ANDREA McKENNA
Director
908-359-2111
Fax: 908-359-5491

MAILING ADDRESS
265 Burnt Hill Road
Skillman, New Jersey 08558

Dear Parent:

Thank you for your interest in Montgomery Township's, Kid Connection Preschool Program. Kid Connection has many programs revolving around a 7:30am-6:00pm day, Monday-Friday. During the school year we offer half day programs, full day programs and before/after school extensions if needed. Please refer to our main website (within the Montgomery Township website) for information on program times and costs.

If you haven't already done so, please call the director of Kid Connection at (908) 359-2111 to verify that the program you wish to enroll your child in is available at this time. If we can meet your schedule request, please print out the entire registration package and fill out all the paperwork. You will need to turn in all of these documents at the time of registration. We will also need a non-refundable $150 deposit (made payable to Montgomery Recreation) at the time of registration. You will receive a call from our registration coordinator to set up an appointment to hand in your completed paperwork, deposit and sign the financial agreement. Once you have signed the financial agreement and turned in your paperwork and deposit, you child will be officially registered with us at that time. If after you have registered with us and wish to reduce services or cancel your child's registration with our program you will incur a $250 administrative fee.

We look forward to meeting you and your child.

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IMPORTANT

PLEASE READ AND SIGN BELOW BEFORE REGISTERING!

Dear Kid Connection Parents:

Montgomery Kid Connection follows the Montgomery Township Board of Education's school calendar for holidays, in-service days, and vacations. This includes snow days, delayed openings, and emergency early dismissals.

****

I have read and understand that the Montgomery Kid Connection will follow the Montgomery Board of Education's school calendar.

____

Child's name

______________________________ ______________________________

Parent's signature Date

My child has the following allergies:

None ____

____

He/She has an EpiPen for these allergies: Yes____ No____

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Dear Parent:

In keeping with New Jersey's child care center licensing requirements, we are obligated to provide you, as the parent of a child enrolled at our center, with this informational statement, and a Kid Connection Parent Manual which includes the following: Information to Parents Document, Policy on the release of children, Positive guidance and discipline policy, Policy on methods of parental notification, Policy on communicable disease management, Expulsion policy, and Policy on the use of technology and social media.

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 program's expulsion policy. It is the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's Department of Children and Families at Hotline 1 (877) NJ ABUSE.

Please read this statement carefully. If you have any questions, feel free to contact me at (908) 359-2111.

Sincerely,

Andrea McKenna

Director

Please complete this portion and return it to the center. Please print.

Name of child______________________________________

Name of parent____

I have read and received a copy of the Information to Parents Statement, and a copy of the information/policies listed above, as stated in the parent manual.

Signature____ Date____

KID CONNECTION CHILD INFORMATION SHEET

Birthdate ______________________ Teacher_________________________
(*For Official Use Only)*

Child's Name ____________________________________ Home Address ____________________________________

Home Phone ____________________________________ ____________________________________

Mother's Name ____________________________________ **Father's Name** ____________________________________

Work Phone ____________________________________ Work Phone ____________________________________

E-mail ____________________________________ E-mail ____________________________________

Cell Phone ____________________________________ Cell Phone ____________________________________

(If there has been a custody decision, please list the name, or names, of persons NOT PERMITTED to pick up your child from the program.)

____

Please list two neighbors or relatives who will pick up, if necessary, and assume responsibility for the care of your child in case of an emergency.

1. Name____Address ____

   Phone____ ____

2. Name____Address ____

   Phone____ ____

Family Doctor ______________________________________Address ____

Phone____ ____

Does your child have allergies? (such as penicillin, insect bites, food, dust, pollen, other) Yes__________________ No ____________________

If *yes*, please explain: ____

If there is a change in the above information, I will notify Kid Connection promptly in writing.

Date _____________________________Signature of Parent/Guardian ____

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*

Gender ☐ Male ☐ Female

Date of Birth / /

Does Child Have Health Insurance? ☐Yes ☐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. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:

Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:

Measure	Value
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

Condition	Status	Comments
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ 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: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***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

 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

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 <u>that is being used to complete the form</u>. 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, Vaccine Preventable Diseases Program at 609-826-4860.
   - 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 or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   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 <u>should</u> 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 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, child care settings, and some other programs. This section can provide valuable data for public heath 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 and the value of the test performed.
   - 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.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

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.

Teacher_______________
For Official Use Only

KID CONNECTION PICK-UP RELEASE FORM

Dear Staff:

I have authorized the following person or persons to pick up my child from school in the event I am not able to do so myself.

I give______________________________authorization to pick up my child,

__________________________________.
Child's Name

Parents Please Note: The person or persons listed above should coordinate with those listed as emergency contacts on your **child's information sheet.** We will not release a child to anyone unless we have the proper identification and your permission.

Brief Description of the person named above:

____

____

____

____

____
Parent/Guardian Signature

For Official Use Only

MONTGOMERY TOWNSHIP KID CONNECTION
BLANKET EMERGENCY RELEASE FORM

In accordance with State Regulations, you are required to sign a Blanket Emergency Release giving the Emergency Room, First Aid Squad, or your child's physician permission to practice emergency medical treatment in case you cannot be reached. Please sign this form and return it to us promptly.

CHILD'S NAME____

I hereby give permission to the facility staff to administer first aid and in the case of an emergency, to transport, secure proper treatment for and order injections, anesthesia or surgery for my child if it is determined to be necessary. I hereby give permission to emergency personnel, including first aid squad personnel, emergency room personnel, and the child's physician to practice emergency medical treatment if it is determined to be necessary. I understand that I will be responsible for all charges not covered by insurance.

_________________________________ _________________________________

Parent/Guardian Signature Date

Name of Insurance______________________ Policy #____________________________

Note any physical or mental conditions to be aware of in case of an emergency.

____
____
____
____
____
____

Other comments:____
____
____
____
____

School Year___________

MONTGOMERY KID CONNECTION
PARTICIPATION INFORMATION SHEET

Name:_______________________________________ Gender:________M________F

1. Nickname and what you would like your child to be called:________________________
2. Child's date of birth:____
3. Prior school/group experience:_______________________________________
4. Will your child tell us when he/she has to use the bathroom?___________________
5. Does your child have known fears? If so, please explain:____________________

   ____

6. Does your child have sisters or brothers?_________________________________

   What are their names and ages?_____________________________________

7. Does your child have a favorite toy?________________________________
8. Primary language spoken at home:__________________________________
9. Please describe your child's demeanor, i.e. active, quiet, verbal:______________

   ____

10. Special Family Situations:____
11. Any Allergies:____
12. Any food rescrictions:____
13. Thank you for helping us at Kid Connection to know and understand your child better. If there is something further regarding your child, not already covered, please use the space below and on the other side to explain.