



PARTNERS IN LEARNING, INC.

Where Children Learn & Grow Together Since 1999

Therapeutic Learning Center
Turnersville, NJ 08012
856-374-2821

Cherrywood Academy & Private Preschool
Clementon, NJ 08021
856-566-1004

Country Acres Private Preschool
Williamstown, NJ 08094
856-881-0400

Partners in Learning Private Preschool
Northfield, NJ 08225
609-377-8337

Student Information Form

_____ SY	Center: _____	Date of Enrollment: _____ Class: _____
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C H I L D	Name of Child	
	Date of Birth	
	Home Address	

G U A R D I A N S	Parent		Parent	
	Name		Name	
	Relationship		Relationship	
	Home Phone		Home Phone	
	Cell Phone		Cell Phone	
	Home Address		Home Address	
	Email Address		Email Address	

W O R K I N F O	Name of Parent		Name of Parent	
	Name of Business		Name of Business	
	Business Telephone		Business Telephone	
	Business Address		Business Address	
	Occupation		Occupation	

E M E R G E N C Y	<p><i>During school hours</i>, if the school needs to close early or your child needs to be picked up due to illness, please put down the following contact numbers for yourself or an authorized caregiver we would need to call in order of importance.</p> <p>Please note: People on the list will need to provide a Photo ID at time of pick up and must be 18 years of age or older.</p>			
	Name of Contact #1		Name of Contact #2	
	Telephone		Telephone	
	Relationship		Relationship	
	Address		Address	

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

C U S T O D Y	Name of Person <u>UNAUTHORIZED</u> to pick up the Child: _____
	If a non-custodial parent is not included among those persons authorized by the custodial parent to pick up the child, please explain below and attach a copy of appropriate court orders.

E R C A R E	I have completed the medical emergency permission form, which authorizes Partners in Learning, Inc. to seek emergency medical care for my child, _____ as deemed necessary by the Director or the director's designee.
	Parent Signature: _____ Date: _____

W A L K S	___ I give my permission for my child, _____ to participate in walking trips within the center's neighborhood.
	___ I do not give my permission for my child, _____ to participate in walking trips within the center's neighborhood.
	Parent Signature: _____ Date: _____

P O L I C I E S	I attest that all of the information on this application is accurate and that I have received the following information for my home records:
	1. Release of Children <input type="checkbox"/> Yes <input type="checkbox"/> No
	2. Emergency Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
	3. Information to Parents <input type="checkbox"/> Yes <input type="checkbox"/> No
	4. Discipline Policy <input type="checkbox"/> Yes <input type="checkbox"/> No
	5. Communicable Diseases <input type="checkbox"/> Yes <input type="checkbox"/> No
Parent Signature: _____ Date: _____	

A D D I T I O N A L I N F O R M A T I O N	What are your child's previous school experiences? _____
	Does your child have regular playmates? _____
	Does your child suck his thumb or use a pacifier? _____
	Is toilet training complete? _____ Was training easy/short, long/difficult or intermittent? _____
	Does your child nap? _____ How long? _____ Are there any sleep problems? _____
	Are there any restrictions in food or drink? _____
	Favorite Foods/Snacks _____
	Special Interests _____
	Does your child have any specific fears? _____
	Has your child had any traumatic experiences? _____
Is your child generally: ___ Cooperative; ___ Shy; ___ Competitive; ___ Aggressive ___ Sensitive; ___ Angry; ___ Happy; ___ Defiant; ___ Whines	

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List other behavior characteristics or special circumstances that will help us understand your child:

Please describe how you would like Partners in Learning, Inc. to help your child:

Parent Signature: _____

Date: _____



PARTNERS IN LEARNING, INC.

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I have read the Parent Handbook online and know at any time I can see it on the website www.partnersinlearningnj.org or request a print out. I understand the policies in the Parent Handbook including but not limited to:

Please check off:

- Screening and Referral Policy (added 8/6/18)
- Environmental Rating Scale Policy (added 8/6/18)
- Home Language Policy
- Information to Parents Disclosure
- Reporting Child Abuse Policy
- Hot Lines for Domestic Abuse (added 8/20/20)
- Student Requirements Letter
- Health, Nutrition, and Safety Policies and Procedures
- Management of Communicable Diseases
- Medication Administration
- Life Sustaining Equipment Policy
- Parent Notification/Tadpoles
- Television, Computer and Video Equipment Usage in Center
- Policy on Television/Electronic Viewing at Home
- Policy on Use of Technology & Social Media
- Discipline & Positive Guidance Policy (rev 8/6/18)
- Discontinuation of Enrollment Policy (rev 8/5/19)
- Policy on Release of Children
- Easing Separation Anxiety (added 8/6/18)
- Drop Off and Pick Up Policy
- Authorized and Unauthorized Pick-Ups
- Parental Custody Agreement/Order (added 8/6/18)
- Emergency Lockdown Procedure
- Emergency Procedure Plan
- Emergency Procedure Requirements
- Video Camera/Surveillance on School Grounds @CWA
- Daycare Sign-Up Policy
- Daycare Cancellation Policy
- NJ Car Seat Law

Child's Name: _____

Both Parents/Guardians are required to read the handbook and sign this form

Parent's Name: _____	Parent's Name: _____
Relationship: _____	Relationship: _____
Signature: _____	Signature: _____
Date: _____	Date: _____



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Dear Parents/Guardians,

Partners in Learning is a non-profit organization and applies for grants. In many grant applications, funders will ask for specific demographic information to be eligible for funding. Please know that this private information we are requesting will be kept confidential and reporting on demographic data globally.

