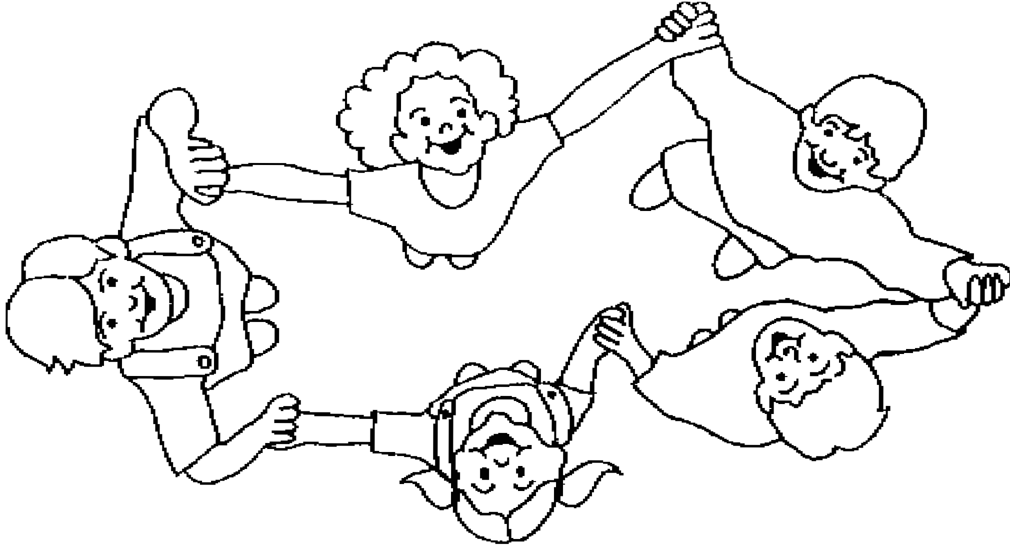
ENROLLMENT APPLICATION



Ring around the Rosie...

NURSERY SCHOOL AND DAY CARE CENTER

100 Garfield Avenue

PO Box 347

Island Heights, NJ 08732

www.ratrpreschool.com

(732) 929-9008

FAX (732) 929-4647

ENROLLMENT APPLICATION

Child's Name ______________________________

Address ______________________________

____

Home Telephone Number ______________________________

Date of Birth ______________________________

Sex ______________________________

Social Security Number ______________________________

Pediatrician's Name ______________________________

Address ______________________________

____

Telephone Number ______________________________

Our center hours are Monday through Friday, 7am to 6pm

Below, please put an X in the days your child will be attending our center.

Monday	Tuesday	Wednesday	Thursday	Friday

Date your child will be starting ______________________________

Our center hours are Monday through Friday, 7 AM until 6 PM
Students can be dropped off anytime after 7 AM and need to be picked up by 6 PM. The only time your child cannot be picked up is between 1:00 PM and 2:30 PM due to down time.
Unless prior arrangements have been made.

*Please remember Blue Room children need to be in by 10:00 AM.

Ring Around the Rosie offers a $40.00 tuition credit for any student that registers as a result of a referral.
If you were referred by someone, please write their name here:

____

Mother or Guardian's Name ______________________________

Home Address ______________________________

____

Mother or Guardian's Social Security Number ______________________________

Telephone Number (   ) ______________________________

Mother or Guardian's Occupation ______________________________

Place of Business ______________________________

Business Address ______________________________

____

Business Telephone Number (   ) ______________________________

Beeper Number (   ) ______________________________

Cell Phone (   ) ______________________________

Father or Guardian's Name ______________________________

Home Address ______________________________

____

Father or Guardian's Social Security Number ______________________________

Telephone Number (   ) ______________________________

Father or Guardian's Occupation ______________________________

Place of Business ______________________________

Business Address ______________________________

____

Business Telephone Number (   ) ______________________________

Beeper Number (   ) ______________________________

Cell Phone (   ) ______________________________

In case of emergency, please list two people other than above who we can contact.

Please list numbers in order of preference.

Name ____________________

Relation to Child ____________________

Phone (   ) ____________________

Name ____________________

Relation to Child ____________________

Phone (   ) ____________________

Please list people who will be picking up your child, other than yourself. Please let them know they will need to show their Driver's License or photo ID before the child will be released. A photocopy will be made for your child's safety. No child will be released to anyone under 16 years of age.

Name ________________________________

Address ______________________________

____

Name ________________________________

Address ______________________________

____

Name ________________________________

Address ______________________________

____

Name ________________________________

Address ______________________________

____

Name ________________________________

Address ______________________________

____

Name ________________________________

Address ______________________________

____

GETTING TO KNOW YOUR CHILD

Child's Name ____

Age ____

Allergies ____

Food(s) your child dislikes ____

____

Does your child have any fears that you are aware of?

____

____

What does your child find soothing or comfortable?

____

____

Can the staff at Ring Around the Rosie take pictures of your child for Special Events?______________

Use the space below for any additional information you wish to share about your child.

PHYSICALS & IMMUNIZATIONS

Pre School Age

Before any pre school age child can attend our school we will need a copy of their most recent immunization records with the Universal Child Health Record. The needed forms are attached.

MEDICATIONS

Ring Around the Rosie will administer medication only as per the policy stated in the handbook. This is a very strict policy and will be upheld to the highest degree.

