
Child's Enrollment Information

Child's name _____

Name child is most often called _____ Date of birth _____

Home address _____

_____ Home phone _____

Father's name _____

Home address if different from child's _____

Father's Cell Phone _____ Home phone _____

Employed by _____ Work phone _____

Work address _____

Days and hours of work _____

Mother's name _____

Home address if different from child's _____

Mother's Cell Phone _____ Home phone _____

Employed by _____ Work phone _____

Work address _____

Days and hours of work _____

Persons to contact in case of emergency if parents cannot be reached:

Name _____ Address _____ Telephone _____

Name _____ Address _____ Telephone _____

Name _____ Address _____ Telephone _____

Child's doctor: Name _____

Address _____ Telephone _____

Child's dentist: Name _____

Address _____ Telephone _____

For provider's use: Date enrolled _____ Date withdrawn _____

Family Information

Person(s) designated to pick up child other than parent(s):

Name _____ Telephone _____

Name _____ Telephone _____

Name any person(s) specifically not permitted to pick up your child:

Name _____ Relationship _____

Name _____ Relationship _____

Language(s) spoken in the home: _____

List other children in the family:

Name _____ Age _____ Sex _____

Name _____ Age _____ Sex _____

Name _____ Age _____ Sex _____

Name _____ Age _____ Sex _____

Name _____ Age _____ Sex _____

List other adults living in your home and their relationship to your child:

Name _____ Relationship to child _____

Name _____ Relationship to child _____

Name _____ Relationship to child _____

List pets in your child's home and their names: _____

List previous experience in day care, including name of facility, dates attended, and type of care (such as family day care, day care center, nursery school, nanny)

Emergency Treatment Information and Authorization

I (name of parent) _____ agree to the administration
of emergency medical treatment to my child (name of child) _____
by a duly qualified health practitioner in my absence. I authorize (name of provider) _____
to arrange for such emergency medical treatment until such time as I can be present.

→ Signature _____ Date _____

What (if any) illness has your child had in the past month? _____

Is your child now taking any type of medication? _____

If yes, explain: _____

Is your child allergic to food, medicine, animals or anything else? If yes, explain:

List any chronic health problems or handicaps your child has, such as seizures, asthma, diabetes, heart disease, respiratory illness:

Parent's hospitalization insurance or medical assistance plan:

Company _____

Identification number _____

Policy is in name of _____

Customer Service 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 <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.

3A:54-6.8(d) Health and immunization requirements for children
May be completed by child's doctor when claiming exemption from immunizations for medical reasons

Medical Contraindication for Immunizations

If an immunization is contraindicated for medical reasons, this form should be completed by the child's physician. It must be kept at the family day care home as part of the child's permanent immunization file. The medical contraindication must state both the reason and the length of the medical contraindication and signed by a physician licensed to practice medicine or osteopathy in any jurisdiction in the United States.

Name of Child _____ Birth Date _____ Sex _____

The following immunizations are medically contraindicated and constitute a threat to the child's health:

ANTIGENS: _____

Reason for exemption: _____

This exemption shall continue until: _____

Physician's signature _____ Date _____

Physician's name and office address (please print or stamp):

3A:54-6.8(d) Health and immunization requirements for children
May be completed by parents when claiming exemption from immunizations for religious reasons

Religious Exemption From Immunizations

If a religious exemption is claimed for a child, this form should be completed and signed by the parent or guardian. It must be kept at the family day care home as part of the child's permanent immunization file.

Name of Child _____ Birth Date _____ Sex _____

I request that immunizations for my child be waived on the grounds that they would interfere with the free exercise of his/her religious rights.

Signature of Parent or Guardian

Date

This exemption may be suspended by the State Commissioner of Health and Senior Services during the existence of an emergency as determined by the Commissioner.

Social Media Policy

It is the policy of my family child care program to protect the privacy and confidence of all the families in my care. While your child/ren attends my program, I will be using various forms of social media to communicate to you about your child's daily activity and advertising for my program.

As your child's provider, I may at times wish to post pictures of the children in my setting through the use of Facebook, YouTube, Craigslist and Shutter fly.

I will also communicate with you about your child's daily activities through text messaging and e-mail.

It is important for you to know that my staff and I will abide by New Jersey laws surrounding the use of social media in a child care setting. In addition, my staff and I will keep all records of your child/ren and your family private and confidential unless requested by my sponsoring organization Child Care Connection or by the New Jersey Department of Children and Families.

Please check the boxes below to give permission to use the following social media platforms:

- Text message

- E-mail

- Facebook

- YouTube

- Craigslist

- Shutter fly

I understand that I do not give permission if any of the above boxes are left unchecked. I also understand that my provider must have a separate permission to photograph my child/ren before any pictures are posted on-line.

Parent _____

Date _____

Provider _____

Date _____

REPORT YOUR CONCERNS

If you have any concerns that your family child care provider is not operating according to State regulations, do something about your concern immediately. If possible, try to resolve your concern directly with your provider. If this is not possible, or if after you have talked to your provider, your concerns remain, call your sponsoring organization or the Office of Licensing. Your name will remain confidential upon request.