We are asking you to fill out and return this form. This is voluntary and confidential. Names are not needed.

Thank you so much for your help! We will let you know if we receive the grants!

Lori Lorenzetti

Director of Behavior Health:Staff Support Services
Fundraising Coordinator

Per attending child from your household:

- | | | |
|---|--------------------------------|--|
| 1. Gender | 2. Age (Years) | 3. Ethnicity |
| <input type="checkbox"/> Male | <input type="checkbox"/> 0-3 | <input type="checkbox"/> African American |
| <input type="checkbox"/> Female | <input type="checkbox"/> 3-5 | <input type="checkbox"/> Hispanic American |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 5-7 | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Prefer not to answer | <input type="checkbox"/> 7-9 | <input type="checkbox"/> Bi-or multi-racial |
| | <input type="checkbox"/> 9-12 | <input type="checkbox"/> Native American |
| | <input type="checkbox"/> 12-15 | <input type="checkbox"/> Asian American/Pacific Islander |
| | <input type="checkbox"/> 15-17 | <input type="checkbox"/> Other: _____ |
| | | <input type="checkbox"/> Prefer not to answer |

4. Is the child to be enrolled diagnosed with a disability? **YES / NO**

If "yes," please specify the diagnosis _____

5. How many individuals reside in the home? _____

Parent/Guardian Information:

6. What is the total annual household income before taxes?

- | | |
|---|--|
| <input type="checkbox"/> \$0-\$9,999 | <input type="checkbox"/> \$100,000-\$124,999 |
| <input type="checkbox"/> \$10,000-\$24,999 | <input type="checkbox"/> \$125,000-\$149,999 |
| <input type="checkbox"/> \$25,000-\$49,999 | <input type="checkbox"/> \$150,000-\$174,999 |
| <input type="checkbox"/> \$50,000-\$74,999 | <input type="checkbox"/> \$175,000-\$199,999 |
| <input type="checkbox"/> \$75,000-\$99,999 | <input type="checkbox"/> \$200,000 and up |
| <input type="checkbox"/> Prefer not to answer | |



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Authorization Pick-Up List

Please complete this form with the names of individuals that you authorize our school staff to release your child to for transport in the event that you are not able to do so yourself. Any person not on this list can be added by written documentation only. **NO PHONE CALLS WILL BE ACCEPTED.** Written documentation must be signed by the parent and can be done in person or sent via fax to the school. After a written note is completed, those persons will be added to the list.

Please note: People on the list will need to provide a Photo ID at time of pick up and must be 18 years of age or older.

Parent's Name: _____	Parent's Name: _____
Relationship: _____	Relationship: _____
Cell #: _____	Cell #: _____
Work #: _____	Work #: _____

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

Name of Child: _____

Name of Parent _____

Parent Signature: _____ Date: _____



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Photography Permission Form

I, _____ give permission for Partners in Learning, Inc. to photograph and/or video tape my child _____.

I understand that my child's photographs/video will be used in school and for promotional purposes which may include pamphlets, brochures and/or on our website at www.partnersinlearningnj.org.

I, _____ do not give permission Partners in Learning, Inc. to photograph and/or video tape my child _____.

I understand that I may change my decision at any time.

Parent Signature: _____

Witness: _____

Date: _____

Title: _____



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Dear Parents:

We are so happy to have your child attending our program! They will learn so many new and wonderful things.

There are a few mandatory immunization requirements. Per the NJ State Commissioner of Health & Senior Services, every child 12 months through 59 months of age enrolling in or attending a licensed child-care center on or after September 1, shall have received at least **one dose of Pneumococcal Conjugate Vaccine (PCV) on or after their first birthday**. Please check with your doctor if you are not sure of this date. If your child's immunizations do not fall under this new regulation, a new immunization of PCV is required.

If your child is **under** the age of 5 as of Sept. 1, they must also receive at least **one dose of the flu vaccination by December 31**. Prior to December 31, your child may start school if s/he has not had the flu vaccine yet. We will need a current shot record submitted after the Influenza Vaccine has been given. **If your child does not receive the flu vaccine by December 31, your child will not be permitted to return to our center**, per state guidelines, until documentation has been provided that the shot has been given or written explanation for exclusion of the shot has been submitted.

If you enroll your child between January 1 and March 31, your child may not start until the flu vaccination is given and documentation is submitted.

PIL is keeping on record COVID-19 Vaccination cards, so please submit your child's copy if applicable.

Per the State of NJ, children cannot start unless we receive a completed packet which includes all health documents.

If you have any questions, please do not hesitate to call me at 856-374-2821.

