student Form**

Dear Staff,

 There is a new student beginning in the class on

 .

Child’s Name:

Scheduled Days: M T W Th F

Hours: Drop off

Pick up:

Emergency phone #(s) and person’s name

Special Information:

 Registration fee paid

 Registration fee outstanding balance in the amount of $

 First week tuition paid

 First week tuition outstanding in the amount of $

 All paperwork turned in

 Needs the following documents:

Signature Date

**2. Enrollment Application**

**General Information:**

Child’s Name Birth Date

Address Phone#

**Mothers Information:**

Mother/Guardian’s Name Cell Phone#

Home Address (if different)

Social Security # Employer

Work Phone# E-mail:

**Father’s Information:**

Father/Guardian’s Name: Cell Phone#

Home Address (if different)

Social Security # Employer

Work Phone# E-mail:

**PERSON’S AUTHORIZED TO PICK CHILD UP:**

The following individuals, other than the Guardian(s) listed above, are authorized to pick up my child from the center. (Please Print)

**Name Address Relationship Home# Work#**



Parent’s/Guardian’s Signature Date

A ONE TIME $100.00 REGISTRATION FEE MUST ACCOMPANY THIS APPLICATION FOR PERSCHOOL CARE.

*Jesus said “Let the little children come to me, and do not hinder them, for the kingdom of heaven belongs to such as these.” (Matthew 19: 14 NIV)*

**3. Authorization for Emergency Medical Treatment**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child allergic to any medications or foods?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child been diagnosed with a disease or developmental condition? Ex. Diabetes, ADHD. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child receive medications daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nearby person to be called in case of an emergency:

Name Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Physician Phone# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY AUTHORIZATION:**

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency medical care. These steps may include, but are not limited to the following:

1. ATTEMPT TO CONTACT A PARENT OR GUARDIAN, THE CHILD’S PHYSICIAN, OR PERSON LISTED IN CASE OF EMERGENCY.
2. If we can not contact you or your child’s physician we will do one of the following
3. Call another physician or the paramedics and/or
4. Have the child taken to an emergency hospital in the company of a staff member.
5. Any expenses incurred under # 2, above, will be borne by the child’s family.

 *(Circle one. If no, explain on back-please be specific)*

In compliance with the above steps, may school personnel perform general first aid procedures

on your child should a minor accident or injury occur? YES NO

In compliance with the above steps, may school authorities make choices for your child in the

event you (or other authorized persons) cannot be reached? YES NO

PARENT/GUARDIAN SIGNATURE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Physician’s Report**

Based on: 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 | Cell Phone / Work Telephone Number | Email |
| Parent/Guardian Name | Cell Phone / Home Telephone Number | Email |
| 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: |
| **SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER** |
| Date of Physical Examination: | Results of physical examination normal? Yes No |  |
| Weight (must be taken within 30 days) | Height (must be taken within 30 days | Head Circumference (if 3 Years) |
| IMMUNIZATIONS  | Next Immunization Due: Immunization Record Attached Date: |
| 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 |
| 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)  | Signature Health Care Provider | Stamp/Date: |

**5. Permission to Dispense Medication**

At times it may be necessary for Little Lambs Preschool staff member to administer prescription medications to my child, Little Lambs Preschool will follow the guidelines of State of New Jersey Department of Children and Families.

1. All prescription medication shall be:

1. Prescribed in the name of and specifically for the child; and

ii. Stored in its prescription container, which has been labeled with the child’s name, the name and expiration date of the medication, the date it was prescribed or updated and directions for its administration

1. Little Lambs Preschool will maintain on file, for the current school year, a record of medication’s administration with the following:
2. The copy of the doctor’s prescription
3. The date and time medication or health care procedure is administered to my child and the name or initials of the staff member who administered it.

 I agree with all terms above and give permission to Little Lambs Preschool staff to administer prescription to my child. I understand it is my responsibility to provide Little Lambs Preschool with medication and documents as described above.

 I do not give permission to Little Lambs Preschool staff to administer medications to my child.

Parent printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**6. Preschool Enrollment Agreement**

 The Little Lambs Preschool, 2 Pemberton-Browns Mills Rd, Browns Mills, New Jersey, 08015; phone (609) 893-4546 (hereinafter referred to as the ‘school’) is a child day care facility operated by the Browns Mills United Methodist Church (same address), a nonprofit corporation. The school is licensed by the State Department of Human Services, Division of Youth and Family Services, Bureau of Licensing, pursuant to Chapter 122 of the State Administrative Code.

 I am enrolling my child in the early childhood program of the Little Lambs Preschool. The terms of the agreement are as follows:

**CALENDAR**

The school is open year round. The calendar year is September 1st through August 31st. The program year is September through June, with a summer camp program beginning in late June through July and August. The following are days and holidays when the center will be closed: Labor Day, Columbus Day, Veterans Day, Thanksgiving Day and the day after, Christmas Eve Day, the week between Christmas and New Year’s Day, including those days, Martin Luther King Jr. Day Presidents’ Day, Good Friday, the Monday after Easter, Memorial Day, Juneteenth, and the Fourth of July. The school will be closed for inclement weather anytime that the Pemberton Township Schools are closed. **Tuition for all of our programs remains the same regardless of sick days, snow days, holidays, or many other days the school is closed or your child does not attend.** There is no tuition for the full week that the center is closed in December, and we also offer each family a maximum of two vacation weeks per year at ½ the regular tuition rate, provided that arrangements are made in advance. Family Service copayments remain the same regardless of ANY school closing, including these two full weeks. The state will adjust any payments made to us.

