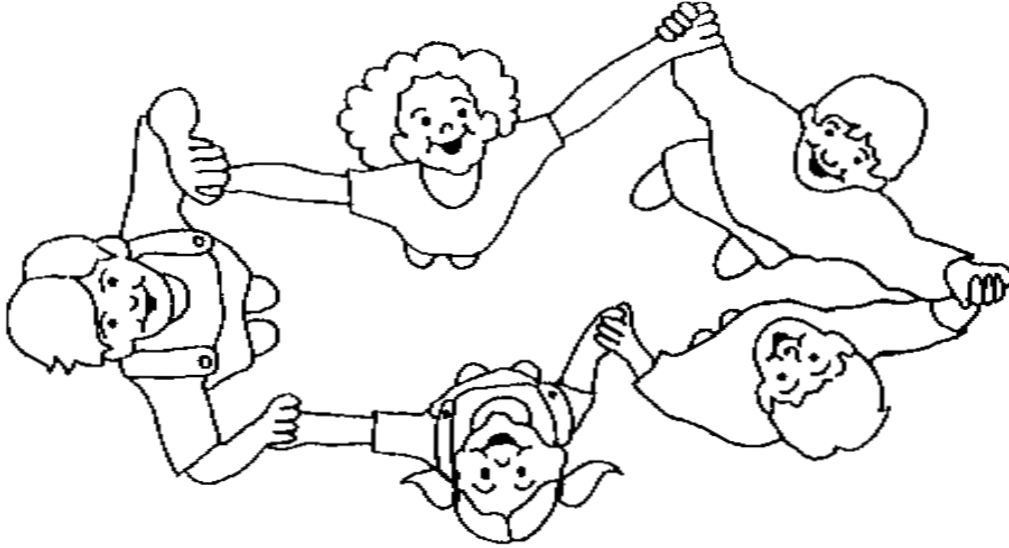


ENROLLMENT APPLICATION



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 _____

Name _____

Address _____

Address _____

Name _____

Name _____

Address _____

Address _____

Name _____

Name _____

Address _____

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 <input type="checkbox"/> M <input type="checkbox"/> F	
NAME OF PARENT/GUARDIAN				TELEPHONE NUMBER(S)			
ADDRESS							
ADDRESS				IMMUNIZATION 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	LEAD SCREENING (Not Required)	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT ¹ , indicate in corner box)						TEST DATE	RESULT
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)						⁽⁵⁾ Document below single antigen vaccine receipt, serology titers, or varicella disease history	
HAEMOPHILUS B (HIB) ⁽²⁾							
HEPATITIS B ⁽³⁾						Hepatitis B	DATE: _____ TITER: _____
VARICELLA ⁽⁴⁾						Varicella	DATE: _____ TITER: _____
PNEUMOCOCCAL CONJUGATE ⁽²⁾						Measles	DATE: _____ TITER: _____
INFLUENZA ⁽⁶⁾						Mumps	DATE: _____ TITER: _____
OTHER, SPECIFY:						Rubella	DATE: _____ TITER: _____
<input type="checkbox"/> Provisional Admission Attached - Date Granted: _____ <input type="checkbox"/> Medical Exemption Attached <input type="checkbox"/> 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 | 1 - Measles | 1 - Haemophilolus B (HIB) |
| 3 - Polio | 1 - Mump | 1 - Varicella/Varivax |
| | 1 - Rubella | 1 - Pneumococcal |
| | MMR | 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 health 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

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 _____ / _____ / _____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 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

- Immunization Record Attached
 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		

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 : \$46.00 per day

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).