

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:	Mon.	FULL DAYS:	Mon.	HALF DAYS:	Mon.	AM	PM
	(circle)	Tue.	(circle)	Tue.	(circle)	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)

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 <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 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. <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 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.

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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 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 _____