Today's Date: _____
Date of Enrollment: _____

CHILD DEVELOPMENT CENTER

Child's Name: _____ Birthday: _____ Sex: _____
Nickname child responds to: _____
Home Address: _____ Home Phone: _____
Your Name: _____ Relationship to child:_____

SS# of party responsible for payment: _____
Parent/Guardian Name: _____
Place of Employment: _____ Occupation: _____
Address: _____
Phone: _____ Email: _____
Cell Phone: _____ Hours of Employment: _____

SS# of party responsible for payment: _____
Parent/Guardian Name: _____
Place of Employment: _____ Occupation: _____
Address: _____
Phone: _____ Email: _____
Cell Phone: _____ Hours of Employment: _____

Siblings of Child:

Name:	Age:	If not living at home, where?
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please read before signing application:

- Parents/Guardians must pay regular tuition for days their child is absent from the program either for sickness or vacations (If illness is prolonged, see the Director).
- A notice of two weeks must be given prior to withdrawal of the child from the CDC or two weeks additional tuition will be charged upon withdrawal. If a student withdraws from the College, his/her child will no longer be eligible for student tuition rates and student scheduling.
- The parent/guardian agrees to abide by all policies and regulations of the Bergen Community College child Development Center.
- We serve the Children who are able to function successfully in a group setting. Children with special needs may be accepted on a case by case basis. If, in the judgment of the professional staff, a child is not able to function in a group setting, or the Centers program is not able to meet the special needs of a particular child, the family may be asked to withdraw the child. In the event of this necessity, the Center will work with the family in finding alternative care.

Parent's Signature: _____ Date: _____

CHILD'S BEHAVIOR PATTERNS AND HABITS:

Does your child have any particular fears, such as: dogs, cats, sirens, etc.? Does he/she have nightmares? Please describe:

_____

_____

Does your child use any peculiar words or expressions, such as "vee-vee" for urine, which may not be understood by an outsider? Please describe:

_____

_____

Briefly describe your child's eating habits and preferences:

_____

_____

Briefly describe your child's present sleeping habits. How does he/she act when tired? Does he/she sleep with a special toy or blanket? How often does he/she nap?

_____

_____

Besides you, are there any other adults or children (relatives, friends) that may have an important influence on your child's life?

_____

_____

Please list all persons (children and adults) who live in your home and their relationship to the child:

_____

_____

What pets do you have and what are their names?

_____

_____

Have you and your child had any extended separations from each other? How long and for what reasons?

_____

_____

How does your child act when you leave him/her? What do you find is best to say at these times?

_____

_____

In general, how does your child react to anxiety or a stressful situation? Does he/she cry, withdraw, throw tantrums, etc.?

_____

_____

Has your child had any previous school or play-group experience? Please describe:

_____

_____

Does your child relate well to other children? Does he/she seek friendship or is he/she a loner?

_____

_____

How does your child relate to adults?

_____

_____

What is your accustomed mode of disciplining your child? What is your "philosophy" of discipline?

_____

_____

Confidentiality Agreement

The Child Development Center adheres to the Family Education Right to Privacy Act. It is your right to have information regarding your child and family treated in a confidential manner. We will not disclose or exchange any information regarding your child without your written authorization.

I, _____, give The Child Development Center's Director, full-time teachers and staff and regulatory authorities' authorization to access my child's file and assessment information.

The following people may also have access to my child's files and assessment information:

_____ _____ _____

_____ _____ _____

_____ _____

(Parent/Guardian signature) (Date)

Record Access

BERGEN COMMUNITY COLLEGE
CHILD DEVELOPMENT CENTER

Name	Date	Reason for accessing file

Blanket permission for walking trips:

Every day, weather permitting, the children are taken out to the playground area or for walks on the college grounds.

The fact that the children leave the Center constitutes a "field trip". To that effect, the law requires parental permission to take the children for walks around the college grounds and facilities.

- I hereby grant permission for my child to take walks around the college grounds and facilities.
- I understand the children will be properly supervised by staff members of the Center.

____ ____________________________

Parent/Guardian signature Date

____ ____________________________

Parent/Guardian signature Date

(It is advisable that both parents sign the permission slip)

- -

I give my permission to the selected class parent to have access to my home telephone number. I understand I will be called regarding school business only.

____ ____________________________

Parent/Guardian signature Date

- -

I understand that as the parent of ____ it is my responsibility to be involved in all school functions (i.e., parent meetings, special events, fundraisers).