**HOURS**

The program operates from 6:30 A.M until 5:30 P.M. All children must be inside the building by 9:00 am and picked up by 5:30 pm. No children will be accepted in the building after 9 am. Particular situations can be discussed in advance. There is a $1.00 per minute fee for each minute past the closing time of each session that you are late. Times will be determined by visual time on EST Satellite Clock.

**FEES**

**A $100.00 registration fee is due with the “Enrollment Application”.** There is no discount on this fee as it is for processing and/or purchasing materials. This fee is non-refundable and non-transferable. IF YOUR CHILD IS WITHDRAWN FROM THE PROGRAM, A $50.00 RE-REGRISTRATION FEE IS REQUIRED FROM HIM/HER TO RETURN. There is a $45.00 fee for ALL returned checks. The program is officially closed at 5:30 P.M. You will be charged a $1.00 fee for every minute you are late picking up your child. This charge is due with your next day of care.

**TUITION**

Tuition payments are collected once a week **in advance**. They are received in the office all day Monday and Friday. Late fees may be assessed at the rate of $10.00 per day for a maximum of five more days at which time you child will be withdrawn from the program. Failure to make payment(s) within 2 weeks of payment date, will result in your child being withdrawn from our program. Any money that remains in your account will be put towards your balance due, as the school requires two weeks’ notice for parents to withdraw a child, to allow us time to find a replacement.

**WITHDRAWAL AND VACATION**

In order to keep your child’s place, Little Lambs Preschool must be notified by email of your vacation two weeks **in advance**. One half of the regular tuition will be charged to save your child’s place. We require two week’s **in advance** written/ email notice to withdraw your child from the program. IF YOUR CHILD IS WITHDRAWN FROM THE PROGRAM A $50.00 RE-REGISTRATION FEE IS REQUIRED FOR HIM/HER TO RETURN.

**FINANCIAL POLICIES**

I understand that I must adhere to the financial policies as outlined in this agreement and/or the “Parent Handbook”.

**PERMISSION TO PARTICIPATE**

I hereby grant permission for my child to use all of the play equipment and participate in all activities of the school, and to leave the school premises under the supervision of a staff member for neighborhood walks and/or field trips.

**EMERGENCY FORM**

As my child’s Parent/ Guardian, I agree to finish a completed emergency form signed by me prior to the first day of school. I understand that it is my responsibility to see that emergency information is always current and up to date.

**INFORMATION TO PARENTS COPY**

I have received a copy of the *Information to Parents* statement prepared by the Bureau of Licensing.

**PARENT HANDBOOK**

I have received and read a copy of the parent handbook distributed by the school and agree to abide by the policies and procedures outlined in the book including, but not limited to the following: Discipline Policy, Publicity Statement, Policy for Sick Children, the Control of Communicable Diseases, Policy for the Release of Children, Policy on Expulsion.

Parent/Guardian printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: Date:

**7. Developmental History**

**Family History:**

Name of Child: DOB:

Does your child have a nickname?

How do you prefer we call your chil?

Mother/Guardian Age:

Father/Guardian Age:

Is the child adopted? At what age was the child adopted?

Custody/visiting arrangements (if any):

Brothers and/or sisters of the child:

Name Age School Grade

Other member of the household (include relationship and age):

If parents do not personally provide care for the child before and after school, please state arrangements for care:

Has your child had a group play experience or attended another preschool? (Please explain)

Does your child have neighborhood playmates? Ages:

When and with whom does your child watch television? List shows:

Would you say your child is: Friendly Aggressive Shy Withdrawn Other

How would you describe your child’s personality?

When upset, how does your child show his/her feelings?

What fears does your child have?

**Eating:**

Is your child usually hungry at mealtime?

What foods does your child refuse?

Does your child have eating problems? (Explain)

Any food allergies?

Is your family vegetarian or have any particular eating habit?

**Personal Information:**

Type of birth: Normal Premature Cesarean

Any complications? (Explain)

Age at which your child: Crept on hands and knees: Sat alone:

Walked alone: Talked:

Does your child have any speech, hearing, or vision problems? (Explain)

At what age was your child toilet trained? (If toilet trained)

What word does your child use for urination and/or bowel movement?

Does your child need help with toileting? (Explain)

Is your child right or left handed?

Does your child dress or undress self? (Explain)

What time does your child go to bed? Awaken?

Does your child share a room; if so, with whom?

What method of behavior control is used in your home?

How does your child react to it?

List any pets you may have and give their names:

**8. Statement of Right to Visit and Observe**

Dear Parents,

In keeping with New Jersey’s child care center licensing requirements, we are obliged to provide you, as the parent of a child enrolled in our center, with this information statement.

This statement highlights, among other things: your right to visit and observe our center at any time without having to secure prior permission, the center’s obligation to be licensed and to comply with licensing standards, and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State Central Registry Hotline 877-652-2873 (877-NJABUSE).

**\* FOLLOWING COVID GUIDELINES WILL MANDATE VISITATION PROCEDURES.**

Please read this statement carefully, and if you have any questions, feel free to contact me at **(609) 893-4546.**

 Sincerely,

 Ailana Cota

 Director, 2021

Please complete and return this portion to the center. (Please Print)

Name of Child

Name of Parent

I have read and received a copy of the Information to Parents Statement prepared by the Office of Licensing, Childcare &Youth Residential Licensing, in the Department of Children and Families.

Signature Date