



## ENROLLMENT APPLICATION

Kiddies Daycare will operate from  
Monday – Friday 8:00am-5:00pm  
Please specify the hours and days your child will attend.

C H I L D	Name of Child	
	Date of Birth	
	Home Address	

**Please keep phone numbers and addresses updated with your child's school.**

P A R E N T	Mother/Guardian		Father/Guardian	
	Name		Name	
	Date of Birth		Date of Birth	
	Home Phone		Home Phone	
	Cellular		Cellular	
	Home Address		Home Address	

W O R K	Mother/Guardian		Father/Guardian	
	Business Name		Business Name	
	Business Phone		Business Phone	
	Address		Address	



Please write contact other than parents that is a valid telephone number.

Persons authorized to pick up your child and/or contact in case of emergency if neither parent/guardian is available to assume responsibility for the child.				
<b>E M E R G E N C Y</b>	Name of Contact #1		Name of Contact #2	
	Home Phone		Home Phone	
	Cellular		Cellular	
	Relationship		Relationship	
	Address		Address	

<b>W A L K S</b>	10:122-6.8 Parent and community participation May be signed by parents to authorize walking trip participation.
	___ I give my permission for my child to participate in walking trips within the center's Neighborhood and to the local park.
	___ I do not give my permission for my child to participate in walking trips within the center's Neighborhood and to the local park.
	I understand that the walking route includes no safety hazards and that the walks will not involve entrance into any facility other than the following: _____ _____ _____
	Parent's/Guardian's Signature: _____ Date: _____

<b>C U S T O D Y</b>	If a non-custodial parent is <u>not</u> included among those persons authorized by the custodial parent to pick up the child, please explain below and <b>attach a copy of appropriate court order.</b>
	Name of person PROHIBITED from picking up the child: _____
	Name _____ Date _____



P O L I C I E S	<p>I (we) attest that all the information on this application is accurate, and that I (we) have received the following information for my (our) home records:</p> <ol style="list-style-type: none"> <li>1. Information to Parents Document</li> <li>2. Policy on the Release of Children</li> <li>3. Philosophy of Discipline</li> <li>4. Policy on the Management of Illness/ Communicable Diseases</li> <li>5. Expulsion Policy</li> </ol> <p>Parent's Signature/Guardian(s): _____ Date _____</p>
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E M E R G E N C Y	<p>I understand that if my child becomes ill, and care is necessary, the school shall make every effort to contact me and/or another person herein designated by me. Upon failure to contact my designee, or me or if any emergency requires immediate attention, I hereby authorize the school to appropriate and necessary care.</p> <p>If your child develops a fever during the time, he/she is at the center, you will be contacted immediately and have 1 hour to pick up your child.</p> <p>I have completed the medical emergency permission form, which authorizes the center to seek emergency medical care for my child as deemed necessary by the director or the director's designee.</p> <p>Parent's Signature/Guardian: _____ Date: _____</p>
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## PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

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

Parent's/Guardian's Name \_\_\_\_\_

Parent's/Guardian's Address \_\_\_\_\_

Home Telephone \_\_\_\_\_ Cellular \_\_\_\_\_

### CHILD'S MEDICAL INFORMATION

Medical Problems \_\_\_\_\_

Allergies \_\_\_\_\_ Medicine(s) Child is taking \_\_\_\_\_

Name of Child's Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

CHILD'S INSURANCE COMPANY/HMO \_\_\_\_\_

Group Number \_\_\_\_\_ Identification # \_\_\_\_\_

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct, we authorize Kiddies Daycare director or director's designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

### The following steps will be followed in an emergency:

1. The parents/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. We will attempt to contact you through all the emergency persons listed on the child's application form.
4. If we cannot contact you or your child's physician, we will do any or all the following:
  - (a) Call for emergency first aid assistance/transportation.
  - (b) Call another physician.
  - (c) Have the child transported to an emergency hospital in the company of a staff member.

Parent Signature: \_\_\_\_\_ Date of Signature: \_\_\_\_\_



## COVER LETTER FOR DYFS INFORMATION TO PARENTS DOCUMENT

Dear Parents:

In keeping with New Jersey's Childcare Center Licensing Requirements, we are required to provide you, as the parent of a child enrolled in our center, with this informational statement. The statement highlights, among other things: your right to visit and observe our center with out 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's Division of Youth and Family Services (DYFS).

