Jewish Community Center
of Middlesex County
"Community Is Our Middle Name"
1775 OAK TREE ROAD, EDISON, NJ 08820
PHONE (732) 494-3232 x.3625
FAX (732) 548-2850

JCC Parents:

In keeping with New Jersey's Child Care 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 provisions from the Manual of Requirements for Child Care Centers.

In keeping with the requirements of the State of New Jersey, we are informing you that medication will not be administered by the teachers or anyone else on the JCC staff.

Please read and retain the "Information to Parents Document" and return the rest of the pages as soon as possible.

Medical forms must be submitted prior to our first day of school in September. No child will be allowed to attend our classes until all his/her forms have been returned in a timely fashion.

Please feel free to contact us with any questions at (732) 494-3232. Thank you for your cooperation.

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Information to Parents Document

A. The center shall give to the parent(s) of every enrolled child and to every staff member a written Information to Parents document designated by the Bureau of Licensing and indicating that the center is required to:
   1) Be licensed by the Bureau of Licensing, Division of Youth and Family Services;
   2) Comply with all applicable provisions of the Manual of Requirements for Child Care Centers;
   3) Post its license in a prominent location within the center.
   4) Retain a current copy of the manual and make it available for parents' review;
   5) Advise parents how they may secure a copy of the Manual of Requirements for Child Care Centers for a nominal fee, by writing to the Bureau of Licensing, Division of Youth & Family Services, P.O. Box 717, Trenton, New Jersey 08625-0717 or by calling 609-292-9220;
   6) Make available to parents, upon request, the Bureau's Life/Safety and Program Inspection/Violation and Complaint Investigation Summary report(s) on the center, as well as any letters of enforcement or other actions taken against the center during the center's current licensing period;
   7) Post a listing or diagram of those rooms and/or areas that have been approved by the Bureau for children's use;
   8) Comply with the inspection/investigation functions of the Division, including the interviewing of staff members and children;
   9) Afford parents the opportunity and time to review and discuss with the center director any questions or concerns about the policies and procedures of the center or whether the center is in compliance with all applicable provisions of the manual;
   10) Advise parents that if they believe or suspect that the center is violating any requirement of the manual, they may report such alleged violations to the center sponsor or director or to the Bureau;
   11) Afford parents of enrolled children an opportunity to participate in the center's operation and activities;
   12) Afford parents of enrolled children the opportunity to visit the center at any time during the center's hours of operation to observe its operation and program activities without having to secure prior approval;
   13) Provide parents with advance notice of any field trip, outing or special event involving the transportation of children away from the center, and, for each event, secure the written consent of the parent(s) before taking a child on such a field trip, outing or special event;
   14) Post a copy of the center's written statement of policy on the disciplining of children by staff members in a prominent location within the center, and make a copy of it available to parents upon request;
   15) Indicate through this document that any person who has reasonable cause to believe that a child has been or is being subjected to any form of hitting, corporal punishment, abusive language, ridicule, or harsh, humiliating or frightening treatment, or any other kind of child abuse, neglect or exploitation by any adult, is required by State law to report the concern immediately to the Division of Youth & Family Services Office of Child Abuse Control, toll-free at 1-800-792-8610;
   16) Advise parents and staff members how they may secure information about child abuse and/or neglect from the Community Education Office, Division of Youth & Family Services, P.O. Box 717, Trenton, New Jersey, 08625;
   17) Inform parents of the center's policy on the release of children, as follows:
      a) The center shall maintain on file and follow a written policy on the release of children, which shall include:
         1. The provision that each child may be released only to the child's parent(s) or person(s) authorized by the parent(s), as specified in N.J.A.C.10:122-6.8(a)2, to take the child from the center and to assume responsibility for the child in an emergency if the parent(s) cannot be reached;
         2. The provision that, if a particular non-custodial parent has been denied access, or granted limited access, to the child by a court order, the center shall secure documentation to this effect, maintain a copy on file, and comply with the terms of the court order;
         3. Written procedures to be followed by staff member(s) if the parent(s) or person(s) authorized by the parent(s) as specified in (a)1. above, fails to pick up a child at the time of the center's daily closing. The procedures shall require that:
            i. The child is supervised at all times;
            ii. Staff members attempt to contact the parent(s) or person(s) authorized by the parents; and

iii. An hour or more after closing time, and provided that other arrangements for releasing the child to his or her parent(s) or authorized person(s) have failed and the staff member(s) cannot continue to supervise the child at the center, the staff member shall call the Division's 24-hour Child Abuse Hotline to seek assistance in caring for the child until the parent(s) or person(s) authorized by the child's parent(s) is able to pick up the child; and

4. Written procedures to be followed by a staff member(s) if the parent(s) or person(s) authorized by the parent(s), as specified in (a)1. above, appear to be physically and/or emotionally impaired to the extent that, in the judgment of the director and/or staff member, the child would be placed at risk of harm if released to such an individual. The procedures shall require that:
   i. The child shall not be released to such an impaired individual;
   ii. Staff members attempt to contact the child's other parent or an alternative person(s) authorized by the parent(s); and
   iii. If the center in unable to make alternative arrangements, as noted in (a)3ii. above, a staff member shall call the Division's 24-hour Child Abuse Hotline to seek assistance in caring for the child;

