

YOUR BUSINESS NAME



Program Agreement Form

I, _____, parent/guardian of _____, agree to pay \$_____ for my child's attendance at _____.

I also understand that any deposits given to secure my child(ren)'s seat is non-refundable unless a 3 month notice prior to the start date is provided to

_____. Payment is due by the 5th of each month or \$25 late fee will be accessed. I understand that my child is permitted one week (5 consecutive business days) vacation per year at no charge to me. My child is also entitled to two (2) sick weeks per year at 50% charge of the tuition for these weeks only. The unused sick/vacation days cannot be rolled over to the next year and must be used during attending year. Any credit for vacation or sick time is also limited to ONLY one (1) week maximum per month. The maximum amount of days your child is permitted to attend within the month that you have notified management of non-attendance is five (5). If you go beyond the five permissible days, you will be responsible for the entire month's tuition less any applicable vacation/sick credits that you may have available and have not exhausted in the last 12 months. If your child is out for 2 consecutive weeks and we are unable to reach you and/or you have not contacted us, your child's seat is subject to being forfeited. Finally, if we are closed due to weather related conditions or events that are out of our control (i.e. no electricity or heat or quarantine restrictions) we are not liable and full tuition will be applied.

_____, and its agents reserve the right to terminate admission into _____ if instances arise that can potentially be harmful or threatening to children attending the facility or staff/management performing their duties. Furthermore, should a parent/guardian of an attending child constitute a threat, either mental or physical to any of the employees, management, or a child attending _____, management reserves the right to preclude admission.

Additionally, in the event that your child requires special needs care that we will unfortunately be unable to provide and once we have exhausted all options at our Center, for the betterment of your child's care and development, we will relinquish services and assist in any way possible in finding alternate care.

***PRICES ARE SUBJECT TO CHANGE**

Parent/Guardian Signature

Your Organization name

Primary Business Address
Address Line 2
Address Line 3
Address Line 4

Phone: 555-555-
5555
Fax: 555-555-5555
Email: someone@example.com

ENROLLMENT APPLICATION

Name Of Child:	Birthdate:	Enrollment Date:
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PARENT/GUARDIAN INFORMATION	<i>Please check the box (☐) to indicate the primary residence of the child listed above.</i>			
	☐ PARENT/GUARDIAN # 1		☐ PARENT/GUARDIAN # 2	
	Name:		Name:	
	Relationship:		Relationship:	
	Cell Phone:		Cell Phone:	
	Home Phone:		Home Phone:	
	Home Address:		Home Address:	
	Employer Name:		Employer Name:	
	Employer Phone:		Employer Phone:	
	Employer Address:		Employer Address:	
E-Mail Address:		E-Mail Address:		

EMERGENCY CONTACTS	Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.			
	Contact Name #1:		Contact Name #2:	
	Relationship:		Relationship:	
	Cell Phone:		Cell Phone:	
	Home Phone:		Home Phone:	
	Employer Phone:		Employer Phone:	

CUSTODY	Name of person PROHIBITED from picking up your child:
	If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to this effect for the center to maintain a copy on file, and to comply with the terms of the court order.

PERMISSIONS	☐ I give permission for my child to participate in <u>WALKING TRIPS</u> within the center's neighborhood, using routes that pose no known safety hazards to children, with the understanding that the walk involves no entrance into another facility unless otherwise indicated.	☐ I <u>DO NOT</u> permission for my child to participate in <u>WALKING TRIPS</u> within the center's neighborhood, using routes that pose no known safety hazards to children, with the understanding that the walk involves no entrance into another facility unless otherwise indicated.
	☐ I give permission for my child to be <u>PHOTOGRAPHED</u> during normal daycare hours, field trips, or activities and understand that photographs may be used in promoting child care services, either in print or on the Internet.	☐ I <u>DO NOT</u> give permission for my child to be <u>PHOTOGRAPHED</u> during normal daycare hours, field trips, or activities and understand that photographs may be used in promoting child care services, either in print or on the Internet.