Please read this statement carefully and, if you have any questions, feel free to contact us at: (908) 759-0123.

Sincerely,

Kiddies Daycare Management

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Name of Child:

\_\_\_\_\_

Name of Parent(s)/Guardian(s):

\_\_\_\_\_

I have read and received a copy of the Information to Parents documents prepared by the Bureau of Licensing in the Division of Youth and Family Services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



### Agreement between Parent and Kiddies Daycare

I understand that I am the person responsible for picking up my child. If I am not able to pick my child up from the center, I will inform the center of another adult that will be responsible for picking up my child from the center. I understand that this person must be at least 18 years of age or older.

Initials \_\_\_\_\_

I have provided the center with 2 or more emergency contacts (friends or relatives) in case I am not available to care for my child in case of any emergency. As well as my own updated home, job and cell phone numbers.

Initials \_\_\_\_\_

I understand that when my child has an accident at home, I will inform the center. I agree to call the center if my child is sick and is going to be late or absent. I will provide a doctors note when my child is sick and has been absent for three days or more.

Initials \_\_\_\_\_

I understand that if my child is picked up after 5:00p.m, a late fee of \$1.00 per minute will be enforced and must be paid within that week.

Initials \_\_\_\_\_



#### 10:122-6.8 Expulsion Policy

May be used to inform parents of the center's policy on the expulsion of children from enrollment.

### **Expulsion Policy**

**NAME OF CENTER:** Kiddies Daycare

**NAME OF CHILD:** \_\_\_\_\_

**SIGNATURE OF PARENT:** \_\_\_\_\_

Unfortunately, there are sometimes reasons we must expel a child from our program either on a short term or permanent basis. We want you to know we will do everything possible to work with the family of the child(ren) to prevent this policy from being enforced. The following are reasons we may have to expel or suspend a child from this center:

#### **IMMEDIATE CAUSES FOR EXPULSION:**

- The child is at risk of causing serious injury to other children or himself/herself.
- Parent threatens physical or intimidating actions toward staff members.
- Parent exhibits verbal abuse to staff in front of enrolled children.

#### **PARENTAL ACTIONS FOR CHILD'S EXPULSION:**

- Failure to pay/habitual lateness in payments.
- Failure to complete required forms including the child's immunization records.
- Habitual tardiness when picking up your child.
- Verbal abuse to staff.
- Other (explain)\_\_\_\_\_

#### **CHILD'S ACTIONS FOR EXPULSION**

- Failure of child to adjust after reasonable amount of time.
- Uncontrollable tantrums/ angry outbursts
- Ongoing physical or verbal abuse to staff or other children
- Excessive biting
- Other (explain)\_\_\_\_\_

#### **SCHEDULE OF EXPULSION:**

- If after the remedial actions above have not worked, the child's parent/guardian will be advised verbally and in writing about the child's or parent's behavior warranting an expulsion. An expulsion action is meant to be a period so that the



- parent /guardian may work on the child's behavior or to come to an agreement with the center.
- The parent/ guardian will be informed regarding the length of the expulsion period.
- The parent/guardian will be informed about the expected behavioral changes required for the child or parent to return to the center.
- The parent/guardian will be given a specific expulsion date that allows the parent sufficient time to seek alternate childcare (approximately two weeks' notice depending on risk to other children's welfare or safety).
- Failure of the child/parent to satisfy the terms of the plan may result in permanent expulsion from the center. ☐

#### **A CHILD WILL NOT BE EXPELLED**

If a child's parent(s):

- Made a complaint to the office of licensing regarding a center alleged violations of the licensing requirements.
- Reported abuse or neglect occurring at the center.
- Questioned the center regarding policies and procedures.

Without giving the parent time to make other childcare arrangements.

