Little Learners
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-Registration Form 2024-2025 School Year

DATE OF APPLICATION:___/___/___ CHILD'S NAME:_________________ SEX:_________

DATE OF BIRTH:___/___/___

ADDRESS:____

STREET CITY STATE ZIP

PARENT 1's NAME:______________ PARENT 2's NAME:_________________

ADDRESS:____________________ ADDRESS:_____________________
IF DIFFERENT FROM ABOVE IF DIFFERENT FROM ABOVE

CELL PHONE:__________________[REQUIRED] CELL PHONE:_______________

CELL PHONE CARRIER:______________________

PLACE OF EMPLOYMENT:_______________ PLACE OF EMPLOYMENT:______________

PHONE:______________________ PHONE:___________________________

EMAIL :______________________[REQUIRED] EMAIL:___________________________

SSN: :___________________[REQUIRED]

I LEARNED ABOUT LITTLE LEARNERS THROUGH:___________________________

OFFICE USE ONLY:

CLASS ENROLLED: **Start Date:**

Room: ____

Infants:	5FD:____	
T1:	5FD:____	
T2-T3:	5FD:____	3FD:____
3YR+ & PRE-K:	5FD:____	3FD:____

Registration Fees: $150 (First Child) $100 (Second Child) ***Non-Refundable**

REG. PAID: Check______ Cash______

NOTES:
***Please attach copies of your driver license with your children's registration form.**
We must have at least one (1) parent's driver license on file or your child will not be considered registered.
***Please attach a copy of your child's shot records with your physician's signature. This is a New Jersey state requirement and we must have it on file at the time of registration.**
***NJ now requires children 6 -59 months of age, and is attending a licensed childcare facility, to receive an annual FLU shot between 9/1 and 12/31 and provide proof of immunization to school.**

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Child's Name:_____ **Preferred Name:**_____

Date of Birth: **Class:**

_____

Parent's Names
Parent's Marital Status_____

Does your child have any allergies (all allergies must be documented by the child's physician) of any type?_____ If yes, please explain:_____

_____

Does your child have any physical or medical conditions that we should be made aware of:_____If yes, please explain:_____

_____

Has your child received any testing for speech, hearing, vision or developmental issues? If yes, please explain_____

_____

Does your child have an IEP or other designation?_____ If yes, please provide the information below _____

Does your child have any individual differences we should be aware of, such as fears or situations that make your child uncomfortable? Please list_____

_____

Has your child had any group experience prior to attending Little Learners program?

If yes, please explain_____

_____

Please share any information regarding family structure and culture, such as dietary restrictions, that you feel are important to share with Little Learners about your child:_____

_____

_____

If other than English, what is the home language for your child?_____

Does your child have any playmates of the same age?_____

Please provide the names and ages of any siblings:_____

_____

Please provide a short description of your child's personality, and, interests, etc.

_____

_____

What do you expect your child to gain from his/her nursery school experience?

_____

_____

Describe what you feel are your child's strengths.

_____

_____

Describe what you feel are your child's weaknesses.

_____

_____

Will your child (or sibling) attend another preschool program other than Little Learners Rockaway? If so, what is the name of the program?

_____

_____

Is there any other information that would be relevant in knowing and understanding your child that has not already been listed above? Please explain:

_____

_____

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NEW JERSEY STATE INFORMATION

In keeping with New Jersey's child care center licensing requirements, we are obliged to provide you, as the parent of a child enrolled at our center, with this information 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 Department of Human Services (DHS).

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

It is the firm hope that the authorization granted on this form will never need to be used. For the safety of the children, however, sound medical practice calls for such authorization. The authorization granted by this form will be used only when absolutely necessary.

AUTHORIZATION

I authorize Little Learners to call an emergency vehicle in case of an accident or acute illness (the determination shall rest solely with the school) and allow possible emergency care if I am not immediately available.

CHILD'S NAME_____BIRTHDATE_____
MM/DD/YY

MEDICAL PROBLEMS: _____

ALLERGIES: _____

MEDICINE(S) CHILD IS TAKING:_____

MEDICINE(S) CHILD IS ALLERGIC TO: _____

NAME OF CHILD'S HEALTHCARE PROVIDER:_____TELEPHONE: _____

NSURANCE COMPANY_____

POLICY NUMBER_____RELATIONSHIP TO CHILD_____

ADDRESS_____
Street City State Zip

By signing this form, you have indicated that you have received and read all of the above.

PARENT'S SIGNATURE_____DATE_____

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PICK UP AUTHORIZATION FORM:

PERSONS AUTHORIZED TO PICK UP CHILD AND /OR BE CONTACTED IN CASE OF EMERGENCY (OTHER THAN PARENT) THIS INFORMATION MUST BE COMPLETED.

CONTACT 1

Name:_____

Relationship to Child_____

Address_____

Cell Phone:_____

CONTACT 2

Name:_____

Relationship to Child_____

Address_____

Cell Phone:_____

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BLANKET PERMISSION FOR WALKING TRIPS

I hereby give permission for my child _____
to participate in walking trips in the immediate vicinity around Little Learners Rockaway. I understand that the walking route includes no safety hazards and that the walks will not involve entrance into any facility.

