

# Saint Stephen's PreSchool

119 Main Street, Millburn, NJ 07041  
(973) 376-0688

CHECK ONE:

5 DAYS:

\_\_\_\_ A.M. \_\_\_\_ P.M. \_\_\_\_ FULL

DESIRED START DATE

\_\_\_\_/\_\_\_\_/\_\_\_\_

## **ENROLLMENT APPLICATION**

Child's Name: \_\_\_\_\_ Application Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Physician: \_\_\_\_\_ Telephone #: (\_\_\_\_) \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_  
Address City ST ZIP

Occupation: \_\_\_\_\_ E-Mail \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_

Business Name: \_\_\_\_\_ Pager Pin \_\_\_\_\_

Business Address: \_\_\_\_\_  
Address City ST ZIP

Parent/Guardian Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_

Home Address: \_\_\_\_\_  
Address City ST ZIP

Occupation: \_\_\_\_\_ E-Mail \_\_\_\_\_

Business Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_ Pager (\_\_\_\_) \_\_\_\_\_

Business Name: \_\_\_\_\_ Pager Pin \_\_\_\_\_

Business Address: \_\_\_\_\_  
Address City ST ZIP

Does your child have any medical condition that requires immediate treatment? \_\_\_ Yes \_\_\_ No

If yes, please describe: \_\_\_\_\_

NAMES & AGES  
OF SIBLINGS:


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## **ENROLLMENT APPLICATION – pg. 2**

If I have not arrived at Saint Stephen's School nor called by 6:00 PM and the people listed on my Emergency Information Form cannot be contacted, I authorize the teaching staff to do the following in numbered order:

- \_\_\_\_\_ Take child to Millburn Police Department
- \_\_\_\_\_ Call NJ Division of Youth and Family Service for emergency care
- \_\_\_\_\_ Other plan (please outline)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

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 appropriate documents. (Court Order)

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

In the event that a medical emergency occurs I authorize Saint Stephen's to seek emergency medical care for my child as deemed necessary by the Director or Teacher in charge;

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

I give permission for my child \_\_\_\_\_ to participate in all school-scheduled health screenings, including but not limited to dental, vision and hearing;

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

I have received the Information to Parents/Guardians as stated in the New Jersey Manual of Requirements;

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

I have received the Policy Guidelines on Positive Discipline as well as the Policy On Release of Children;

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

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## **AGREEMENT WITH POLICIES AND PROCEDURES**

Name of Child: \_\_\_\_\_

We have read, understood, and agree to abide by the policies and procedures of Saint Stephen's PreSchool; (All parents, guardians, or other responsible persons involved in the daily care of the child are required to sign)

Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/ Guardian \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Other Responsible Person \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Other Responsible Person \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **PHOTOGRAPHY CONSENT**

Name of Child: \_\_\_\_\_

This will give my permission for my child to be photographed under the following conditions while that are a student at Saint Stephen's PreSchool:

1. Insertion in the school photograph album: \_\_\_\_\_ Yes \_\_\_\_\_ No
2. School projects to be sent home: \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Possible use in Future School Brochures: \_\_\_\_\_ Yes \_\_\_\_\_ No
4. News Releases (i.e. graduation photographs) \_\_\_\_\_ Yes \_\_\_\_\_ No
5. Newspaper Advertisements (i.e. group on playground) \_\_\_\_\_ Yes \_\_\_\_\_ No

I understand that it is the policy of Saint Stephen's PreSchool that unless expressly permitted by a parent at the time a photograph is used or printed that names of children will never be associated with their photograph.

Parent/Guardian Signature:

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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(DYFS Record Copy)

## EMERGENCY INFORMATION

Name of Child: _____	Birth date: ____/____/____		
Home Address: _____			
Address	City	State	Zip
Home Telephone(s) (____) _____; (____) _____			

We need the following information in case of an accident or sudden illness while your child is in our care. We will:

1. Call the parent/guardians immediately, *and if you cannot be reached*;
2. Call the people on your emergency list in order, *and if they cannot be reached*;
3. Call your Doctor; *and if he/she cannot be reached and conditions warrant*;
4. Call the Millburn Emergency Squad (*if condition is serious Squad will be called immediately*)

<b>1</b>
Parent/Guardian Name: _____ Daytime Phone: (____) _____
Place of Business: _____
Parent/Guardian Name: _____ Daytime Phone: (____) _____
Place of Business: _____

<b>2</b>
1st Name: _____ Daytime Phone: (____) _____
Relationship to Child _____
2nd Name: _____ Daytime Phone: (____) _____
Relationship to Child _____
3rd Name: _____ Daytime Phone: (____) _____
Relationship to Child _____

<b>3</b>			
Physician's Name: _____ Daytime Phone: (____) _____			
Office Address: _____			
Address	City	State	Zip

### **4**

**In case of emergency and the above cannot be reached, I hereby give permission to the staff of Saint Stephen's PreSchool to authorize emergency treatment for my child;**

Parent/Guardian Signature:

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## **DISMISSAL INFORMATION FORM**

My Child, \_\_\_\_\_, is to be dismissed to:

Parent/Guardian: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Other Persons: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

No child will be dismissed to any person other than those listed unless we receive written permission.

