LOVING TOUCH NURSERY SCHOOL

365 Broadway • Hillsdale, NJ 07642 • Tel. (201) 722-8500 • Fax (201) 722-9613

www.LovingTouchNurserySchool.com

Please return all completed forms along with 2 checks:

Registration Fee: $50.00

Tuition Deposit: $ _____

Tuition deposit will be used towards your child's last month in our program. Registration fees are non— refundable.

Registration fee is an annual fee.

Also, please contact your pediatrician's office and have them fax us an updated copy of your child's immunization records.

Our fax number is (201) 722—9613

_____

Parent Signature

Thank You,

Loving Touch Nursery School

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Name of Child: _____

Age Starting: _____ Date of Birth:_____

Address: _____

Home Phone #: _____ E-Mail Address: _____

Mother Cell Phone #: _____ Father Cell Phone #: _____

Business Information: (Name of Company, Address, and Phone #)

Mother: _____
_____

Father: _____
_____

Program (Class and Days): _____

Hours: _____

Start Date: _____

A Registration Fee & Tuition Deposit
Must Accompany This Application.

Paid: $_____ Check #: _____ Date: _____

Paid: $_____ Check #: _____ Date: _____

Parent Signature: _____

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	Child's Name	Sex	Age	Toilet Trained?
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____

Parents Name: _____

Address: _____

State: _____ Zip: _____ Phone: _____

Child's Physician: _____

Address: _____

State: _____ Zip: _____ Phone: _____

Medical Facts

Allergies: _____

Medications: _____

Communicable Diseases

Mumps: _____ Measles: _____ German Measles: _____

Chicken Pox: _____ Other: _____

Date of last Tetanus Shot: _____

In Case of Emergency Contact:

Name: _____ Phone: _____

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I would like Loving Touch Nursery School to contact *Mother / Father* **first**,
(Circle one)
in case my child becomes ill or is injured.

Phone #: _____

I give my consent for my child's doctor to treat my child if he/she becomes ill or is injured.

Doctor's Name: _____ Phone #: _____

Address: _____ Town: _____

If the above named doctor is not available, Loving Touch may take my child to Valley Hospital.

I give permission for Valley Hospital and/or _____
to treat my child for any and all medical needs. (other medical facility)

_____ _____ _____
Child's Name Parent's Signature Date

_____ _____
Witnessed By Date

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

I hereby grant permission for Loving Touch Nursery School 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 on the emergency form.

2. If we cannot contact you or your child's physician we will do one or both of the following:

   (a) call another physician or paramedics

   (b) have your child taken to an emergency hospital in the company of a staff member.

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

4. The school will not assume responsibility for a child who has not been signed in upon arrival for the day.

Signed: _____ Date: _____

Signed: _____ Date: _____

Witnessed: _____ Date: _____

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Persons authorized to pick up child:

Name: _____

Address: _____

_____

Relationship: _____

Home Phone: _____

Business Phone: _____

Name: _____

Address: _____

_____

Relationship: _____

Home Phone: _____

Business Phone: _____

Name: _____

Address: _____

_____

Relationship: _____

Home Phone: _____

Business P hone: _____

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HEIGHT: _____

WEIGHT: _____

BLOOD PRESSURE: _____

NUTRITION: _____

POSTURE: _____

SKIN: _____

EYES/LIDS: _____

VISION: _____

EARS: _____

REARING: _____

NOSE: _____

THROAT: _____

TEETH/GUMS: _____

LYMPH NODES: _____

HEART: _____

LUNGS: _____

SPINE JOINTS: _____

FEET: _____

NERVOUS SIGNS: _____

DEFORMITIES: _____

URINALYSIS: _____

HBG OR HCT: _____

_____ **STUDENT MAY PARTICIPATE IN PHYSICAL EDUCATION ACTIVITIES (PLEASE CHECK)**

SIGNED: _____ M.D.
(PLEASE PRINT OR STAMP PHYSICIAN'S NAME AND OFFICE ADDRESS)

IMMUNIZATIONS (MONTH, DAY, YEAR)
DPT SERIES:

1. _____
2. _____
3. _____

DPT BOOSTERS: 1. _____

2. _____

MMR #1: _____

MMR #2: _____

HIB #1: _____ **#3:** _____

#2: _____ **#4:** _____

ORAL POLIO

1. _____
2. _____
3. _____

BOOSTERS:

HEPATITIS B- 1. _____

2. _____

3. _____

VARIVAX: _____

TUBERCULIN:
MANTOUX (PPD):_____

PERTINENT MEDICAL HISTORY:

ILLNESSES:_____

1. CHICKEN POX (AGE): _____

2. ASTHMA: _____

SURGERIES: _____

INJURIES: _____

<u>CHILD PICK UP CARD</u>

I hereby give authorization for my child:

____

To be picked up by:

____

Relationship to child: ________________

Parent Signature: Date:

____

<u>CHILD PICK UP CARD</u>

I hereby give authorization for my child:

____

To be picked up by:

____

Relationship to child: ________________

Parent Signature: Date:

____

<u>CHILD PICK UP CARD</u>

I hereby give authorization for my child:

____

To be picked up by:

____

Relationship to child: ________________

Parent Signature: Date:

____

<u>CHILD PICK UP CARD</u>

I hereby give authorization for my child:

____

To be picked up by:

____

Relationship to child: ________________

Parent Signature: Date:

____

<u>CHILD PICK UP CARD</u>

I hereby give authorization for my child:

____

To be picked up by:

____

Relationship to child: ________________

Parent Signature: Date:

____

<u>CHILD PICK UP CARD</u>

I hereby give authorization for my child:

____

To be picked up by:

____

Relationship to child: ________________

Parent Signature: Date:

____

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PHOTO PERMISSION FORM

Permission to Photograph Child

I give my permission for _____ to be photographed and/or videotaped by teachers and staff of Loving Touch Nursery School and/or local news organizations approved by and accompanied by the Director for purposes of advertising, public relations and family enrichment. The snapshots which may include my child may be published.

Parent's Signature_____ Date_____

I give Loving Touch Nursery School permission to have my child photographed by the press of the facility to use for Public Relation purposes at any time.

Parent's Signature_____ Date_____

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Emergency Contact Sheet:

Child's Name: _____

Parent's Names: _____

Mom Work #: _____

Mom Cell #: _____

Dad Work #: _____

Dad Cell #: _____

If we cannot reach you please leave an emergency contact:

Name: _____ Phone #: _____

Relationship to Child: _____

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CERTIFICATE OF GOOD HEALTH

_____was seen in our office on

_____(Date)

He/She is in good health and has no restrictions or allergies, unless otherwise noted below.

Comments:

_____
_____
_____
_____
_____
_____

Physician's 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 setting.
   a. **If the child has a complex medical condition, a special care plan should be completed and attached.** Note any significant medical conditions or major surgical history.
   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 likely 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.
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.

UNIVERSAL CHILD HEALTH RECORD

American Academy of Pediatrics New Jersey Chapter

Endorsed by: New Jersey Department of Health and Senior Services

New Jersey Academy of Family Physicians

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /

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		

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	