#### **PROACTIVE ACTIONS THAT CAN BE TAKEN IN ORDER TO PREVENT EXPULSION**

- Staff will try to redirect child from negative behavior.
- Staff will reassess classroom environment, appropriate activities, supervision.
- Staff will always use positive methods and language while disciplining children.
- Staff will praise appropriate behaviors.
- Staff will consistently apply consequences for rules Child will be given verbal warnings.
- Child will be given time to regain control.
- Child's disruptive behavior will be documented and maintained in confidentiality.
- Parent/guardian will be notified verbally.
- Parent/guardian will be given written copies of the disruptive behavior that might lead to expulsion.
- The director, classroom staff and parent/guardian will have a conference to discuss how to promote positive behaviors.
- The parent will be given literature or other resources regarding methods of improving behavior.
- Recommendation of evaluation by professional consultation on premises
- Recommendation of evaluation by local school district child study team





Source: Medication Administration in Childcare, Healthy Childcare New Jersey  
**PERMISSION TO GIVE MEDICATION IN CHILDCARE**  
 (Please use one form per medication)

10:122—7.5 Administration and control of prescription and non-prescription medicines and health care procedures. May be used to record permission for administration of medication children.

**INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE**

Name of Child \_\_\_\_\_

Child's condition for administering medication:

\_\_\_\_\_cold \_\_\_\_\_sore throat \_\_\_\_\_rash \_\_\_\_\_ear infection \_\_\_\_\_teething  
 \_\_\_\_\_injury \_\_\_\_\_other \_\_\_\_\_

Name of medication/procedure \_\_\_\_\_

\_\_\_\_\_Prescription \_\_\_\_\_Non-prescription \_\_\_\_\_ Doctor's approval required.

Amount to be administered \_\_\_\_\_

Time(s) to be administered \_\_\_\_\_

Dates to be administered from \_\_\_\_\_ to \_\_\_\_\_

Refrigeration necessary Yes \_\_\_\_\_ No \_\_\_\_\_

Refrigeration necessary Yes \_\_\_\_\_ No \_\_\_\_\_

Special instructions

Possible adverse reactions

I authorize the administration of medication to my child.

\_\_\_\_\_ Date \_\_\_\_\_

Parents Signature

\* Is all the above information complete? \*Has the medication been placed out of reach of children? \*Is the medication in the original container with the prescription label on it? \* Is the child's name on the container? \* Is the date of medication updated?

Dates Administered	Times Administered	Adverse reactions observed	Staff members initials

Kiddies Daycare  
Food Allergy/Intolerance Information Sheet

Child's Name \_\_\_\_\_

Grade \_\_\_\_ PS \_\_\_\_

Current Food Course \_\_\_\_\_

***Food Allergy***

Parents – Please Initial:

\_\_\_\_\_ My child has a food allergy. Please complete additional questions below.

\_\_\_\_\_ My child does NOT have a food allergy.

Please indicate which food/s your child is allergic to. Check all that apply.

☐ Tree nuts

☐ Wheat

☐ Peanuts

☐ Eggs

☐ Dairy

☐ Gluten

☐ Other \_\_\_\_\_

Please indicate which method/s of contact cause a reaction. Check all that apply.

☐ Inhalation (air borne)

☐ Ingestion

☐ Touch

This statement is to verify that I have read/viewed each item in its entirety and have completed this form in regards to my child's food allergies/intolerances.

Print Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

### **Social Media Policy for Parents:**

We at Kiddies Daycare value your and your child's privacy. The following is different circumstances in which your child's picture would be taken, given your consent. Please sign if you consent. *If no signature is given, no photos of your child will be taken.*

Here at Kiddies Daycare we like to decorate and personalize the classrooms, which includes labeling your child's crib and cubby with their name and picture. I consent to my child's photo being taken and presented in the classroom.

Signature\_\_\_\_\_

Date\_\_\_\_\_

Our facility uses ClassDojo, a classroom app that allows us to upload photos and messages to parents throughout the day, ensuring parents get constant updates on their child's wellbeing and progress. I consent to my child being photographed for the exclusive use of ClassDojo.

Signature\_\_\_\_\_

Date\_\_\_\_\_

Our Instagram account is @kiddies.daycare. I consent to the uploading of my child's image on the Kiddies Daycare public account.

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 <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth / /	
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ( ) -	
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>					
Signature/Date				This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	
SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER					
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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)			
<b>IMMUNIZATIONS</b>		<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____			
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:		<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		
<input type="checkbox"/> <b>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.</b>					
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](http://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](http://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 health 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.

