Student Registration Form
ENROLLMENT APPLICATION

Name Of Child:	Birthdate:	Enrollment Date:

PARENT/GUARDIAN INFORMATION

Please check the box (☐) to indicate the primary residence of the child listed above.

☐ 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

Check boxes below to indicate if your child has any special needs/services:

☐ None
☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy
☐ Allergies (Please list) ____
☐ Other ____

Please provide information here **AND** discuss with your child care provider:

PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

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 ***WALKING TRIPS*** 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 ***DO NOT*** permission for my child to participate in ***WALKING TRIPS*** 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 ***PHOTOGRAPHED*** 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 ***DO NOT*** give permission for my child to be ***PHOTOGRAPHED*** 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: ______________________

Parents will receive a copy in 2024 Handbook.

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:

OCL/10.26.2017

Updated Allergy form

Childs Name: _______________

Childs DOB: ________________

Food Allergies: ____________________________

Drink Allergies:_____________________________

Medication Allergies: ________________________

Latex allergy?:_______________________________

Nut Allergy:_________________________________

Pet Allergy:_________________________________

Plant Allergy:________________________________

Skin Sensitivity/Condition?:_____________________

Where on the body is the condition:_______________

Bug Allergies:________________________________

Epi Pen? Yes No

My child has asthma: Yes NO My child takes this medication for asthma:__________

My child has seasonal allergies: Yes NO Medication for Seasonal Allergies:____________

ECLC Emergency Contact Information

Person must be local, able to pick up child asap, and reliable

Childs Name: ____________________

DOB:__________________________

Mom name:___________________

Dad's name: __________________

Emergency Contact 1:

Name: _________________________

Relation:________________________

Phone:__________________________

Address: ________________________

Emergency Contact 2:

Name: _________________________

Relation:________________________

Phone:__________________________

Address: ________________________

Emergency Contact 3:

Name: _________________________

Relation:________________________

Phone:__________________________

Address: ________________________

BLANKET PERMISSION
FOR WALKING TRIPS

Center Name: *Dr. Lorenzo Harris Early Childhood Learning Center*

Child's Name: ______________________________

I hereby give permission for my child to participate in walking trips in the neighborhood around the center. I understand that the walking route is within the center's neighborhood, includes no known safety hazards, and that the walks will not involve entrance into any facility other than the following:

The Launch Center - Springwood Ave *Kula Farms - Atkins Ave*

Springwood Park/Playground *The Splash Pad/Playground - Atkins Ave*

Open field (grassy area) next to the splash pad for sports/activities *AP Library*

______________________________ ______________

Signature of Parent/Guardian Date

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

Condition		Comments
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	

 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider