

ENROLL NOW

Student's Name:

D.O.B.

At



195 West Market, Newark, NJ 07103

Tel: 862-240-1009

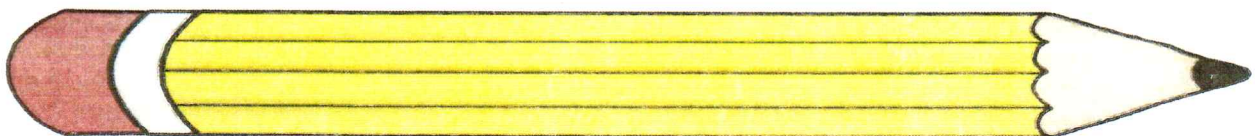
IG @kiddies_kare

FB @kiddieskarellc

Website: www.kiddieskare.com

Email: contact@kiddieskare.com

ENROLLMENT APPLICATION





APPLICATION CHECK OFF LIST

CHILD'S NAME: _____

DOB _____

☐ Enrollment Application

- Parents' and Emergency Contact Information (*parent's email address*)
- Health Information
- Consent for Emergency Treatment
- Permission to Go on Outings
- Photographic / Video-graphic Waiver / Social Media Waiver

☐ Child's Birth Certificate

☐ Child's Immunization Record (*must be up to date*)

☐ Universal Child Health Record (*Must be current. Completely filled out, signed, stamped & dated by physician. Parent complete Section I, sign & date.*) [CH-14, Universal Child Health Record](#)

☐ OOL Information to Parents (*Receipt of Parent's Signature*) – upon enrollment

☐ Parent Handbook (*Receipt of Parent's Signature*) – upon enrollment

☐ OTHER: _____



KIDDIES KARE

195 West Market Street, Newark, New Jersey 07103

Where adventures begin and dreams grow

T: (862)240-1009

IG @kiddies_kare

FB @kiddieskarellc

Maleeha Khan, Director

ENROLLMENT APPLICATION

CHILD'S NAME: _____ BIRTHDATE: _____

PREVIOUS CENTER/SCHOOL ATTENDED: _____

HOME ADDRESS: _____

LANGUAGE(S) SPOKEN AT HOME: _____

OTHER CHILDREN IN THE FAMILY ENROLLED IN THE CENTER (list names, if applicable): _____

* * * * *

MOTHER/GUARDIAN'S NAME: _____

HOME ADDRESS: _____

CELL #: _____ WORK # _____

HOME #: _____ EMAIL: _____

FATHER/GUARDIAN'S NAME: _____

HOME ADDRESS: _____

CELL #: _____ WORK # _____

HOME #: _____ EMAIL: _____

SIGNATURE OF PARENT/GUARDIAN

DATE

FOR OFFICE USE ONLY	
DATE SUBMITTED	
REVIEWED BY	
ENROLLMENT DATE	

CLASSROOM EMERGENCY FORM

CHILD'S NAME: _____ BIRTHDATE: _____

PARENT/GUARDIAN'S NAME: _____

HOME ADDRESS: _____

E-mail: _____

HOME: _____ CELL: _____

WORK: _____ OTHER: _____

Custody Arrangements *(if applicable)*

Are there custody arrangements pertaining to legal right of access to your child? ☐ YES ☐ NO

If YES, please provide a copy of the appropriate legal documentation (e.g., court orders).

Name(s) of custodial parent(s): _____

IN THE EVENT OF AN EMERGENCY, IF A PARENT CANNOT BE REACHED, THE FOLLOWING INDIVIDUALS MAY BE CONTACTED. PLEASE LIST IN ORDER OF PREFERENCE.

NAME: _____ RELATIONSHIP TO CHILD: _____

ADDRESS: _____ ☐ AUTHORIZED TO PICK-UP CHILD

PHONE NUMBERS: _____ PHONE NUMBERS: _____

NAME: _____ RELATIONSHIP TO CHILD: _____

ADDRESS: _____ ☐ AUTHORIZED TO PICK-UP CHILD

PHONE NUMBERS: _____ PHONE NUMBERS: _____

PICK-UP AUTHORIZATION:

I, _____, (PARENT/GUARDIAN) GIVE THE FOLLOWING ADDITIONAL INDIVIDUALS PERMISSION TO PICK UP MY CHILD. (Photo ID will be required to confirm identify before the child will be released.) PLEASE LIST 3 PEOPLE OTHER THAN YOURSELF.

NAME	RELATIONSHIP TO CHILD	PHONE NUMBERS (H, C, W)
		()
		()
		()

SIGNATURE OF PARENT/GUADIAN

DATE

HEALTH INFORMATION

If your child has had any history of communicable diseases (e.g., chicken pox, measles), please list them below (see Quick Reference of communicable diseases from NJ Department of Health):

Child's Healthcare Provider:

Dr.'s Name: _____ Tel#: _____

Does your child have any medical need(s) that requires additional support:

Asthma ☐ YES ☐ NO Food Allergy ☐ YES ☐ NO Seizure ☐ YES ☐ NO Other _____

If yes, an individualized plan for children with medical needs must be completed, signed, dated and stamped by their pediatrician and submitted prior to the child's first day of school.

For Food Allergy, please provide details, including what your child is allergic to, symptoms of a reaction and treatment required:

Have your child ever had?

Heart disease ☐ YES ☐ NO ☐ Onset

Fainting ☐ YES ☐ NO ☐ Onset

Kidney disease ☐ YES ☐ NO ☐ Onset

Sickle Cell ☐ YES ☐ NO ☐ Onset

Lead Poisoning ☐ YES ☐ NO ☐ Onset

Asthma ☐ YES ☐ NO ☐ Onset

Lead Poisoning ☐ YES ☐ NO ☐ Onset

Ear infections ☐ YES ☐ NO ☐ Onset

Lung disease ☐ YES ☐ NO ☐ Onset

Diabetes ☐ YES ☐ NO ☐ Onset

Chickenpox ☐ YES ☐ NO ☐ Onset

Does your child use pull-ups? ☐ YES ☐ NO

If no, my child:

☐ Uses the bathroom independently

☐ Requires some assistance

☐ Requires full support

Please provide relevant details:

What medication(s) does your child take?

Medication	Dosage	Frequency and time of day taken

Parent

Are you concerned about your child's physical development? ☐ YES ☐ NO

Explain _____

Are you concerned about your child's mental or emotional development? ☐ YES ☐ NO

Explain _____

Are you concerned about your child's attention span? ☐ YES ☐ NO

Explain _____

AUTHORIZATION FOR NON-PRESCRIPTION SKIN PRODUCTS

Child's Name: _____ Date of Birth: _____

The following non-prescription items may be applied to my child in accordance with the manufacturer's instructions on the original container (please check off):

☐ Sunscreen ☐ Diaper Creams/Ointment ☐ Lip balm ☐ Hand sanitizers

☐ Insect repellent ☐ Lotions

Kiddies Kare has agreed to provide:	Parent has agreed to provide:

Note: Consider adding the brand name of the non-prescription items for transparency.

Parent's Signature: _____ Date: _____

EMERGENCY CONSENT FORM

In case of an emergency resulting from a serious accident or illness, if prompt medical attention is deemed necessary, 9-1-1 will be called. Parents and/or legal guardians will be contacted immediately after this call has been made. My child, _____, will be taken via ambulance to the nearest medical facility to proceed with any medical treatment. I understand that any medical expenses incurred are my responsibility.

Parent's signature: _____ Date: _____

PERMISSION TO GO ON OUTINGS

I / We give permission for my child, _____, to take part in out-of-school events, such as Nature Walks, Local Neighborhood Visits, etc., during the school year at Kiddies Kare.

Parent's signature: _____ Date: _____

PHOTOGRAPHIC / VIDEO-GRAPHIC WAIVER / SOCIAL MEDIA WAIVER

I / We authorize my child, _____, to have their picture taken and/or have a video made for the use of Kiddies Kare solely within the school premises.

Parent's signature: _____ Date: _____

REPORT CARD PERMISSION FORM

Due to the "Freedom of Information Act", Kiddies Kare is required to seek written permission to complete a Report Card for your child.

I / We authorize Kiddies Kare to complete a developmental Report Card for my child, _____.

I understand that this report card will be made available to me at a later date.

Additional Information

Please indicate any additional information that is relevant to the care of your child (e.g., prone to colds, ear infections, etc.):

Parent's Name: _____

Parent's Signature: _____

Date: _____

Staff's Name: _____

Staff's Signature: _____

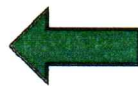
Date: _____

Note: 'Parent' is defined as a person having lawful custody of a child or person who has demonstrated a settled intention to treat a child as a child of his/her family and includes legal guardians.

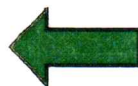
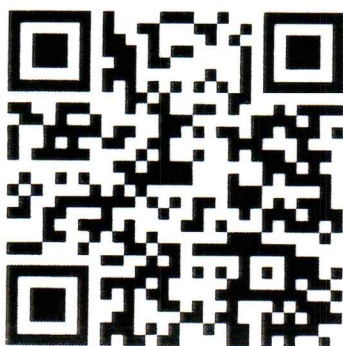
How did you learn about Kiddies Kare?

Newspaper _____ Flyer _____ Referral _____ Signage _____ Website _____

Google _____ Social Media _____ Walk-In _____ Other _____



Follow Us on
Instagram



Follow Us on
Facebook

Thank You

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:	<table border="1"> <tr> <td>Weight (must be taken within 30 days for WIC)</td> <td></td> </tr> <tr> <td>Height (must be taken within 30 days for WIC)</td> <td></td> </tr> <tr> <td>Head Circumference (if <2 Years)</td> <td></td> </tr> <tr> <td>Blood Pressure (if ≥3 Years)</td> <td></td> </tr> </table>	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)	
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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 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)

Signature/Date