MY SCHOOL ENROLLMENT AGREEMENT FORM

NAME OF CHILD_____BIRTHDATE_____

NAME OF 2nd CHILD_____BIRTHDATE_____

Home Address_____ _____
(Street) (Town) (Zip) (School District)

Home Telephone_____Mom's Cell_____Dad's Cell_____

Mother's Name_____Occupation_____Hrs_____

Employer's Name_____Location_____Phone_____

Father's Name_____Occupation_____Hrs_____

Employer's Name_____Location_____Phone_____

I HEARBY AUTHORIZE_____PHONE_____

ADDRESS_____RELATIONSHIP TO CHILD_____
TO PICK UP MY CHILD IN AN EMERGENCY IF PARENTS CANNOT BE REACHED.

Days child will attend My School

Here 12 Months (check one)_____

Off All Summer _____

MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY	
_____		_____		_____		_____		_____	
AM	PM	AM	PM	AM	PM	AM	PM	AM	PM

Weekly Tuition Fee:_____Payable:_____

CHILD CARE IS A WEEKLY FEE PAYABLE REGARDLESS OF ATTENDANCE. THERE IS A LATE FEE FOR EVERY FIVE(5) MINUTES AFTER 6:00 PM.

IF A DELIQUENT ACCOUNT GOES INTO COLLECTION, I WILL BE RESPONSIBLE FOR ALL FEES AND COURT COSTS INCURRED BY MY SCHOOL.
I HAVE RECEIVED A COPY OF THE PARENT HANDBOOK AND I AGREE TO ABIDE BY THE TERMS OF THIS AGREEMENT:

DATE:_____ _____
Signature of Parent/Guardian

APPENDIX H

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	

MY SCHOOL CHILDCARE PARENT INFORMATION FORM

CHILD'S NAME_____NAME USUALLY CALLED_____

BIRTHDATE_____PLACE OF BIRTH_____

BROTHERS & SISTERS_____DATE OF BIRTH_____

_____DATE OF BIRTH_____

OTHER CHILDREN IN HOUSEHOLD – Name_____Age_____

Relationship to this child_____

MOTHER'S MARITAL STATUS Single_____Married_____Separated_____Divorced_____

FATHER'S MARITAL STATUS Single_____Married_____Separated_____Divorced_____

Other Adults in Household – Name_____Relationship to this child_____

What is your child's favorite: Toy_____Book_____

Pet_____Holding Object_____

Does your child have any particular habits such as thumb sucking, nail biting, head banging, etc.? Please describe:

_____

Does your child have particular fears?

_____

What word does your child use for bowel movement_____Urination_____

Does your child know proper toilet hygiene?_____

What peculiar words or expressions does he/she use that may not be understood by an outsider?

_____

How does your child react to anxiety or stressful situations? Does he/she cry, withdraw, and have temper tantrums?

Please explain:_____

Does your child relate to other children?_____

What is your accustomed mode of disciplining your child?_____

Of rewarding or reassuring?_____

To the best of your knowledge, does your child have any language problems?_____

Are there any significant circumstances regarding your child's physical or emotional status that we should be aware of?_____

OVER

PARENT INFORMATION FORM PAGE 2

Does your child have a special diet or formula?_____

Does your child have any allergies?_____Please specify:_____

Do you have any particular concerns about your child's eating habits?_____

Does your child sleep well?_____Does your child nap?_____How long?_____When?_____

Do you have particular concerns about your child's sleeping habits?_____

Is your child left or right handed?_____

How did you learn about My School?_____

IF THERE ARE ANY SPECIAL INSTRUCTIONS OR ANY PERSONS WHO ARE NEVER TO BE AUTHORIZED TO PICK UP YOUR CHILD, PLEASE LIST BELOW.

_____

If person listed is a parent, written legal documentation must be provided prohibiting custody of the child.

