Child's Name_____

Program_____

Start Date_____

Y's Owls Preschool	Full Day Program
2 Days	M T W R F
3 Days	M T W R F
4 Days	M T W R F
5 Days	M T W R F
Y's Owls Preschool	Extended Day Program
2 Days	M T W R F
3 Days	M T W R F
4 Days	M T W R F
5 Days	M T W R F

Y's Owls Preschool	Partial Day Program
5 Days	M T W R F

Hamilton Area YMCA
Early Childhood Program Registration Form

Child's Name_____

Age in Sept._____ Date of Birth____/____/____ Sex ___M ___ F

Child's Address_____

_____

Mother's Name_____

Phone Number (H)_____(W)_____

Cellular Number_____

Mother's Address _____

Place of Employment _____

Father's Name_____

Phone Number (H)_____ (W_____

Cellular Number_____

Father's Address_____

Place of Employment_____

Family e-mail address_____

Child Release Information

The following information is considered confidential. **Parents are asked to keep this information current by contacting the Hamilton Area YMCA with changes.** Any adult picking up a child will be asked for identification. All persons must be at least 18 years of age. Policies and Procedures for the Release of Children must be strictly adhered to. Your cooperation is requested and appreciated.
In addition to the parent(s) who have signed below, the following person(s) are authorized to pick up the child or to be contacted in case of an emergency if neither parent is available to assume responsibility for the child.

Name _____Phone Number_____

Address_____

Name _____Phone Number _____

Address_____

Please list any person(s) that are PROHIBITED from picking up the child:_____

If a non-custodial parent is **not included** among those persons authorized by the custodial parent to pick up the child, please explain below and attach a copy of the appropriate document (court order) required by DYFS.

_____

Parent Signature Date

Child's Name_____

Hamilton Area YMCA
Y's Owls Preschool Program Medical Form

COPIES OF IMMUNIZATION RECORDS MUST BE SUBMITTED TO THE EARLY CHILDHOOD DIRECTOR PRIOR TO CHILD'S START DATE.

Is your child under any medical restrictions? ___Yes ___No If yes, check all that apply:

_____Asthma _____Hearing loss _____Diabetes _____Convulsions _____Other:_____

Is your child taking any medication? _____Yes _____No If yes, please list:_____
(If medication is needed during the Program, an authorization form must be completed. The form can be obtained from the Director or from the child care office.)

Is your child allergic to any medications/food/insect stings? _____Yes _____No If yes, Please list_____

_____

Child's Physician_____ Telephone Number_____

Physician's Address_____

Please notify the Hamilton Area YMCA office if your child is exposed to any communicable diseases during the school year.

As a parent/guardian of the above participating child, I certify that he/she is in good physical health and may participate in all of the activities of the Early Childhood Program, except as noted above.

Parent/Guardian Signature_____ Date_____

Parental Authorization for Emergency Treatment

In the case of emergency, illness, or accident to the child named on this form, the Hamilton Area YMCA is authorized to proceed as indicated below:

1. The Parent/Guardian will be contacted immediately.
2. If the Parent/Guardian cannot be reached, we will attempt to contact him/her through the emergency persons listed on the child's registration form.
3. If the Parent/Guardian still cannot be reached, the child's physician will be contacted.
4. If none of the above can be contacted, we will do any or all of the following:
    a. Call for emergency first aid assistance/transportation.
    b. Call another physician.
    c. Have the child transported to an emergency hospital in the company of a Hamilton YMCA staff member. (Robert Wood Johnson University Hospital at Hamilton)

I state that I am the Parent/Guardian having legal custody of the above child and attest that the information at the top of the form is correct. I authorize the Hamilton Area YMCA staff to obtain emergency treatment for our child. I consent to an e-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

Parent Name (Print)_____Parent Signature_____

Date of Signature_____

American Academy of Pediatrics
New Jersey Chapter

Endorsed by:
New Jersey Department of
Health and Senior Services

New Jersey Academy of
Family Physicians

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Date of Birth / /
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		

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

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.

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.

Medical Conditions - Please list any ongoing medical conditions that might impact the child's health and well being in the child care setting.

a. **If the child has a complex medical condition, a special care plan should be completed and attached.** Note any significant medical conditions or major surgical history.

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 likely 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.

Screening - This section is required for school, WIC, Head Start and some other programs. This section may be optional for routine child care settings but 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.
- 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.

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.

Hamilton Area YMCA
Early Childhood Parent Handbook

Acknowledgement Form

Dear Parents/Guardians,

In keeping with the New Jersey's Child Care Center Licensing Requirements, we are obligated to provide you, as the parent of a child enrolled in our program, with the Information to Parents statement.

The statement highlights your right to visit and observe our program at any time without having to secure prior permission; the program's obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State Child Abuse Hotline 1-877-NJ ABUSE.

Names(s) of Child(ren)_____

Name of Parent/Guardian_____

___I have read the Early Childhood Parent Handbook and am aware of the policies and procedures regarding the **Release of Children, Discipline, Expulsion, and Illness or Injury.**

___I have read the **Information to Parent's Statement** prepared by the Office of Licensing, Child Care and Youth Residential Licensing, in the Department of Children and Families.

___I give permission for my child to participate in the A**ctivities and Events** conducted by the Hamilton Area YMCA. Such activities and events may include, but are not limited to, nature walks, outdoor play and/or additional classes held on the JKR Campus. Advanced notice and permission slips will be provided for planned field trips.

FULL DAY STUDENTS ONLY
___I give permission for my child, _____, to leave the Preschool classroom to attend **Swim Class**. I understand that my child will be escorted to and from the classroom by a teacher or swim instructor. I also understand that a Preschool staff member may assist my child in changing in and out of his/her swimsuit, if necessary.

_____ _____
Parent/Guardian Signature Date