

**The Blue Kangaroo Day School
At
Dewy Meadows Village
409 King George Road
Basking Ridge, New Jersey 07920
908-647-2600**

Dear Parent:

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

This statement highlights, among other things: your rights 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's Division of Youth and Family Services (DYFS).

Please read this statement carefully and, if you have any questions, feel free to contact me.

Sincerely,

Denise Severini
Executive Director

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

Name of Child _____

Name of Parent _____

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

Signature _____

Date _____

ENROLLMENT CHECKLIST

Child's Name: _____

1. _____ Contract (Accompanied by deposit equal of two weeks tuition. The first month's tuition is due on the first day of care.)
2. _____ Admission Records
3. _____ Health Status Form (completed by physician)
4. _____ Immunization Record
5. _____ Permission to administer over the counter medication (signed by a physician)
6. _____ Authorization Form
7. _____ Information to Parents Forms
8. _____ \$40.00 Bedroll fee (for children 12 months and up)
9. _____ Food Allergy Authorization Waiver (for children with ANY food allergies)
10. _____ Expulsion Policy
11. _____ Exemption for face-up sleeping position (for infants— 18 months old)

CONTRACT

<i>For Office Use Only:</i>	
Today's Date _____	
Deposit Received _____	CK# _____
Napper received _____	CK# _____

Child's Name: _____

Date of Birth: _____

Class: *Infants* _____ *Woddler 1* _____ *Woddler 2* _____ *Toddler* _____
PK 1 _____ *PK 2* _____ *PK 3* _____ *Kindergarten* _____ *After-School Program* _____
DropIn/Sat.Night _____ *Summer Camp* _____

Parents Names: _____

Address: _____ Phone _____ (home)
 _____ (work)

I agree to enroll my child, _____ in The Blue Kangaroo Day School, located at 409 King George Rd., Basking Ridge, N.J. beginning _____. I have read the Parent's Handbook and agree to abide by the rules and regulations as stated. I agree to pay _____ per week for _____ full _____ 1/2 days per week and understand that monthly tuition is due on the first of each month for the upcoming month. The amount due will be the weekly tuition times the number of Mondays in that month. A deposit equal to two weeks tuition \$ _____ is due payable with this contract and will be applied towards the last two weeks that your child attends providing 30 day written notice has been given by you to the school's director prior to termination. If this notice is not given the deposit will be forfeited and tuition due for that 30 day period will remain due. In the event I decide not to enroll my child in The Blue Kangaroo, after completion of this signed contract, I understand this deposit is non-refundable. A contract can not be changed or broken until 30 days *after* the start date of the signed contract.

My contracted hours and days are as follows:

Days: _____

Drop off time: _____

Pick up time: _____

I understand the importance of keeping this schedule and realize that an additional late fee of \$20.00 per 15 minute period will be charged after 12:30 PM for the morning program and after 6:00 PM for the afternoon/full day program . After 7:00 PM there is a \$25.00 per 15 minute fee.

I agree to complete and submit the following forms prior to my child's attendance:

1. Admission Record
2. Health Status Form
3. Authorization Form
4. Permission to Administer Over-the Counter Medication Form
5. Immunization Records signed by Doctor

I have read this agreement and the information contained in the Parent's Handbook. I fully understand and agree to both.

Parent: _____ Date: _____

CHILD'S ADMISSION RECORD * *It is very important the ALL INFORMATION (names, addresses and phone numbers) be completely filled out.*

Date of Enrollment: _____ Child's Age on Start Date: _____

Last Name: _____ First Name: _____ Middle: _____
Name by which the child is most often called: _____

Birth Date: _____

Home Address: _____

Phone: _____

Father or Guardian's Name: _____

Address: _____

Phone: (home) _____ (work) _____ (cell) _____

Employer: _____

Work Address: _____

Position/Title: _____

E-Mail Address: _____

Mother or Guardian's Name: _____

Address: _____

Phone: (home) _____ (work) _____ (cell) _____

Employer: _____

Work Address: _____

Position/Title: _____

E-Mail Address: _____

If neither parent nor guardian can be reached, in case of emergency, call: (Name, address & phone) **MUST BE COMPLETED:** _____

Person(s) designated to pick up or deliver child (Name, address and telephone): _____

Person(s) not permitted to pickup child: _____

Child's Doctor: _____

Address and Phone: _____

Child's Dentist: _____

Address and Phone: _____

Other children in family: _____

Other adults in family (please state relationship to child): _____

Please list any information concerning your child which will be helpful to your child's teacher

Play habits: _____

Eating behavior: _____

Type of Formula: (infants only) _____

Sleeping pattern: _____

Likes and Dislikes: _____

Previous experience in child care: _____

Medical Information

What illnesses has your child had in the past month? _____

What treatment was given? _____

When was the last prescription medicine given to this child? _____

List any chronic or handicapping problems your child has. (I.e. seizures , asthma, diabetes, heart disease, respiratory illness, drug reaction, etc. _____

List any psychological findings: _____

Describe any allergies, including foods which have caused adverse reactions, or any food not to be given to the child for health or religious reasons: _____

Has your child had contact with tuberculosis? _____

Signature of Parent or Guardian

Date

10: 122-6.4(a) Rest and sleep requirements for early childhood programs
Must be completed by child's health care provider and parent when requesting exemption from placing a child 18 months of age or younger in a face-up sleeping position.