MY SCHOOL CREATIVE CHILD CARE

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT FOR A MINOR CHILD

This form may be used to provide medical or surgical treatment for your child while you are on vacation or at any other time. Complete the form and leave it with the person supervising your child during your absence.

I (we)_____
Name(s)

of _____
City County State

do hereby state that I am (we are) the parent(s)/guardian(s) having legal custody

of _____ , a minor, age _____, born_____
Child's Name Age Birth Date

Who resides with me (us) at _____
Address

I (we) authorize_____, an adult

who resides at _____, in the

City of _____ , County of_____

State of_____, to consent to any 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.

Dated this_____ day of _____, 20__,

_____
Signature of Parent(s) or Guardian (s)

This authorization will expire on_____
Date

Witness_____Date:_____

Existing Medical Problems of Child, if any:_____

Child's allergies, if any:_____

Child's Doctor:_____Parent's Doctor_____

Choice of Specialist(s):_____

Medicine(s) child is taking:_____

Insurance Company:_____Group No._____

Identification No.:_____Last tetanus shot date:_____

MY SCHOOL CREATIVE CHILD CARE

PERSONAL INFORMATION RECORD FOR INFANTS AND TODDLERS

CHILD'S NAME_____AGE_____

1. What is our child's current daily sleeping schedule? Morning wake-up_____

   Evening bedtime_____Daily naps_____

2. Is your child sleeping through the night?_____

3. What upsets or frightens your child?_____

4. What does your child find soothing or comforting?_____

5. How is your child now reacting to strangers?_____

6. Is your child using a cup, bottle or both?_____

7. What are the times your child is now receiving the bottle each day?_____

8. Is your child taking formula, whole milk, skim milk or other?_____

9. How many ounces is your child now taking at each bottle feeding?_____

10. Are there any special instructions concerning bottle feeding your child?_____

11. Is your child now on baby food or table food?_____

12. Is your child now eating finger foods?_____(If yes, describe routine)_____

---

13. When does your child usually have bowel movements?_____

14. Has your child begun potty training?_____(If yes, describe routine)_____

15. What does your child call bowel movements?_____Urination?_____

16. List any other information you wish to share about your child:_____

PARENT'S SIGNATURE_____DATE_____

PARENT
RECEIPT OF INFORMATION

- **EXPULSION POLICY**
- **DISCIPLINE POLICY**
- **POLICY ON THE USE OF TECHNOLOGY AND SOCIAL MEDIA**
- **POLICY ON THE MANAGEMENT OF COMMUNICABLE DISEASES**
- **POLICY ON THE RELEASE OF CHILDREN**
- **PARENTAL NOTIFICATION METHODS**

I/We have read and received a copy of the information/policies listed above.

Parent/Guardian Name Parent/Guardian Signature

Parent/Guardian Name Parent/Guardian Signature

Date

MY SCHOOL
• CREATIVE CHILD CARE & PRESCHOOL •

321 OAK RIDGE ROAD
P.O. BOX 302
OAK RIDGE, NJ 07438
T: 973-697-3341
Fax: 973-697-8785

Parent COVID-19 Acknowledgement Waiver

I have read and understand the new policies/procedures at My School Creative Childcare. I always agree to follow them and be honest about my child and family's health. I understand My School Creative Childcare has and is taking all precautions possible to continue to provide a clean, healthy, and safe childcare environment.

I understand that during my child's participation at My School Creative Childcare my child may be exposed to the COVID-19 virus or the risk of such exposure, which risk cannot be eliminated. These hazards and risks include, but are not limited to, the dangers of serious illness, death, and possible transmission to others. I fully realize, accept, acknowledge, and understand the hazards of having my child attend My School Creative Childcare and voluntarily assume all the risks.