Parent/Guardian Signature:

\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## **ACTIVITIES PERMISSION FORM**

Name of Child: \_\_\_\_\_

I hereby grant permission for my child to use all play equipment and to participate in all activities of the school;

Further, I hereby grant permission for my child to leave the school premises, under adequate supervision by the staff, for neighborhood walks or park play (by foot, stroller, or carriage);

Further, it is my understanding that these trips may be taken at any time without further consent from me.

Parent/Guardian Signature:

\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# Saint Stephen's PreSchool

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(Classroom Copy)

## EMERGENCY INFORMATION

Name of Child: _____	Birth date: ____/____/____		
Home Address: _____			
Address	City	State	Zip
Home Telephone(s) (____) _____; (____) _____			

We need the following information in case of an accident or sudden illness while your child is in our care. We will:

5. Call the parent/guardians immediately, *and if you cannot be reached*;
6. Call the people on your emergency list in order, *and if they cannot be reached*;
7. Call your Doctor; *and if he/she cannot be reached and conditions warrant*;
8. Call the Millburn Emergency Squad (*if condition is serious Squad will be called immediately*)

<b>1</b>
Parent/Guardian Name: _____ Daytime Phone: (____) _____
Place of Business: _____
Parent/Guardian Name: _____ Daytime Phone: (____) _____
Place of Business: _____

<b>2</b>
1st Name: _____ Daytime Phone: (____) _____
Relationship to Child _____
2nd Name: _____ Daytime Phone: (____) _____
Relationship to Child _____
3rd Name: _____ Daytime Phone: (____) _____
Relationship to Child _____

<b>3</b>			
Physician's Name: _____ Daytime Phone: (____) _____			
Office Address: _____			
Address	City	State	Zip

### **4**

**In case of emergency and the above cannot be reached, I hereby give permission to the staff of Saint Stephen's PreSchool to authorize emergency treatment for my child;**

Parent/Guardian Signature:

\_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

# 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	
<b><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></b>					
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)			
<b>IMMUNIZATIONS</b>		<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"/> <b><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></b>					
Name of Health Care Provider (Print)			Health Care Provider Stamp:		
Signature/Date					

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

NAME OF CHILD (LAST, FIRST, MI)				DATE OF BIRTH		SEX M _____ F _____	
PARENT OR GUARDIAN				NAME		TELEPHONE NUMBER	
STREET ADDRESS				CITY, STATE, ZIP		NAME OF DOCTOR	
VACCINE TYPE				DISEASE MO/DAY/YR		1 <sup>ST</sup> DOSE MO/DAY/YR	
DIPTHERIA, TETANUS, PERTUSSIS (DTP)				////////////////////		////////////////////	
(IFTd, DtaP or DT*, indicate in corner box)				////////////////////		////////////////////	
POLIO - ORAL POLIO VACCINE (OPV)				////////////////////		////////////////////	
(If Salk vaccine indicate IPV in corner box)				////////////////////		////////////////////	
MEASELES, MUMPS, RUBELLA (MMR)				////////////////////		////////////////////	
MEASELES				////////////////////		////////////////////	
RUBELLA				////////////////////		////////////////////	
MUMPS				////////////////////		////////////////////	
HAEMOPHILUS B (HIB)**				////////////////////		////////////////////	
HEPATITIS B***				////////////////////		////////////////////	
VARICELLA				////////////////////		////////////////////	
PREVNAR				////////////////////		////////////////////	
<input type="checkbox"/> Check if Provisional Admission Attached - Date Granted _____				<input type="checkbox"/> Medical Exemption Attached		<input type="checkbox"/> Religious Exemption Attached	

\*REQUIRES MEDICAL EXEMPTION  
 \*\*REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 MONTHS - 5<sup>TH</sup> BIRTHDAY ONLY)  
 \*\*\*REQUIRED FOR K-GRADE 1 (WHICHEVER IS FIRST) AND GRADE 6 BEGINNING SEPTEMBER 1, 2001