ST. ALBAN'S PRE-SCHOOL

1 Church Lane, Oakland, NJ 07436
(201) 337 – 5928 * FAX (201) 651 - 9486

APPLICATION FOR ADMISSION

Child's Name ____ Boy [ ] Girl [ ] Birth Date______________

Home Address ____ Phone _____________

____ Zip Code ____________

Preferred E-Mail Contact____

Class: 1's ( ) 2's ( ) 3's ( ) 4's ( ) TK ( )

CHILD'S PROGRAM:	**CARE CLUB:** (circle)		**FULL DAYS:** (circle)		**HALF DAYS:** (circle)			
		Mon.		**Mon.**		**Mon.**	**AM**	**PM**
		Tue.		**Tue.**		**Tue.**	**AM**	**PM**
		Wed.		**Wed.**		**Wed.**	**AM**	**PM**
		Thu.		**Thu.**	**AM: 9-12**	**Thu.**	**AM**	**PM**
		Fri.		**Fri.**	**PM: 1-4**	**Fri.**	**AM**	**PM**

How did you learn about St. Alban's Pre-School? ____

For Emergency Contact (If parents cannot be reached):

Name ____ Phone ___________________

Name ____ Phone ___________________

FAMILY INFORMATION

Father's Name ____ Home Phone _________________________

Cell Phone___________________________

Father's Home Address____

Father's Occupation & Business Address____

Business Phone _______________________

Mother's Name ____ Home Phone ________________________

Cell Phone__________________________

Mother's Home Address ____

Mother's Occupation & Business Address____

Business Phone _______________________

Other Children in the Family

Name ____________________________________ Date of Birth ________________________ Sex __________
Name ____________________________________ Date of Birth ________________________ Sex __________
Name ____________________________________ Date of Birth ________________________ Sex __________

I have read and received a copy of the ``Information to Parents'' statement prepared by the Office of Licensing – Youth and Family Services in the Department of Human Services and the "General Information Letter".

________________________ ____
(Date) (Parent's Signature)

Pre-Enrollment Conference Date ______________________

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STUDENT ENROLLMENT INFORMATION

Child's Name: ____ DOB: _________

Physician Name & Phone: ____

Physician Address: ____

EATING HABITS
Does the child feed himself? ____ _________

Does the child violently dislike any foods? ____

Has feeding ever been a problem? ____

SLEEPING HABITS
Does the child tire easily? ________ If so, responding how? ____________________________________

Does the child nap every day? _______ At what time? ____

Does the child awaken easily? ____

TOILET HABITS
Is the child toilet trained? _____________ Night? Daytime? ________________ Naptime? ___________

Does the child ask to go to the toilet? __________ If so, how? _________________________________

IN GENERAL
What are your child's principal interests? ____

Does the child have habits such as thumb-sucking, throwing tantrums? ___________________________

____

Does your child have any noteworthy fears? ________ Examples (such as noise, the dark) _____________

When did your child start talking? __________________Does your child like to talk?_________________

(OVER)

Does your child get along well with other children? ____

With whom does your child play? ___________________________ Playmates' ages ___________________

Does child have any behavior problems? ____

____

Does child have any special problems when it comes to you? _______________________________________

____

Do you have pets? __________Type? ____________________________ Names? ______________________

Does your child have any allergies? ___________ What are they? ___________________________________

Symptoms? ___________________________________ Medication? __________________________________

Discuss any special circumstances tending to affect your child's progress at school:

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FINANCIAL POLICY

I hereby contract enrollment for ____

and request that the school place my child ________ full days per week or ________ half days per week (AM or PM)

at the monthly rate of $ ________________ .

I enclose a check for the registration fee and a tuition deposit with this form. I understand that this amount is not refundable.

Tuition for all pre-school and kindergarten students is due by the first (1st) of each month. St. Alban's Pre-School reserves the right of refusal to class if tuition is not received. Should tuition be received after the fifth (5th) of the month St. Alban's shall charge a $20.00 late fee. If a check is returned from the bank, St. Alban's shall charge a $30.00 late fee. Any collection agencies costs incurred due to a delinquent tuition account will be the responsibility of the account holder.