18) Inform parents of the center's policy on dispensing medication; in keeping with the requirements of the State of New Jersey, medication will not be administered by the teachers or anyone else on the staff; and

19) Provide parents with a copy of the center's policy on management of communicable diseases, as follows:
   a) A center that seeks to serve any children who have any of the illnesses, symptoms of illness or diseases specified in (c) and (d) below, shall meet all applicable provisions of this subchapter and all provisions of N.J.A.C. 10:122-8.
   b) Under no circumstances shall any center serve or admit any child who has any illness, symptom of illness or disease that a physician has determined require the child to be:
      1. Confined to home under a physician's immediate care; or
      2. Admitted to a hospital for medical care and treatment.
   c) The following provisions relate to illness and/or symptoms of illness:
      1. A center serving well children shall not permit a child who has any of the illnesses or symptoms of illness specified in (c)1.i. through xv. below to be admitted to the center on a given day unless medical diagnosis from a licensed physician, which has been communicated to the center in writing, or verbally with a written follow-up, indicates that the child poses no serious health risk to himself or herself or to other children. Such illnesses or symptoms of illness shall include, but not be limited to, any of the following:
         i. Severe pain or discomfort;
         ii. Acute diarrhea, characterized as twice the child's usual frequency of bowel movements with a change to a looser consistency within a period of 24 hours;
         iii. Two or more episodes of acute vomiting with a period of 24 hours;
         iv. Elevated oral temperature of 101.5 degrees Fahrenheit or over or axillary temperature of 100.5 degrees Fahrenheit or over in conjunction with behavior changes;
         v. Sore throat or severe coughing;
         vi. Yellow eyes or jaundiced skin;
         vii. Red eyes with discharge;
         viii. Infected, untreated skin patches;
         ix. Difficult rapid breathing;
         x. Skin rashes, excluding diaper rash, lasting more than one day;
         xi. Weeping or bleeding skin lesions that have not been treated by a physician or nurse;
         xii. Swollen joints;
         xiii. Visibly enlarged lymph nodes;
         xiv. Stiff neck; or
         xv. Blood in urine.
      2. Once the child is symptom-free, or a licensed physician indicates that the child poses no serious health risk to himself or herself or to other children, the child may return to the center.
      3. If a child who has already been admitted to the center manifests any of the illnesses or symptoms of illness specified in (c)1. above, the center shall remove the child from the group of well children to a separate room or area, as specified in N.J.A.C. 10:122-5.2(p)4, until:
         i. He or she can be taken from the center; or
         ii. The director or his or her designee has communicated verbally with a licensed physician, who indicates that the child poses no serious health risk to himself or herself or to other children, at which time the child may return to the group.
   d) The following provisions relate to excludable communicable diseases

1. The center shall not permit a child or staff member with an excludable communicable disease, as specified in the table below, to be admitted to or remain at the center, until;
   i. A note from the child's or staff member's licensed physician states that the child or staff member, respectively, as been diagnosed and presents no risk to himself, herself, or to others;
   ii. The center has contacted the Communicable Disease Program in the State Department of Health and Senior Services, or the local health department pediatric health consultant, and is told the child or staff member poses no health risk to others;
   iii. If the child or staff member has chicken pox, the center obtains a note from the parent or staff member stating either that at least six days have elapsed since the onset of the rash, or that all sores have dried and crusted.

TABLE OF EXCLUDABLE COMMUNICABLE DISEASES

Respiratory Illnesses
Chicken Pox
German Measles*
Hemophilus Influenzae*
Measles*
Meningococcus*
Mumps*
Strep Throat
Tuberculosis*
Whooping Cough*

Gastro-Intestinal Illnesses
Giardia Lamblia*
Hepatitis A*
Salmonella*
Shigella*

Contact Illnesses
Impetigo
Lice
Scabies
*Reportable diseases, as required by N.J.A.C. 10:122-7.10(a).

B. The center shall provide the Information to Parents document to each child's parent(s) upon enrollment, and to every person upon becoming a staff member.

1. The center shall secure and maintain on file a record of each parent's and staff member's signature attesting to receipt of the document. 2. The center shall maintain on file a copy of the Information to Parents document.

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I have read the Information to Parents Document provided by the New Jersey Division of Youth and Family Services.

_____	_____	_____
Parent's Signature	Child's Name	Date

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Permission Release Form

- I have read and understand all of the information as stated in this information packet.
- I hereby give permission for the JCC of Middlesex County to photograph or video my child(ren) and to use these pictures for brochure or promotional purposes.
- The JCC children's programs are not responsible for clothing or personal property lost on its premises or while on school related trips.
- I hereby give permission for my child to participate in JCC programs and activities, including trips away from the JCC of Middlesex County.
- The JCC does not assume responsibility for injury. In the event that I or my physician cannot be contacted in an emergency, I hereby grant permission to contact the nearest medical facility or physician to give emergency treatment at no cost to the JCC.

