



1 Barnida Drive, East Hanover, NJ – 973-503-9010

APPLICATION FOR CHILD'S ENROLLMENT

CENTER		Date of Enrollment:
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C H I L D	Name of Child	
	Date of Birth	
	Home Address	

MOTHER			FATHER	
P A R E N T	Name		Name	
	Home Phone		Home Phone	
	Home Address		Home Address	
	Cell #		Cell #	

MOTHER WORK			FATHER WORK	
W O R K	Name of Business		Name of Business	
	Business Phone		Business Phone	
	Business Address		Business Address	

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.

E M E R G E N C Y	Name of Contact #1		Name of Contact #2	
	Phone		Phone	
	Relationship		Relationship	
	Address		Address	

D O C T O R	Child's Doctor	
	Telephone	
	Address	

C U S T O D I A N	Name of person PROHIBITED from picking up the child: _____
	If a non-custodial parent is <u>not</u> 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.

E M E R G E N C Y	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: _____

W A L K I N G	_____ I give my permission for my child to participate in walking trips within the Center's neighborhood.
	_____ I do not give my permission for any child to participate in walking trips within the Center's neighborhood.
	Parent's signature: _____ Date: _____

P O L I C Y I S S U E	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
_____ Date: _____		
Parent's signature		

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: 4-5 hours in the a.m. or p.m.

The lunch fee for all full time toddler, preschool and kindergarten children is \$6.00 per day. If you wish for your part time child to join us for lunch, the fee is \$5.00 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 to our families that pay weekly. We refer to this as your "FREEZE WEEK" (see Center Policies page). The FREEZE WEEK does not apply to monthly fees.

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 center 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 _____

Medicine(s) Child is Allergic to _____

Name of Child's Doctor _____ Phone _____

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.



**1 Barnida Drive
East Hanover, NJ 07936
973-503-9010
973-503-0569 (fax)
www.overtherainbownj.com**

**OFFICE OF LICENSING
INFORMATION TO PARENTS DOCUMENT**

Dear Parent or Guardian:

In keeping with New Jersey's child care center licensing requirements, we are obliged to provide you, as the parent/guardian of a child enrolled at our center, with this informational statement. The statement highlights, among other things: your right to visit and observe our center at any time without having to secure prior permission; the center's obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's DHS Child Abuse/Neglect Hotline Toll Free at (877) NJABUSE (1-877 652-2873).

Please read this statement carefully and, if you have any questions, feel free to contact me at: 973-503-9010.

Sincerely,

Judith Treanor
Director

Please complete and return this portion to the center. (Please print)

Name of Child: _____

Name of Parent(s): _____

I have read and received a copy of the Information to Parents document prepared by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Human Services.

Signature of Parent: _____ Date: _____



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Photographic Release

Over the Rainbow Children's Center occasionally takes photographs of children at the center. Please check if you do ____, or do not ____ authorize the use and reproduction of any photographs, training videos, slides, negatives, or proofs of your child. The photos may be used within the center, on the Over the Rainbow website, Facebook (Over the Rainbow Learning Center) or for the center's promotional purposes.

Child's Name: _____ Date: _____

Parent/Guardian's Signature: _____

EMAIL ADDRESS REQUEST

To save on the amount of paper we use we would like to start sending information through email. Please provide us with your email address: _____

You can email our Director at: jtreaor@overtherainbownj.com

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 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		<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 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.					
Name of Health Care Provider (Print) _____			Health Care Provider Stamp: _____		
Signature/Date _____					