# 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*

| | | |
|---|---|---|
| ***2022 Summer Fun*** | ***Elementary Site Location:***<br>***Alice Costello Elementary School***<br>***301 Haakon Rd, Brooklawn, NJ 08030*** | **Date of Enrollment:_____**<br>**Class: Elementary** |

| | | |
|---|---|---|
| CHILD | Name of Child | |
| | Date of Birth | |
| | Home Address | |

| | | Parent | | Parent |
|---|---|---|---|---|
| GUARDIANS | Name | | Name | |
| | Relationship | | Relationship | |
| | Home Phone | | Home Phone | |
| | Cell Phone | | Cell Phone | |
| | Home Address | | Home Address | |
| | Email Address | | Email Address | |

| | | | | |
|---|---|---|---|---|
| WORK INFO | Name of Parent | | Name of Parent | |
| | Name of Business | | Name of Business | |
| | Business Telephone | | Business Telephone | |
| | Business Address | | Business Address | |
| | Occupation | | Occupation | |

| | | | | |
|---|---|---|---|---|
| EMERGENCY | ***During school hours***, 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. | | | |
| | Name of Contact #1 | | Name of Contact #2 | |
| | Telephone | | Telephone | |
| | Relationship | | Relationship | |
| | Address | | Address | |

| | | |
|---|---|---|
| DOCTOR | Child's Doctor | |
| | Telephone | |
| | Address | |

| | |
|---|---|
| CUSTODY | Name of Person ***UNAUTHORIZED*** to pick up the Child:_____<br><br>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. |

| | |
|---|---|
| ER CARE | 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.<br><br>Parent Signature:_____ Date:_____ |

**WALKS**

___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:_____

**POLICIES**

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 | ☐ Yes | ☐ No |
| 2. Emergency Treatment | ☐ Yes | ☐ No |
| 3. Information to Parents | ☐ Yes | ☐ No |
| 4. Discipline Policy | ☐ Yes | ☐ No |
| 5. Communicable Diseases | ☐ Yes | ☐ No |

Parent Signature:_____ Date:_____

**ADDITIONAL INFORMATION**

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

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

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

Parent Signature:_____ Date:_____

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## Policy Changes per COVID-19 Dept. of Children & Families & PIL Protocols:

These changes will commence upon reopening and remain in place until further notice. We appreciate your full cooperation and understanding as we all adjust to these new protocols and policies designed to increase health and safety at our centers.

Group Size:
Groups of children will not exceed 30 or recommended classroom capacity. Staff will remain consistent per group as much as possible. Groups will not share materials with other groups. Groups will minimize contact within groups as much as possible as well as when transitioning. Outdoor areas and usage times per group will be scheduled to minimize contact.

Arrival Health Screenings:
Arriving children will be screened at the door by an approved center staff member. Arriving child/children will need to be checked for temperature. Children will not be allowed to enter the center if they show temperature exceeding100.4. Staff will also conduct a visual inspection of the child for signs of illness (e.g., flushed cheeks, rapid breathing/difficulty breathing without recent physical activity, fatigue, extreme fussiness, etc.).

Staff will sanitize thermometers between child screenings as well as change gloves per screening.

Additionally, parent/guardian will need to respond to the following questions upon each arrival:
1) Confirm that child does not have a fever, shortness of breath, or cough
2) Was child or household members in close contact with someone with COVID-19?
3) Has anyone in the household had symptoms of respiratory illness?

(*) Children will not be able to enter building if any of the above responses are "Yes" or if they show symptoms of respiratory illness/COVID-19
*Note: staff will be screened in a similar manner before being allowed entrance to the center per shift.*

Signs of illness/return to center criteria:
Children and /or staff who have temperature readings above 100.4 will be required to leave ASAP and seek medical attention. A child and/or staff may not return before being symptom free for 72 hours minimum, without medication. A doctor's note must be provided stating return is medically approved.