_____ _____

Parent/Guardian Date

_____ _____

Parent/Guardian Date

321 OAK RIDGE ROAD
P.O. BOX 302
OAK RIDGE, NJ 07438
T: 973-697-3341
Fax: 973-697-8785

Dear Parents,

If you would like to be notified of a snow closing, delayed opening or early closing please sign the form below. We will notify you at 6AM for closings or delays and by noon for an early closing. Please remember that if there is an early closing you must have someone available to pick up your child as we cannot have staff staying late in adverse conditions . We will also have a message on our answering machine when possible, so check that first before coming out in adverse conditions.

If you intend to have your child remain at home when the center has <u>not</u> closed, PLEASE contact us to let us know so we can adjust staffing as needed. You can leave a message at 973-697-3341

Name_____ Contact me by phone__ e-mail__ text__

Phone number_____

e-mail_____

MY SCHOOL
• CREATIVE CHILD CARE & PRESCHOOL •

321 OAK RIDGE ROAD
P.O. BOX 302
OAK RIDGE, NJ 07438
T: 973-697-3341
Fax: 973-697-8785

Dear Parents,

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

The 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 Child Abuse Hotline (877) NJ ABUSE.

Please read the statement carefully and, if you have any questions, feel free to contact me at (973)697-3341.

Sincerely,

Laura Woody

Director

Please complete and return this portion to the center (please print)

Name of Child:_____

Name of Parent(s):_____

I have read and received a copy of the Information to Parents statement prepared by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children and Families and also My School's Expulsion Policy.

Signature:_____Date:_____

MY SCHOOL CREATIVE CHILD CARE

AUTHORIZATION TO RELEASE CHILD/REN

I hereby authorize the following individuals to pick up my child_____ if I am unable. I understand that I will notify staff the morning of the pick, up by written note, with the individual's name and an approximate time they will be arriving. The individual must present a picture ID before the child will be released to them.

Name: _____ ID verified by_____
Staff name

Name: _____ ID verified by_____
Staff name

Name: _____ ID verified by_____
Staff name

Name: _____ ID verified by_____
Staff name

Name: _____ ID verified by_____
Staff name

Name: _____ ID verified by_____
Staff name

Name: _____ ID verified by_____
Staff name

Name: _____ ID verified by_____
Staff name

_____

Parent Signature Date

MY SCHOOL CREATIVE CHILD CARE

EMERGENCY INFORMATION

Child's Name _____

Address _____

Home phone _____

Mother: _____ cell# _____work#_____

Father: _____ cell# _____ work# _____

Please list nearby relatives or neighbors who will pick up and care for your child if you cannot be reached.

1. Name_____ phone # _____
2. Name_____ phone # _____
3. Name_____ phone #_____

MY SCHOOL
CREATIVE CHILD CARE & PRESCHOOL

321 OAK RIDGE ROAD
P.O. BOX 302
OAK RIDGE, NJ 07438
T: 973-697-3341
Fax: 973-697-8785

STANDARD PHOTO RELEASE FORM

Child's Name:

_____

Parent/Guardian's Name:

_____

I hereby authorize My School Creative Child Care to publish the photographs taken of my child, and my child's name, for use in My School's Facebook page and website.

I acknowledge that my participation in the websites produced by My School is voluntary.

I release My School Creative Child Care from liability for any claims by me or any third party in connection with my participation.

Parent/Guardian Signature:_____

Date:_____

Street Address:

_____

City, State, Zip:

_____

MY SCHOOL CREATIVE CHILD CARE

PERMISSION FORM

I hereby grant permission for my child_____to use all the play equipment and participate in all the routine activities of My School Creative Child Care Center.

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

1. Contact parents and/or guardians.

2. Contact child's physician.

3. Contact parents through any of the persons listed under emergency information.

4. If we cannot contact parents or child's physician, we will do any or all of the following:
    a. Call the West Milford Rescue Squad
    b. Call the Milton First Aid Squad
    c. Have the child take (or take the child) to an emergency hospital in the company of a staff member.

MY SCHOOL will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

I have received a copy of the policy statement on the disciplining of children by staff members and a copy of the Parent Handbook.

Dated:_____ _____

Signature of Parent or Legal Guardian