**EXEMPTION FOR PLACING A CHILD 18 MONTHS OF AGE OR YOUNGER
IN A FACE-UP SLEEPING POSITION**

I hereby grant permission for (child) _____, to
sleep in a position other than face-up at The Blue Kangaroo Day School.

Description of requested sleeping position:

Health Care Provider's Signature: _____ Date: _____

Parent's Signature: _____ Date: _____

AUTHORIZATION FORM

1. AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I/we _____ hereby give my/our permission to _____
_____, to call a doctor or emergency squad for my/our child _____

Should an emergency arise. It is understood that a conscientious effort will be made to locate Me/us before medical action will be taken (depending on severity of incident) but if this is not possible, the expenses of emergency medical care or treatment will be accepted by me/us.

Parent/Guardian

Date

2. PERMISSION FOR WALKS

I/we give permission to my/our child to go on walks away from the school in the company of staff of The Blue Kangaroo Day School.

Parent/Guardian

Date

3. PERMISSION TO BE PHOTOGRAPHED

I/we give permission for my/our child to be photographed in the company of staff of The Blue Kangaroo Day School. I/we also give permission for these photographs to be used in our local town newspapers and school website.

Parent/Guardian

Date

4. ACKNOWLEDGMENT OF BABYSITTING POLICY

I/ we understand that no employee of The Blue Kangaroo Day School, past or present, shall be allowed to baby-sit, transport, or otherwise work in my/our employ in reference to the care of my/our child.

Parent/Guardian

Date

PERMISSION TO ADMINISTER
OVER THE COUNTER MEDICATION

Child's Name: _____

Age: _____

Providers Choice:

Brand Name:

- Sunblock/Lotion
- Diaper Cream
- Burn/Insect Bite Spray
- Insect Repellent
- Congestion
- Fever
- Diarrhea
- Vomiting
- Upset Stomach
- Headache

Permission to administer over the counter medication when needed, as well as written authorization, is given to a representative of The Blue Kangaroo Day School for my child,
_____.

Parent's Signature _____

Date _____

Doctor's Signature _____

Date _____

Provider's Notes:

FOOD ALLERGY
AUTHORIZATION FORM

The Blue Kangaroo Day School highly recommends that children with ANY food allergies only eat foods that have been provided from home. We cannot guarantee that we can prevent an allergic reaction from hot lunches/group snacks that are served at our school. This also includes school birthday parties/special events. If you choose to have your child participate in group snack/hot lunch etc., please complete and sign the waiver below.

AUTHORIZATION FOR CHILDREN WITH FOOD ALLERGIES

I/we _____ hereby give my/our permission to The Blue Kangaroo Day School, to allow _____ to participate in The Blue Kangaroo group snack and hot lunch program.

Should an emergency arise, it is understood that a conscientious effort will be made to locate _____ Me/us before medical action will be taken, (depending on severity of incident) but if this is not possible, the expenses of emergency medical care or treatment will be accepted by me/us.

Parent/Guardian

Date

The Blue Kangaroo Day School
Expulsion Policy

The following is a listing of reasons/causes for expulsions from *The Blue Kangaroo Day School*. We will do everything possible to work with our families to prohibit expulsion, whether temporary or permanent. We must look at the best interest of the other children enrolled at our school therefore making expulsion necessary. An initial expulsion is a determined period of time that is to be used to work on the child's behavior outside of a group environment. The parent will be informed of the length of time as well as the expected behavioral changes in order to return to the center. The parent will be informed of the expulsion with enough time allowed to arrange alternate plans for their child's care.

Including, but not limited to, the following reasons can result in expulsion:

Conduct

- A child is behaving in a manner that is reason to believe he/she is posing serious risk to himself/herself or other children enrolled in the center.
- A child fails to adjust to the program in which he/she is enrolled within a reasonable amount of time.
- A child demonstrates continuous tantrums or angry aggression in an uncontrolled manner.
- A child demonstrates physical or verbal abuse to children, staff or parents of children enrolled in the center.
- A child continues to demonstrate excessive biting or hitting.
- A parent threatens physical action towards a staff member or child enrolled in the center.
- A parent displays verbal abuse or sexual harassment towards staff especially when in the presence of children enrolled in the center.
- A parent fails to pay tuition in a timely manner.
- A parent continuously picks up their child after 7:00pm or enters the building prior to 7:00am.
- A parent does not provide necessary information required by the center or The Department of Human Services/Office of Licensing.

Please sign below indicating that you understand these reasons/causes for expulsion.

Expulsion Policy

I have read and understand the terms of The Blue Kangaroo's Expulsion Policy.

Name of Child: _____

Name of parent: _____

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 and Senior Services

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 _____	
<i>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</i>					
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)		
IMMUNIZATIONS		<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"/> <i>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.</i>					
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 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 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.state.nj.us/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.