Sincerely,

Kelley L. Dinardo

Kelley L. Dinardo

Administrative Coordinator



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Immunization Record Form

ATTACH HERE

All medical forms must be completed in full, signed, dated and stamped by your child's doctor.

As a condition of enrollment in the program, except for any immunizations for which parents are using a religious/medical exemption for, all medical forms, including a current shot record, must be returned to the school before your child's start date.

Your child must have had a physical 1 year prior to today's date to admission to school.

The Universal Child Health Record form must be updated annually.

_____ If your child has a religious or medical exception for immunizations, please check this line **and** submit a letter of exception with your child's Universal Health Record form.

If your child has received the COVID-19 Vaccinations, please include a copy of their card.

_____ **My child has not received the COVID-19 Vaccinations**

Name of Child: _____

Parent Signature: _____

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 <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 <input type="checkbox"/> List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments <input type="checkbox"/> List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity <input type="checkbox"/> List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs <input type="checkbox"/> List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities <input type="checkbox"/> List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements <input type="checkbox"/> List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis <input type="checkbox"/> List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans <input type="checkbox"/> 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 _____					



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Care Plan for Children with Special Health Needs

I have received the Care Plan for Children with Special Health Needs form and have determined that this form

_____ Does apply to my child

_____ Does not apply to my child

Name of Child: _____

Parent Signature: _____

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

	Today's Date
Child's Full Name	Date of Birth
Parent's/Guardian's Name	Telephone No. ()
Primary Health Care Provider	Telephone No. ()
Specialty Provider	Telephone No. ()
Specialty Provider	Telephone No. ()
Diagnosis(es)	
Allergies	

ROUTINE CARE

Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects

List medications given at home:

NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: _____

Classroom Activities: _____

Naptime/Sleeping: _____

Toileting: _____

Outdoor or Field Trips: _____

Transportation: _____

Other: _____

Additional comments: _____

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

SUGGESTED SPECIAL TRAINING FOR STAFF

Health Care Provider Signature

Date

PARENT NOTES (OPTIONAL)

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.

Parent/Guardian Signature

Date

Important: *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*



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Parental Authorization/Permission Slip for Emergency Treatment

PARENT(S) NAME: _____

Parent(s) Address _____

CHILD'S NAME: _____

Age _____

Date of Birth _____

Address _____

MEDICAL INFORMATION:

Existing Medical Problems _____

Allergies _____

Medicine(s) Child is taking _____

Medicine(s) Child is allergic _____

Child's Doctor _____

Name

Telephone

INSURANCE:

Company/HMO _____

Group Number _____

Identification Number _____

Last tetanus shot _____

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 directors 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. There will be an 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 paramedic assistance/transportation. (b) Call another physician (c) Have the child transported to an emergency hospital in the company of a staff member.
5. The center will not be responsible for complications that may occur as a result of false information given at the time of enrollment.

Parent Signature: _____

Date of Signature: _____

Date Permission Terminated: _____

Witness: _____

Date of Signature: _____



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Allergy Questionnaire

Child's Name: _____

What type of allergies does your child have?

What is the severity of reaction if he/she should come in contact with these allergens?

If a food allergy (i.e. peanut), will your child have an allergic reaction if he/she touches the food or just through ingestion?

What actions must be taken if your child has an allergic reaction?

Does your child require an epi-pen / inhaler / medication?

If yes, a doctor's note must be submitted if you require the school to maintain medication on the premises.

Other information you would like the teachers to know:

Parent Signature: _____

Date: _____



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Training of Life Sustaining Equipment

Before administering a health care procedure associated with a child's health condition, such as the use of a blood glucose monitor, nebulizer, or epinephrine pen, the center shall ensure that all staff members who administer the procedure are taught to do so by the child's parent or another appropriately trained person.

_____ Does apply to my child.

To be completed by staff and parent:

I, _____ certify that I have been trained accordingly on the usage and administration of _____ by _____.

_____ Does not apply to my child

Name of Child: _____

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____



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Dear Parents/Guardians:

Please keep the Medication Authorization Form in case medication needs to be disbursed during the school year. This form must be completed by you and your child's doctor and returned to the center before any medication can be disbursed. Additional forms can be found online on our website, partnersinlearningnj.org.

Thank you.



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MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Name of Child _____	Date of Birth _____
Medication/Strength _____	
Dosage to be Given _____	Time to be Given _____
Route of Administration _____	Diagnosis _____
Side Effects _____	
Duration of Order (no longer than duration of school year _____)	

TO BE COMPLETED BY PARENT/GUARDIAN: I hereby give consent for the following:

_____ Center staff may administer the medication to my child according to the physician's directions above.

_____ The Center's Director has my permission to contact the physician should there be any questions or concerns regarding this medication. I understand that this medication must be delivered to school personnel by the parent/guardian and that students are NOT to transport medication unless it is an approved emergency medication. I understand that this medicine must be in the original, labeled container. The medication provided must match the physician's order. I hereby release the Center, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Phone: Home _____ Cell _____ Work _____

Center Director Signature: _____

Date _____