

OVER THE RAINBOW CHILDREN'S CENTER
1 Barnida Drive, East Hanover, NJ 07936
973-503-9010
973-503-0569 (fax)

APPLICATION FOR CHILD'S ENROLLMENT

Center		Date of Enrollment:
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Child:	
Name of Child:	
Date of Birth:	
Home Address:	

Parent(s) Contact Information:	
Mother's Name:	
Home Address:	
Home Phone:	
Father's Name:	
Home Address:	
Home Phone:	

Work Information - Mother:	
Name of Business:	
Business Address:	
Work #:	
Work Information - Father:	
Name of Business:	
Business Address:	
Work #:	

Emergency Contact:	
Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.	
Name of Contact #1:	
Phone:	
Relationship:	
Address:	

Name of Contact #2:	
Phone:	
Relationship:	
Address:	

Doctor Information:	
Child's Doctor:	
Phone:	
Address:	
Custody:	

Name of person 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 appropriate court order.

Emergency:

I have completed the medical emergency permission form which authorizes the Center to seek emergency medical care for my child as deemed necessary by the Director or the Director's designee.

Parent's Signature: _____ Date: _____

Walks:

____ I give my permission for my child to participate in walking trips within the Center's neighborhood.
 ____ I do not give my permission for my child to participate in walking trips within the Center's neighborhood.

Parent's Signature: _____ Date: _____

Policies:

I (we) attest that all of the information on this application is accurate, and that I (we) have received the following information for my (our) home records:

- | | | |
|--|----------|---------|
| 1. Information to Parents Document | ____ Yes | ____ No |
| 2. Policy on the Release of Children | ____ Yes | ____ No |
| 3. Policy on Discipline | ____ Yes | ____ No |
| 4. Policy on the Expulsion of Children from Enrollment | ____ Yes | ____ No |
| 5. Policy on the Management of Illnesses/Communicable Diseases | ____ Yes | ____ No |

Parent's Signature: _____ Date: _____

ENROLLMENT CONTRACT

Registration Fee: \$100.00

Paid: _____

Weekly Tuition Fee: _____

Please circle the days your child will attend:

Monday Tuesday Wednesday Thursday Friday

Please specify the hours your child will attend:

From: _____ To: _____

Full time hours are: 7:00 a.m. – 6:00 p.m.
Part time hours are: 4 hours in the a.m. or p.m.

The lunch fee for all full time toddler, preschool and kindergarten children is \$5.00 per day. Part time hours do not include lunch. If you wish for your part time child to join us for lunch, the fee is \$4.00 per day.

Please note, the above tuition fee is expected to be paid whether your child attends or does not attend due to sickness, etc. We do allow one free week per year for vacation/sickness. We refer to this as your “FREEZE WEEK” (see Center Policies page).

Due to staff/child ratios, please do not switch your child’s days unless it is an emergency.

By signing this contract, I agree to abide by all the Center’s policies and procedures.

Parent’s Signature

Date

Management Signature

Date

PARENTAL AUTHORIZATION FOR EMERGENCY TREATMENT

Child's Name: _____

Age: _____ Date of Birth: _____

Address: _____

Parent(s) Name: _____

Parent(s) Address: _____

Child's Medical Information:

Medical Problems: _____

Allergies: _____

Medicine(s) Child is Taking: _____

Name of Child's Doctor: _____ Telephone: _____

Child's Insurance:

Company/HMO: _____

Group Number: _____ Identification # _____

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize the above child care center director or director's designee to obtain emergency treatment for my child. I consent to an x-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.

The following steps will be followed in an emergency:

1. The parent/guardian will be contacted immediately;
2. The child's physician will be contacted;
3. We will attempt to contact you through all of the emergency persons listed on the child's application form.
4. If we cannot contact you or your child's physician, 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 staff member.

Parent Signature: _____

Date of Signature: _____ Date Permission Terminated: _____

Witness: _____ Date: _____

EXPULSION POLICY

NAME OF CENTER: _____

NAME OF CHILD: _____

SIGNATURE OF PARENT: _____

Unfortunately, there are sometimes reasons we have to expel a child from our program either on a short term or permanent basis. We want you to know we will do everything possible to work with the family of the child(ren) in order to prevent this policy from being enforced. The following are reasons we may have to expel or suspend a child from this Center.

IMMEDIATE CAUSES FOR EXPULSION

The child is at risk of causing serious injury to other children or himself/herself.

Parent threatens physical or intimidating actions toward staff members.

Parent exhibits verbal abuse to staff in front of enrolled children.

PARENTAL ACTIONS FOR CHILD'S EXPULSION

Failure to pay/habitual lateness in payments.

Failure to complete required forms including the child's immunization records.

Habitual tardiness when picking up your child.

Verbal abuse to staff.

Other (explain)

CHILD'S ACTIONS FOR EXPULSION

Failure of child to adjust after a reasonable amount of time.

Uncontrollable tantrums/angry outbursts.

Ongoing physical or verbal abuse to staff or other children.

Excessive biting.

Other (explain).

SCHEDULE OF EXPULSION

If after the remedial actions above have not worked, the child's parent/guardian will be advised verbally and in writing about the child's or parent's behavior warranting an expulsion. An expulsion action is meant to be a period of time so that the parent/guardian may work on the child's behavior or to come to an agreement with the Center.

The parent/guardian will be informed regarding the length of the expulsion period.

The parent/guardian will be informed about the expected behavioral changes required in order for the child or parent to return to the Center.

The parent/guardian will be given a specific expulsion date that allows the parent sufficient time to seek alternate child care (approximately one to two weeks notice depending on risk to other children's welfare or safety). Failure of the child/parent to satisfy the terms of the plan may result in permanent expulsion from the Center.

A CHILD WILL NOT BE EXPELLED

If a child's parent(s):

- Made a complaint to the Office of Licensing regarding a center's alleged violations of the licensing requirements.
- Reported abuse or neglect occurring at the Center.
- Questioned the Center regarding policies and procedures.
- Without giving the parent sufficient time to make other child care arrangements.

PROACTIVE ACTIONS THAT CAN BE TAKEN IN ORDER TO PREVENT EXPULSION

Staff will try to redirect child from negative behavior.

Staff will reassess classroom environment, appropriate of activities, supervision.

Staff will always use positive methods and language while disciplining children.

Staff will praise appropriate behaviors.

Staff will consistently apply consequences for rules.

Child will be given verbal warnings.

Child will be given time to regain control.

Child's disruptive behavior will be documented and maintained in confidentiality.

Parent/guardian will be notified verbally.

Parent/guardian will be given written copies of the disruptive behaviors that might lead to expulsion.

The director, classroom staff and parent/guardian will have a conference(s) to discuss how to promote positive behaviors.

The parent will be given literature or other resources regarding methods of improving behavior.

Recommendation of evaluation by professional consultation on premises.

Recommendation of evaluation by local school district child study team.

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 _____					