Extended care costs are not included in this contract, and, when needed, will be billed separately at the end of each month.

St. Alban's Pre-School reserves the right to refuse or discontinue enrollment of a child when the association is not conducive to the welfare of the school, its teachers, and the other children, as determined by the school administration The Director reserves the right to dismiss any child from the school upon non-payment of tuition on time or for any other reason. If such action ever becomes necessary, St. Alban's Pre-School will refund a pro-rated amount of the prepaid tuition.

No credit or make-up days will be allowed for absences due to illness, withdrawal, religious or legal holidays, snow days or any other reasons.

All health forms must be returned by the first day of school.

______________________ ______________________________________
(Date) (Parent's Signature)

Please circle or list the holiday your family celebrates. We will be learning about all holidays.

OTHER______________________

BIRTHDAY INVITATIONS must be mailed to the home. The only exception will be if the entire class is invited to the party (then you may put them in the cubby).

CLASS DIRECTORY My child's name, address, phone number and email address may (YES) or may not (NO) be included in the class directory. Circle one:

YES NO

REMINDER! We do not allow toys with weapons, guns or action figures to be brought to school. **(OVER)**

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PERMISSION FOR WALKING TRIPS

I hereby give permission for my child _________________________ to participate in walking trips within the neighborhood. I understand these walks: (1) do not involve entrance into any facility; (2) are supervised by a teacher; and (3) involve no safety hazards along the way.

____
____
(Date) (Parent's Signature)

AUTHORIZATION FOR CHILD PICK-UP

I authorize the following people to pick up my child from St. Alban's Pre-School. All others must present a written request from me for my child to be discharged into their hands, and such in writing absolves St. Alban's Pre-School from responsibility after the child leaves the school. All written request will remain on file at the school. St. Alban's Pre-School has the right to verify identification by asking for proof, such as a driver's license.

__________________________ __________________________________
(Date) (Parent's Signature)

Name:
____

Address:
____

Relationship to Child:
____

Name: ____

Address: ____

Relationship to Child: ____

Name:
____

Address:
____

Relationship to Child: ____

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PARENTAL CONSENT TO ADMINISTER MEDICINE

Medication shall only be administered by St. Alban's Pre-School personnel upon my written request and will only be that prescribed by a physician. When I authorize St. Alban's Pre-School personnel to administer medication to my child during school hours, I hereby absolve St. Alban's Pre-School from any responsibility for any ill effects that may occur from the administration of such medication.

_______________ ____
(Date) (Parent's Signature)

PARENTAL CONSENT FOR EMERGENCY TREATMENT

I hereby authorize St. Alban's Pre-School to call an emergency ambulance in case of accident or acute illness, and to allow possible emergency care if I am not immediately available. In the case of an emergency, if I and/or my physician cannot be reached, I hereby authorize the Administrator/Director of St. Alban's Pre-School to provide any necessary medical treatment. It is understood that I will be advised of the nature and extent of such treatment.

_______________ ____
(Date) (Parent's Signature)

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 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.

   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.

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 ☐ 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	

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APPLICATION UPDATE

TODAY'S DATE ____________

Child's Name ____ Boy [ ] Girl [ ] Birth Date _________

Home Address ____ Phone ______________

____ Zip Code ___________

Preferred E-mail Contact____

Class: 1's ( ) 2's ( ) 3's ( ) 4's ( ) TK ( )

For Emergency Contact (If parents cannot be reached):

Name ____ Phone __________________

Name ____Phone __________________

FAMILY INFORMATION

Father's Name ____ Home Phone ___________________

Cell Phone_________________________

Father's Home Adress____

Father's Occupation & Business Address____

Business Phone ____

Mother's Name ____Home Phone _______________________

Cell Phone_________________________

Mother's Home Address ____

Mother's Occupation & Business Address ____

Business Phone ____

Other Children in the Family

Name __________________________________ Date of Birth ______________________ Sex _________

Name __________________________________ Date of Birth ______________________ Sex _________

Name __________________________________ Date of Birth ______________________ Sex _________