Heaven's Nest Learning Center
1614 Salem Road, NJ 08016
Phone: (609) 387-1714 • Fax: (609) 387-1715

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

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:		Contact Name #3:	
Relationship:		Relationship:		Relationship:	
Cell Phone:		Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:		Home Phone:	
Employer 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 ***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.

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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:

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PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

Name Of Child:	Birthdate:	Enrollment Date:

PARENT/GUARDIAN INFORMATION

☐ 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:	
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:		Contact Name #3:	
Relationship:		Relationship:		Relationship:	
Cell Phone:		Cell Phone:		Cell Phone:	
Home Phone:		Home Phone:		Home Phone:	
Employer 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.

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:	

AUTHORIZATION FOR EMERGENCY MEDICAL 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 Signature #1:	Date:	Parent/Guardian Signature #2:	Date:

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Infant Feeding Plan

A written plan shall be maintained on file and available for the caregiver of any child less than 12 months of age.

Child's Name:	Date:	Birthdate:

Formula:

☐No ☐Yes Is your child fed formula[1]?
☐No ☐Yes Will formula be prepared (mixed) at home?
☐No ☐Yes Will formula be prepared by the caregiver?
If the caregiver will be preparing the formula, please indicate any special instructions:

_____

Breast Feeding/Breastmilk

☐No ☐Yes Is your child breast fed?
☐No ☐Yes I will nurse my child at the center at these times:

_____

☐No ☐Yes I will provide breast milk[1].
If breast milk is unavailable for a feeding, the center should:

_____

Feedings:

☐No ☐Yes Does your child take a bottle? (Note: Bottles are required to be labeled with child's name and the current date.)
- ☐No ☐Yes Is the bottle warmed[2]?
- ☐No ☐Yes Does your child hold their bottle?
- ☐No ☐Yes Can the child feed his or herself?
- ☐No ☐Yes Are there any special instructions for bottle feeding your child?

If "yes," please explain:

_____

☐No ☐Yes Is your child using a sippy cup? (Note: Sippy cups must be labeled with the child's name.)
☐No ☐Yes Does your child have any problems with feeding, such as choking or spitting up?
If "yes," please explain:

_____

☐No ☐Yes Are there any special instructions concerning feeding your child?
If "yes," please explain:

_____

Foods and Feeding Schedule:

Liquids (formula, breastmilk, 100% fruit juice in a cup)	☐N/A ☐Introducing ☐Familiar	☐Breast Feeding ☐by bottle ☐by breast ☐Bottle Feeding ☐by caregiver ☐with help ☐independently ☐Cup Feeding ☐with help ☐independently		Amounts:
Semisolid Foods (infant cereal, strained fruits and/or vegetables)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:
Modified Table Foods (mashed, soft, diced fruit and /or vegetables, strained meat or poultry, pieces of soft bread)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:
Finger Foods (small pieces of soft/cooked table food, chopped food)	☐N/A ☐Introducing ☐Familiar	☐Spoon Feeding ☐by caregiver ☐with help ☐independently	Kinds of Food:	Amounts:

Other:

☐No ☐Yes Does your child take a pacifier?
Note: Pacifiers with straps or other types of attachment devices are not permitted. Pacifiers must be removed when the child is crawling or walking.

Additional Information:

I will promptly provide any updates to my child's feeding plan as needed.	PARENT'S SIGNATURE:	DATE:

[1]Breast milk shall be gently mixed but not be shaken. Refrigerated breast milk shall be used within 24 hours. Formula or breast milk that is served, but not completely consumed or refrigerated, shall be discarded. [2] No milk, formula, or breast milk shall be warmed in a microwave oven.

OOL/10.16.2017

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Policy on the Management of Communicable Diseases

If a child exhibits any of the following symptoms, the child should not attend the center. If such symptoms occur at the center, the child will be removed from the group, and parents will be called to take the child home.

- Severe pain or discomfort
- Acute diarrhea
- Episodes of acute vomiting
- Elevated oral temperature of 101.5 degrees Fahrenheit
- Lethargy
- Severe coughing
- Yellow eyes or jaundiced skin
- Red eyes with discharge
- Infected, untreated skin patches
- Difficult or rapid breathing
- Skin rashes in conjunction with fever or behavior changes
- Skin lesions that are weeping or bleeding
- Mouth sores with drooling
- Stiff neck

Once the child is symptom-free, or has a health care provider's note stating that the child no longer poses a serious health risk to himself/herself or others, the child may return to the center unless contraindicated by local health department or Department of Health.

EXCLUDABLE COMMUNICABLE DISEASES

A child or staff member who contracts an excludable communicable disease may not return to the center without a health care provider's note stating that the child presents no risk to himself/herself or others.

Note: If a child has chicken pox, a note from the parent stating that all sores have dried and crusted is required.

If a child is exposed to any excludable disease at the center, parents will be notified in writing.

COMMUNICABLE DISEASE REPORTING GUIDELINES

Some excludable communicable diseases must be reported to the health department by the center. The Department of Health's Reporting Requirements for Communicable Diseases and Work-Related Conditions Quick Reference Guide, a complete list of reportable excludable communicable diseases, can be found at:

http://www.nj.gov/health/cd/documents/reportable_disease_magnet.pdf.

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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	

CH-14 JUL 12 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider