



419 North Avenue
Dunellen, NJ 08812

**Registration
Packet**

Welcome to Just Us Children!!!

This registration packet contains the following:

1. Registration Form
2. Registration Form – Child information
3. Permission slip
4. Health Form
5. Physician Information
6. Release Form
7. List of things to bring
8. Emergency Information
9. Hot Lunch Program
10. Waiver of photographs usage
11. Universal Child Health Record Form
12. Acknowledgement of Receipt

If you are missing any of these, please let us know.
Please complete the forms and return to the Office.

Thank You,
Director

Registration Form

Just Us Children

Today's Date: _____ Start Date: _____

Child's Name: _____

Date of Birth: _____

Address: _____

Mother

Father

Name:	Name:
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Address:	Address:
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Phone:	Phone:
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Place of Business:	Place of Business:
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Address:	Address:
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Phone:	Phone:
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Marital Status (circle one): Married Separated Divorced Single

If separated or divorced, with whom does the child live? _____

Number of siblings: _____

Please indicate names and Ages of siblings:

Religion: _____ Church: _____

Circle where applicable: Pre-K-4 year old; Pre-K-3 year old; Toddler; Infant

Program Type: Half day (9-12) Mid Day (9-3) Extended Care (7-6) Other: _____

Please indicate your anticipated "pick-up" time: _____

(3)

Just Us Children

Please sign, date and return this form immediately

1. I give "Just Us Children" my permission for care for my child in the event that I cannot be reached.

Signature of Parent or Guardian: _____

Date: _____

2. I give permission for my child _____ to participate in walking trips within the Center's neighborhood. I understand that these walks DO NOT involve entrance into any facility except "Just Us Children." The route of any trip involves no safety hazards and that such trips are under supervision of authorized personnel of the school.

Signature of Parent or Guardian: _____

Date: _____

(4) Health Form - to be completed by parent

Just Us Children

Child's Name: _____

Date of Birth: _____

Address: _____

Phone #: _____

Medical History Alert

List any conditions applicable to your child - (example: asthma, epilepsy, hypertension, etc)

List any allergies applicable to your child - (examples: environmental, pollen, food allergies, etc)

Special Medications to be given: _____

Date of last attack: _____ Emergency Treatment if
reoccurrence: _____

I understand that if any emergency should occur and the child's parents or family doctor cannot be reached, I authorize "Just Us Children" or its agents to arrange for medical help. I understand that the school can only administer medication prescribed by a physician. Medication must be labeled with the child's name, dosage amount and administration instructions. Parents must complete a medical consent form before the administration of any medication.

Please be sure to notify the school immediately if your child's medical profile should change or if your child contacts a communicable disease. Thank you.

(5) Physician Information

Just Us Children

Physician's Name: _____

Address: _____

Phone: _____

Hospital Affiliation: _____

Parent's Signature: _____

I have received the Policy on the Management of Communicable Diseases:

Parent's Signature: _____

(6) Release Form

At times you may need to arrange for your child to be picked up by someone other than yourselves. For the child's protection, please list the names and telephone numbers of the people you authorize us to release your child to: No child will be released to anyone whose name is not on this list unless the parents notify us in writing. Proper identification will have to be provided by the person who is picking up your child.

Please release my child to the following people:

Name: _____ Phone: _____

Relationship to child: _____

Name: _____ Phone: _____

Relationship to child: _____

Name: _____ Phone: _____

Relationship to child: _____

Please do not release my child to the following people:

Name: _____ Phone: _____

Relationship to child: _____

Name: _____ Phone: _____

Relationship to child: _____

Please Note: If you are divorced or separated and there is a court order stating that your spouse may not be with your child, a copy of that must accompany this form for our records.

JUST US CHILDREN

(8) Emergency Information

Child's Name: _____
Birthday: _____
Home Address: _____
Home Phone: _____
Father's Name: _____
Mother's Name: _____

Contact Information:

Father - Name: _____ Home: _____ Work: _____
Cell: _____ Email: _____

Mother - Name: _____ Home: _____ Work: _____
Cell: _____ Email: _____

Alternate Emergency Contact Person (s)

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____



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Waiver for Use of Photographs of Enrolled Children

We would like to take pictures of the children sometimes when they are doing some special activities. We would like post them in our Parent Bulletin Board as well as post it in our own website (www.justuschildren.com) sometimes.

Please complete this form and return it to the center. Please note that all consents are valid until revoked through express written notice from the consented party.

Thank You,
Director

Name of the Child: _____

Name of the Parent/Guardian: _____

Relationship to child: _____

Photo Usage: (Check one only)

Use my child's picture individually or in a group

Use my child's picture in a group (2+ children) ONLY

Do not use my child's picture

Signature of the Parent: _____

Date: _____



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Dear Parents:

Please make sure you read our policies and become familiar with them. These are posted in the parent board at all times. If you need a copy, you can request for one.

Please take specific note of the following policies:

1. Tuition payment policy
2. Sickness Policy
3. Information to Parents
4. List of Communicable diseases
5. Discipline Policy
6. Expulsion Policy
7. Inclement weather plan
8. Sign-in and Sign-out your child's attendance daily

Please sign below to indicate you have read and understood these school policies.

Student's Name _____

Parent/Guardian's Name _____

Parent/Guardian's Signature _____ Date: _____

UNIVERSAL CHILD HEALTH RECORD - Attach immunizations record & special care plans
 MUST be given to parents to be completed by health care provider & updated annually

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

List of things to bring

1. *Change of Clothes*
2. *Blanket and Sheets*
3. *Food*
4. *Diapers and Wipes*
5. *Box of Tissues*
6. *Hand Towel*
7. *Crayon Box*
8. *Immunization record*
9. *Universal child health record*