IMPORTANT CONTACTS

Parents may contact their local sponsoring organization for information regarding referrals for child care, information on other community resources available for parents and children and any questions regarding family child care.

YOUR LOCAL SPONSORING ORGANIZATION IS:

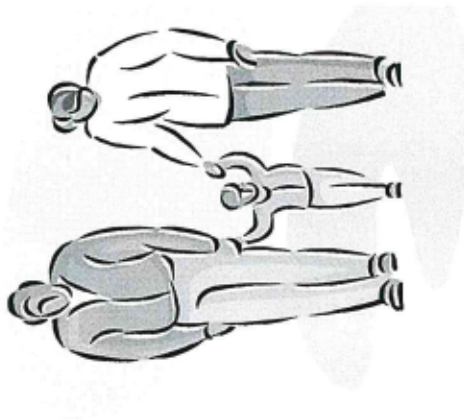
CHILD CARE CONNECTION
1001 SPRUCE STREET, SUITE 201
TRENTON, NJ 08638
609-989-7770 EXT 132 OR 154

- To report child/abuse neglect, call the DCF Child Abuse/Neglect Hotline: toll-free at **1-877-NJABUSE** or **1-877-652-2873**.
- Parents may secure information about child abuse and neglect by contacting the Department of Children and Families, Office of Communications and Legislation at 609-292-0422. Requests are accepted by e-mail at dcf.publications@dcf.state.nj.us, or by fax to 609-984-2123. Some publications may be downloaded at <http://www.nj.gov/dcf/news/publications>.
- To secure a copy of the Manual of Requirements for Family Child Care Registration, write or telephone your local sponsoring agency at (609-989-7770 ext.132)
- To report alleged violations of the Manual of Requirements for Family Child Care Registration, call your local sponsoring agency at (609-989-7770 ext. 132) or call the Office of Licensing toll -free at **1-877-667-9845**.

INFORMATION TO PARENTS

ABOUT

FAMILY CHILD CARE REGISTRATION



Information to Parents about Family Child Care Registration

Under the provisions of the Manual of Requirements for Family Child Care Registration (N.J.A.C. 3A:54), every family child care provider in New Jersey is required to supply each parent of an enrolled child with this Information to Parents Statement that has been supplied to a provider by the sponsoring organization in this area. (See last page for the name, address, and telephone number of your sponsoring organization). In keeping with this requirement the provider must secure every parent's signature attesting to his/her receipt of this information.

- A registered family child care provider has received a Certificate of Registration. The provider's Certificate of Registration must be posted in a prominent location within the family child care home during operating hours.
- To be registered, a provider must comply with the Manual of Requirements for Family Child Care Registration, the official registration regulations. The regulations cover such areas as physical environment, safety, provider qualifications, health, program, food and nutrition, supervision, rest and sleep requirements and others.
- Parents may receive a copy of the N.J.A.C. 3A:54 Manual of Requirements for Family Child Care Registration by contacting the sponsoring organization.
- Parents may report alleged violations of the Manual of Requirements for Family Child Care Registration to the sponsoring organization or to the Office of Licensing.
- Any person who has reasonable cause to believe that a child enrolled in the family child care home has been or is being subjected to any kind of child abuse/neglect by any person, whether in the family child care home or not, is required by State law to report such allegations to the DCF Child Abuse/Neglect Hotline: Toll-Free at **1-877-NJABUSE or 1-877-652-2873**.
- Parents of enrolled children shall be permitted to visit the family child care home at any time when enrolled children are present without having to secure the prior approval of the provider. Parents may be restricted to visit only those areas of the home designed for family child care.

- The operation of the family child care home is subject to monitoring by the sponsoring organization at least once every two years and by the Department of Children and Families.
- The provider is required to comply with the inspection/ investigation functions of the sponsoring organization and the Department, including the interviewing of adults and children in the family child care home.
- Parents may request that the sponsoring organization provide technical assistance to the parent or the provider, and referrals, to appropriate community resources.
- The provider is required to notify parents in writing when a substitute or alternate provider will be caring for the children, unless there is an emergency on a particular day, in which case the provider is required to verbally notify the parent.
- The provider shall notify parents if weapons are present and explain precautions taken to ensure that they are inaccessible to the children.
- When an enrolled child has been identified as or is suspected of having a developmental delay or disability, the sponsoring organization shall:
 1. Inform the parent of the child's right to early intervention and special education services, if eligible;
 2. For preschool special education services, refer the parent to the New Jersey Department of Education Project Child Find at **1-800-322-8174** (toll-free) in order to refer a child for an evaluation to determine eligibility, and if eligible, the development of an Individualized Education Plan to address the child's need for preschool education services; and
 3. Refer the parent of a child under 13 years of age with special health care needs to the New Jersey Department of Health and Senior Services, Special Child Health and Early Intervention Services Program at **(609) 777-7778** for information about programs and services.