New Jersey Department of Health and Senior Services
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX ☐M ☐F
NAME OF PARENT/GUARDIAN	TELEPHONE NUMBER(S)	
ADDRESS		
ADDRESS	IMMUNIZAITON REGISTRY NUMBER	

VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)					
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB) [2]					
HEPATITIS B [3]					
VARICELLA [4]					
PNEUMOCOCCAL CONJUGATE [2]					
INFLUENZA [6]					
OTHER, SPECIFY:					

LEAD SCREENING *(Not Required)*	
TEST DATE	RESULT

[5] Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	DATE:	TITER:
Varicella	DATE:	TITER:
Measles	DATE:	TITER:
Mumps	DATE:	TITER:
Rubella	DATE:	TITER:

☐Provisional Admission Attached - Date Granted: ____________ ☐Medical Exemption Attached ☐Religious Exemption Attached

[1] REQUIRES MEDICAL EXEMPTION.
[2] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
[3] REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04.
[4] REQUIRED FOR DAY/CHILD CARE ENROLLEES (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04.
[5] MMR single antigen receipt requires MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
[6] REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months – 59 Months)

IMM-8
MAR 08

J0012

Please feel free to use your Doctor's Immunization Record if you prefer. A copy will be required with this application.

Every child must have the following Immunizations required by state law, before starting at Ring Around the Rosie Pre School:

4 - DTP
3 - Polio

1 - Measles
1 - Mump
1 - Rubella
(MMR)

1 - Haemophilolis B (HIB)
1 - Varicella/Varivax
1 - Pneumococcal
1 - Influenza yearly

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 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.

4. **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.

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 Pesiatrics New Jersey Chapter	*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 / /
Does Child Have Health Insurance? ☐ Yes ☐ No	If Yes, Name of Child's Health Insurance Carrier	
Parents/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parents/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 Amy 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	

TUITION & FEES

A One Time Family Registration fee of $40.00 must be paid prior to enrollment when completing the application.

Tuition : $40.00 per day or
$175.00 a week

Weekly or Monthly payments are available. If paying weekly, all money for the next week is payable by Friday of the prior week. If paying monthly, all money will be paid by the 10th of the month for that month. If paying by check, please make it payable to Ring Around the Rosie.

School will be closed for the following Holidays;

Good Friday
Memorial Day
Fourth of July
Labor Day
Thanksgiving
Friday after Thanksgiving
Christmas Eve through New Years Day
Last Week of Summer

In keeping with New Jersey's child care licensing requirements, we are obliged to provide you, as the parent or guardian of a child enrolled at our center, with this information handbook.

By my signature, I attest:

- I have received the parent handbook, including the Information to Parents Statement and Expulsion Policy.
- the information I filled out is correct
- that in the event of a medical emergency, I authorize, Ring Around the Rosie to seek emergency medical care for my child as deemed necessary. I understand that I will be contacted should treatment be necessary and that my pediatrician will be called.
- that I understand the payment and pick up schedule of the center. I understand that if the required fee is not paid, my child will be excluded from child care service.
- In case of an emergency evacuation, I give Ring Around the Rosie permission to leave the center with my child.

______________________________	______________________________
Parent or Guardian	Ring Around the Rosie Staff
______________________________	______________________________
Date	Date

POTASSIUM IODINE (KI) PERMISSION SLIP

Dear Parent /Guardian:

Our school building is located within the ten mile emergency planning zone of the (Oyster Creek - Artificial Island) nuclear generating station. In January 2001, the Federal Nuclear Regulatory Commission amended its policy on the availability and usage of the over-the-counter drug, potassium iodine (KI), during radiological emergency. As a result, the State of New Jersey revised its policy regarding providing KI to the general population within ten miles of a nuclear generating station. Part of this revised policy allows for the storage and use of KI at schools located in the 10 mile emergency planning zone.

KI is an over-the-counter drug that protects the thyroid from exposure to radioactive iodine and can reduce the risk of thyroid cancer after a severe nuclear emergency event resulting in the release of radiation. It is a supplement to evacuation or sheltering. **Evacuation and sheltering** remains New Jersey's primary public protective actions in the event of an accident at any nuclear generating station.

Please read this KI information sheet and mark the appropriate box which will alert the school officials of your choice to have your child receive or not receive KI in the event of a radiological release. This form will remain in effect as long as your child attends this school: unless you notify us in writing that you have changed your choice.

Should the County and/or State Health Official recommend the use of KI during an emergency; the school will have KI available on-site for your child. Evacuation remains our primary protective radiological action. In the even that evacuation is not immediately possible, and KI is recommended by County and/or State Health officials, an appropriate dose of KI will be available for your child.

Child's Name:________________________
Parent/Guardian Signature:_________________________
Date:___________________

I have read the above fact sheet on potassium iodine and understand that in an event of a nuclear release my child may be given KI, subject to this permission slip.
Please be advised that your child should not receive KI if he or she is allergic to iodine, or has a rare disorder of dermatitis herpetiformis or hypocomplementemic vasculitis. If you should have any concerns regarding the emergency use of KI or questions on your child's health and the use of KI, please discuss with your child's doctor.

☐ I **do want** my child to be given potassium iodine (KI) in the event of a radiological emergency when recommended by County and/or State Health Officials.

☐ I **do not want** my child to be given potassium iodine (KI).