As children are waiting for pick up due to elevated temperature, they will be moved to an area of isolation in the center with monitoring by an assigned staff member until parent/guardian arrives. Children with elevated temperatures and/or showing any symptoms of COVID--19 must remain home for 14 days minimum and be symptom free per Dr. note before being allowed to return. Contacting the center upon diagnosis of COVID-19 is highly recommended as soon as possible to help reduce the potential spread of COVID-19.

Additional sanitizing of all areas/materials that were in contact of individuals showing COVID-19 symptoms will be done within 24 hours following potential exposure for safety. Additionally, the Center will seek immediate direction from County Health Department in the event a child or adult on site is diagnosed with COVID-19.

For all other identified symptoms/illness not related to COVID-19 but requiring leaving the center, child and/or staff may not return before being symptom free for 72 hours, minimum without medication. A doctor's note must be provided stating return is medically approved.

Please note, if a COVID-19 test is administered, it is very helpful to notify us and report results. We are required to report positive cases to the Department of Health upon notification.

Wearing of Masks:
Children will not be required to wear a mask unless a quarantine returns to the state. Children over 2 years old will be encouraged to wear masks at times when social distancing is not possible, unless they have a documented medical condition that makes wearing a mask unsafe. No child will be forced to wear a mask. No masks will be worn during rest time, or while eating.
**All staff are permitted to wear approved face coverings (e.g., masks) but it is not mandatory.*

Naps
Children must bring in own napping blankets, etc. and take home **at the end of each week** for washing. During rest, children will lay head to foot and 6 ft. apart while napping whenever possible. Children **will not** wear masks during rest time.

Lunch/Snacks:
Children must bring in own lunch and snacks daily. No heat ups are allowed at this time to reduce common use of microwaves. Lunches needing to remain cool must come with own ice pack. Children will be separated with table partitions during lunch and snack times. Please speak with your center director regarding any dietary or food concerns.

Materials from home (all must be clearly labeled & be cubby size):
Children must supply the following daily:
- 2 full changes of clothing (weather appropriate) including socks and shoes
- personal hand sanitizer
- lunch/snack box with beverages (all containers/utensils within are to be clearly marked)
- Bedding supplies (can include 1 soft toy/"Lovey" for sleeping)
- bag or container to carry bedding home weekly (must fit in cubby)
- personal changing supplies (if needed own wipes, diapers/pull-ups)

Visitors:
No outside visitors, vendors, entertainers, or those not scheduled to work at the center will be permitted to enter. This includes parents/guardians and family members. Exceptions are for therapists, Emergency personnel or those sent by NJ Dept. of Children and Families Office of Licensing.

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Please acknowledge that you have reviewed the Partners in Learning new COVID Policies.

Name of Child:_____

Name of Parent_____

Parent Signature:_____ Date:_____

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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, Inc. is in the process of applying for several grants. The grant applications call for the following standard demographic questions for each attending child: Age, Gender and Ethnicity.

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
Associate Director of Inclusion
Fundraising Coordinator

## Per attending child from your household:

1. Gender
____Male
____Female

2. Birth Date
_____

3. Ethnicity
____African-American
____Hispanic – American
____Caucasian
____Other
____Native-American
____Asian-American/Pacific Islander
____Bi-or Multi-racial

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# Authorization Pick-Up List
# 2022 Summer Fun

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.**

| | | |
|---|---|---|
| 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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## 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 by your child's first day of class.

Your child must have had a physical 1 year prior 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.

Name of Child:_____

Parent Signature:_____

*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 ☐ 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: | 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<br>☐ Date Next Immunization Due: _____ |
|---|---|

### MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>☐ List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>☐ List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>☐ List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>☐ List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>☐ List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>☐ List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>☐ List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>☐ List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ 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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# *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.<br>**(  )** |
| Primary Health Care Provider | Telephone No.<br>**(  )** |
| Specialty Provider | Telephone No.<br>**(  )** |
| Specialty Provider | Telephone No.<br>**(  )** |
| 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:

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

_____ The school 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 physicians order. I hereby release the School, 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 _____

School Director Signature: _____ Date _____