_____ _____
Signature of Parent or Guardian Date

Child Information Form

Child's Name (full name)_____
Name child goes by_____
Date of Birth_____Sex_____
Child's Home Address_____
Child's Home Telephone Number_____
Please list languages understood by child_____
_____
Please list languages spoken by child_____
_____

Parent or Guardian Information

Mother's Name_____
Mother's Address_____
Mother's occupation and place of employment_____
_____
Mother's work number_____Cell phone number_____
Father's Name_____
Father's Address_____
Father's occupation and place of employment_____
Father's work number_____Cell phone number_____
List all languages understood by mother_____
List all languages spoken by mother_____
List all languages understood by father_____
List all languages spoken by father_____

Family Information

Brothers and/or sisters (please indicate ages and whether they live with the child)_____
_____
Please list all other persons living with the child and their relationship (if any) to the child_____
_____
Please list any other persons responsible for the child's care(if any) and their relationship to the child_____
_____
List all languages understood by the caregiver_____
List all languages spoken by the caregiver_____

Personal History

Is child right-handed or left-handed?_____

Has child had a previous group or preschool experience?_____
If so, where and when?_____
_____

Does child have any allergies?_____
_____

Are there any medical problems of which we should be aware? Explain.
_____
_____

Does your child use the restroom independently?_____

Does your child have any fears?_____

Are there any special food or eating instructions?
_____
_____

Does your child have a history of physical impairment?
_____Visual Impairment?____Speech problems? _____Hearing Impairment?

Any additional information such as discipline, child's communication, comforting, etc.?_____
_____
_____
_____
_____

Please sign and return.

_____	_____	_____
Parent's Name	Child's Name	Date

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Emergency Release Form

Please fill out the following information that is pertinent to giving your child immediate emergency care.
Return this form prior to your child's first day at the JCC.

Teacher's Name: _____
Child's Name: _____
Mother's Name: _____ Home #:_____
Mother's Work #:_____ Cell #:_____
Father's Name:_____
Father's Work #:_____ Cell #'s:_____

Name of person to be contacted in case of an emergency:
(Please list only those people who are available and authorized to make a decision as to who or what immediate emergency care can be given)

1) Name:_____ Relationship:_____
   Home #:_____ Work #:_____
   Cell #:_____
2) Name:_____ Relationship:_____
   Home #:_____ Work #:_____
   Cell #:_____
3) Name: _____ Relationship:_____
   Home #:_____ Work #:_____
   Cell #:_____

Does your child have any food allergies? Yes ☐ No ☐
If yes, please list._____

Are there any medical problems or medications taken, of which we should be aware? Yes ☐ No ☐
If yes, please explain. _____

6/18/09

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Notary Form

I hereby give my consent for JFK Hospital to administer emergency care to my child(ren):

Name Of Child(ren)_____

_____

_____

Parent's Name *(please print)* _____

Parent's Signature_____
Date_____

Notary Public Signature & Seal_____

Child's Photo

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Please have your child's physician fill out this immunization record and return immediately.

The physician must give specific dates for each immunization, for example 5/3/05 (the month, the day and the year must be stated). Then have your physician stamp or sign the form for our records.

New Jersey Department of Health and Senior Services
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)	DATE OF BIRTH (Mo./Day/Yr.)	SEX ☐M ☐F
NAME OF PARENT/GUARDIAN	TELEPHONE NUMBER(S)	
ADDRESS		
ADDRESS	IMMUNIZAITON REGISTRY NUMBER	

VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)					
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB) [2]					
HEPATITIS B [3]					
VARICELLA [4]					
PNEUMOCOCCAL CONJUGATE [2]					
INFLUENZA [6]					
OTHER, SPECIFY:					

LEAD SCREENING *(Not Required)*	
TEST DATE	RESULT

[5] Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	DATE:	TITER:
Varicella	DATE:	TITER:
Measles	DATE:	TITER:
Mumps	DATE:	TITER:
Rubella	DATE:	TITER:

☐Provisional Admission Attached - Date Granted: _____ ☐Medical Exemption Attached ☐Religious Exemption Attached

(1) REQUIRES MEDICAL EXEMPTION.
(2) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)
(3) REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04.
(4) REQUIRED FOR DAY/CHILD CARE ENROLLEES (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04.
(5) MMR single antigen receipt requires MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
(6) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months – 59 Months)

IMM-8
MAR 08

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Physician

Child's Doctor_____
Doctor's Address_____ Phone #_____

Results of Examination

Please indicate any condition which might affect this child's performance at school or any condition of which the staff should be aware: (medical treatments, special requirements as to diet, allergies, avoidance of certain activities and other care)._____
_____

Recommendations
_____
_____
_____

The above-named child has been given a routine medical examination and has been found to be free of infectious or contagious diseases.

Signature of Physician_____
Address_____
Telephone Number_____
Date_____

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 ☐ 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 ☐ 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)	Health Care Provider Stamp:
Signature/Date	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions -** Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications -** List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity -** Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities -** Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans -** May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.