_____ _____

Parent Signature **Date**

PHOTOGRAPH RELEASE FORM

This letter serves to inform you that on occasion, Little Learners Rockaway, may be featured on our website/Facebook page/Instagram Page/newspaper/magazine articles. Photographs of children who are enrolled at the center may be used for promotional purposes. Please take a moment to sign the form below.

Please check one:

☐ I authorize my child's photo to be used in a promotional manner for Little Learners.

☐ I do not authorize my child's photo to be used in a promotional manner for Little Learners.

Parent Signature: _____

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Child's Name_____

TOPICAL OINTMENT AUTHORIZATION

AUTHORIZATION FORM FOR THE APPLICATION OF NON-PRESCRIPTION TOPICAL OINTMENTS (NEOSPORIN) AND/OR CREAMS, INCLUDING BUT NOT LIMITED TO SUNSCREEN, BUG REPELLANT, DIAPER OINTMENT, TEETHING GEL, VASELINE, POWDER, OR BABY WASH/SHAMPOO ALL CONTAINERS ARE TO BE MARKED WITH THE CHILD'S NAME IN PERMANENT MARKER. AUTHORIZATION MUST BE GIVEN BY INITIALING BELOW FOR EACH NON-PRESCRIPTION ITEM USED.

TOPICAL OINTMENT OR CREAM (NEOSPORIN)	INITIAL
DIAPER CREAM	INITIAL
SUNSCREEN	
BUG REPELLANT	INITIAL
TEETHING GEL	INITIAL
VASELINE	INITIAL
POWDER	INITIAL
BABY WASH AND/OR SHAMPOO	INITIAL

BY INITIALIZING ABOVE YOU AUTHORIZE LITTLE LEARNER STAFF TO APPLY THE FOLLOWING NON-PRESCRIPTION OINTMENTS AND/OR CREAMS TO THE ABOVE MENTIONED CHILD, AS NEEDED. I UNDERSTAND THAT THESE PRODUCTS WILL ONLY BE APPLIED ACCORDING TO LABELED DIRECTIONS. ANY DEVIATIONS FROM LABELED DIRECTIONS WILL REQUIRE A TREATING PHYSICIANS' WRITTEN AUTHORIZATION. FOR CHILDREN UNDER TWO YEARS, PLEASE INSURE THEIR AGE IS REPRESENTED ON THE LABEL OR A TREATING PHYSICIAN'S WRITTEN AUTHORIZATION WILL BE REQUIRED.

_____ _____

PARENT'S SIGNATURE DATE

PARENT
RECEIPT OF INFORMATION:

☐ Information to Parents Document

☐ Policy on the Release of Children

☐ Policy on Methods of Parental Notification
(Applicable only if a method other than a phone call is used to notify parents of an injury to a child's head, a bite that breaks the skin, a fall from a height, or an injury requiring professional medical attention.)

☐ Policy on Communicable Disease Management

☐ Expulsion Policy

☐ Policy on the Use of Technology and Social Media

I have read and received a copy of the information/policies listed above.

Child(ren)'s Name: _____

Parent/Guardian's Name: _____

_____ _____

Signature **Date**

APPENDIX H

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	Date of Birth
		☐ Male ☐ Female	/ /

Does Child Have Health Insurance?	If Yes, Name of Child's Health Insurance Carrier
☐ Yes ☐ No	

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:		
	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:	☐ 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 signs/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	

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Parent Contract

This contract page highlights the main points of the parent handbook, which will be emailed to you upon registration of your child or children at Little Learners. This contract highlights of our center's important information and terms. This will serve as the parent agreement between Little Learners and the parent/parents, whose has signature is listed below.

1. **Tuition is due in full by the 5th of every month. Failure to pay on time will result in a $25 late fee/per week until paid in full. Failure to pay the tuition in full will result in suspension of your child. Returned checks will be charged $35.**
2. **Our hours of operation are 6:45 am to 6:00 pm.**
3. **If you pick up past 6:00 pm, you will be charged $30/per 15 minutes you are late.**
4. **Classes all start their mornings by 9 am. Please have your children in the building before that so they are not missing out on the beginning of their day.**
5. **Refer to our illness policy that is outlined in our tour folder and parent handbook.**
6. **If you are not on a 5 day schedule, please refer to our policy on missed days.**
7. **There is no credit given for any missed time during enrollment.**
8. **If for any reason a child must be withdrawn, a 4 week WRITTEN notice must be provided to the Director.**

By my signature, I/we acknowledge that I/we have read this contract and received the parent handbook via email and am willing to comply with the rules, regulations, and policies of Little Learners. In the event that my account becomes delinquent for more than 30 days I agree to pay all fees associated in collecting the balance due, including lawyer and court fees incurred by Little Learners.

Child(rens) Name(s): _____

Parent Signature _____ **Date** _____

Parent Signature _____ **Date**_____

Director Signature _____ **Date**_____