

*Saint Stephen's PreSchool*

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

CHECK ONE: 5 DAYS: ____A.M. ____P.M. ____FULL
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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: _____ <small>Address City ST ZIP</small>		
Occupation: _____	E-Mail _____	
Business Phone:(____) _____	Cell Phone (____) _____	Pager (____) _____
Business Name: _____	Pager Pin _____	
Business Address: _____ <small>Address City ST ZIP</small>		

Parent/Guardian Name: _____	Home Phone: (____) _____	
Home Address: _____ <small>Address City ST ZIP</small>		
Occupation: _____	E-Mail _____	
Business Phone:(____) _____	Cell Phone (____) _____	Pager (____) _____
Business Name: _____	Pager Pin _____	
Business Address: _____ <small>Address City ST ZIP</small>		

Does your child have any medical condition that requires immediate treatment? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

- \_\_\_\_\_ Call NJ Division of Children and Families 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)

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

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

3	
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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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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)

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

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

3	
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:				
<b>MEDICAL CONDITIONS</b>							
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			
<b>PREVENTIVE HEALTH SCREENINGS</b>							
<b>Type Screening</b>		<b>Date Performed</b>	<b>Record Value</b>	<b>Type Screening</b>		<b>Date Performed</b>	<b>Note if Abnormal</b>
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		
CITY, STATE, ZIP			STREET ADDRESS			NAME OF DOCTOR		
VACCINE TYPE			DISEASE MO/DAY/YR		1 <sup>ST</sup> DOSE MO/DAY/YR		2 <sup>ND</sup> DOSE MO/DAY/YR	
DIPHTHERIA, TETANUS, PERTUSSIS (DTp)			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
(If Td, DTap or DT*, indicate in corner box)			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
POLIO - ORAL POLIO VACCINE (OPV)			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
(If Salk vaccine indicate IPV in corner box)			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
MEASELES, MUMPS, RUBELLA (MMR)			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
MEASELES			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
RUBELLA			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
MUMPS			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
HAEMOPHILUS B (HIB)**			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
HEPATITIS B***			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
VARICELLA			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
PREVNAR			////////////////////		<input type="checkbox"/>		<input type="checkbox"/>	
<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