RECEIPT OF POLICIES

I (we) attest that all of the information on this application is accurate, and that I (we) have received the following information:

- ☐ Center Policies and Procedures
☐ Information to Parents Document
☐ Policy on the Expulsion of Children from Enrollment
☐ Policy On The Use Of Technology And Social Media
☐ Policy On The Management Of Illnesses/Communicable Diseases
☐ Policy On The Release Of Children
☐ Policy on the Methods of Parental Notification of Injuries (if applicable)
☐ Other: _____
☐ Other: _____

MEDICAL INFORMATION

Child's Health Care Provider:

Health Care Provider Phone:

Health Care Provider Address:

Name Of Insurance Company/Hmo:

Group #:

Identification #:

Subscriber's Name On Insurance Card:

Known Allergies (including medication):

Medication My Child Is Taking:

List Special Conditions, Disabilities,
Medical/Physical Restrictions, Medical
Information For Emergency Situations:

HEALTH STATEMENT

As the parent/guardian of the above named child, I certify that he/she is in good physical health and may participate in the normal activities of the program and has no conditions or specific needs that require specific accommodations, unless otherwise indicated in the medical information provided above or an attached Universal Health Record or a Care Plan for Children with Special Health Needs.

Parent/Guardian Initials:

EMERGENCY TREATMENT

As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified.

Parent/Guardian Initials:

Parent/Guardian Signature #1:

Date:

Parent/Guardian Signature #2:

Date:

EXPULSION POLICY

NAME OF CENTER: _____

Unfortunately, there are sometimes reasons we have to 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) in order 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 a 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 of time 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 and the expected behavioral changes required in order 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 child care (approximately one to 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 PARENT/GUARDIAN:

- Made a complaint to the Office of Licensing regarding a center's 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 sufficient time to make other child care arrangements.

PROACTIVE ACTIONS THAT CAN BE TAKEN IN ORDER TO PREVENT EXPULSION:

- | | |
|---|--|
| • Try to redirect child from negative behavior. | • Document the child's disruptive behavior and maintain confidentiality. |
| • Reassess classroom environment, appropriateness of activities, supervision. | • Give the parent/guardian written copies of the disruptive behavior that might lead to expulsion. |
| • Always use positive methods and language while disciplining children. | • Schedule a conference including the director, classroom staff, and parent/guardian to discuss how to promote positive behaviors. |
| • Praise appropriate behaviors. | • Give the parent literature of other resources regarding methods of improving behavior. |
| • Consistently apply consequences for rules. | • Recommend an evaluation by professional consultation on premises. |
| • Give the child verbal warnings. | • Recommend an evaluation by local school district study team. |
| • Give the child time to regain control. | |

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.

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.

Custodial Information

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 appropriate documents. (Court Order)

Authorizations

Medical Emergency

In the event that a medical emergency occurs and I cannot be reached, I authorize Bright Start Educational Center to seek emergency medical care for my child

Date _____ Parents Signature _____

Field Trips

My child has my permission to go on any walking field trips planned by Bright Start around the neighborhood (Beaver Dam Park, County Park).

Date _____ Parents Signature _____

Note: For all other field trips special permission documents will be issued for parent/guardian signature.

Permission to Apply Sun Block and Other Ointments and Creams

I give my permission for the staff of Bright Start Educational Center to apply sun block and any other ointment or cream to my child (including diaper creams) as needed by my child at the staff's discretion.

Date _____ Parents Signature _____

Parent's Signature for Receipt of Parents' Package

I have received and read the Parents' Package which contains the List of Holidays, Daily Schedule, Health Policy, Expulsion Policy, Information to Parents.

Date _____ Parents Signature _____

Enrollment/ Tuition

I have read and agree to the terms and conditions concerning tuition. I understand that no refunds are made for any reason whatsoever including illness, vacation, holidays, emergency or snow closings, or early withdrawals.

Date _____ Parents Signature _____

Permission for Taking and Posting Pictures

I authorize Bright Start Educational Center to use my child's picture in any promotional material (web, print, or media).

Date _____ Parents Signature _____

For Center Use Only:

Date of Enrollment _____

Days and Hours Attendance:	Monday	Tuesday	Wednesday	Thursday	Friday
From:	_____	_____	_____	_____	_____
To:	_____	_____	_____	_____	_____

Date of Withdrawal _____

PARENT

RECEIPT OF INFORMATION:

- ☐ Information to Parents Document
- ☐ Policy on the Release of Children
- ☐ Policy on Methods of Parental Notification
(Applicable only if a method other than a phone call is used to notify parents of an injury to a child's head, a bite that breaks the skin, a fall from a height, or an injury requiring professional medical attention.)
- ☐ Policy on Communicable Disease Management
- ☐ Expulsion Policy
- ☐ Policy on the Use of Technology and Social Media

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

Child(ren)'s Name:

Parent/Guardian's Name:

Signature

Date