____ ____________________________

Parent/Guardian signature Date

OFFICE OF PUBLIC RELATIONS RELEASE FORM

The Bergen Community College Child Development Center is a laboratory school which is used for the training of future teachers; in addition, various departments at eh college are involved in photographing and video graphing the children and the staff at the CDC.

These photographs and videos are used for educational purposed exclusively. They may be used by the college cable station and other public broadcasting systems. Participation in these educational activities is totally voluntary.

Date: _____

☐ I, _____ (please print) give Bergen Community College permission to record my image and/or voice and grant Bergen Community College all rights to use these sound, still, or moving images for promotional and recruitment purposes which may include publications, print and broadcast advertisements, the Bergen Community College Website, and other purposes that support the mission of the College. I agree that the rights to sound, still, or moving images belong to Bergen Community College.

- I also Grant permission to Bergen Community College to use by name and/or biographical material information for promotional and recruitment purposes, which may include publications, print and broadcast advertisements, the Bergen Community College Website, and other purposes that support the mission of the College.
- I understand that I will receive no compensation for my participation and that I have no claim on the finished product.

☐ I, _____ (please print) ***DO NOT*** give permission to have my student information, image or biographical information shared with the public through the Public Relations Office at Bergen Community College.

(In order to better serve our students, please take a moment to tell us why you do not grant permission. This information will be kept confidential between the Office of Public Relations and the Office of Student Life.)

_____ _____
Parent or Guardian (please print) Date

_____ _____
Parent or Guardian (please print) Date

Student Address: _____ Email: _____
_____ Phone: _____

****

For office use only

Project: _____

Sunscreen/Insect Repellent Permission Slip

Sunscreen permission

I, _____, grant Bergen Community College Child Development Center permission to use and apply the recommended dose of _____ (name of sunscreen) sunscreen to my child for afternoon outdoor activity. I understand I am responsible for the application of sunblock to my child in the morning before school and for supplying the sunscreen to be used by us in the afternoon. Sunscreen cannot be applied unless form is returned.

_____ _____

Name of Child Date

_____ ❑ I **do not** give the CDC permission to

Parent Signature apply sunblock to my child.

Insect repellant permission

I, _____, grant Bergen Community College Child Development Center permission to use Insect repellent on my child. **Insect repellant will only be applied when public health authorities recommend use due to a high risk of insect-borne disease**. Please know that only repellant containing DEET is used as per NAEYC guidelines. Insect repellent will only be applied once a day and only with your consent.

_____ _____

Name of Child Date

_____ ❑ I **do not** give the CDC permission to

Parent Signature apply insect repellant to my child.

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

CHILD'S NAME: _____

Age: _____ Date of Birth: _____

Address: _____

PARENT(S)/GUARDIAN(S) NAME: _____

Address (if different from above): _____

CHILD'S MEDICAL INFORMATION:

Medical Problems: _____

Allergies: _____

Medicine(s) child is taking: _____

Medicine(s) child is allergic to: _____

Name of child's Doctor: _____

Doctor's phone number: _____

CHILD'S INSURANCE

Company/HMO: _____

Group number: _____ Identification number: _____

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. I (we) authorize the above childcare center 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.

<u>The following steps will be followed in an emergency:</u>

1. The parent/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. We will attempt to contact you through all of 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 of 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/Guardian Signature: _____

Date of Signature: _____ Date Permission Terminated: _____

Witness: _____ Date: _____

EMERGENCY INFORMATION FOR CHILD'S FILE

Child's Name: _____ Date of Birth: _____

Address: _____

Parent's Social Security #: _____

Mother's Name: _____ Father's Name: _____

Mother's Work Phone: _____ Father's Work Phone: _____

Mother's Cell: _____ Father's Cell: _____

Mother's Home #: _____ Father's Home #: _____

Child's Pediatrician: _____

Pediatrician Phone #: _____

Hospital Affiliation: _____

If we cannot contact you, who may we contact in an emergency?

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Names of individuals authorized by the family to have access to health information about the child:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

The following people may pick up my child:

Name: _____ Name: _____

Name: _____ Name: _____

If there are any persons who are prohibited from picking up the child, please list below:

_____

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 the appropriate court order:

_____

_____

Allergies: _____

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.

- 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.

CH-14 *(Instructions)*

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.

OCT 17