Sari Isdaner EARLY CHILDHOOD CENTER at the Katz JCC

Student Information

2026-2027 School Year

Child Name: _____ DOB: _____

Program (select):

☐ Infant (6 weeks-12 months) ☐ Toddler (13-24 months) ☐ Preschool (2-5 years)

Contact Information:

Parent/Guardian 1 Name: _____

Phone: _____ Email: _____

Parent/Guardian 2 Name: _____

Phone: _____ Email: _____

Emergency Contacts: (other than parent/guardian)

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Authorized Pick-Ups:

The following individuals are authorized to pick up my child from the Katz JCC Sari Isdaner Early Childhood Center. **I authorize the release of my child to their care.**

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

If, due to unforeseen circumstances, or an emergency, it is necessary for someone else to pick up your child, an email or phone call from the parent is necessary. Photo identification will be requested before release. Please provide any legal documents that restrict pick up to Early Childhood Center Administration.

Emergency Permissions

I, _____, give permission for my child _____

(parent/guardian) (child)

to be treated for illness or injury as needed at the Sari Isdaner Early Childhood Center at the Katz JCC. I give permission to transport my child to the nearest emergency room when appropriate.

Parent/Guardian Signature: _____ Date: _____

Authorization for Over-the-Counter Skin Products

This form must be completed by the parent/guardian to authorize the use of:

- Sunscreen
- Insect Repellent
- Diaper Ointment/Cream

The Sari Isdaner Early Childhood Center has my permission to apply the over the counter (OTC) skin product listed below to my child:

Product Name: _____

All OTC products must be in the original container, unexpired, and labeled with the child's name. Sunscreen must have a minimum sun protection factor (SPF) of 15.

This authorization is effective for the duration of the 2026 summer session.

Parent/Guardian Signature: _____ Date: _____

Authorization for Over-the-Counter First Aid Products

This form must be completed by the parent/guardian to authorize the ECC Nurse's use of:

- Antibiotic Ointment/Cream (Neosporin)
- Antiseptic Spray with Lidocaine (Bactine)

The Sari Isdaner Early Childhood Center Nurse has my permission to apply the over the counter (OTC) first aid products listed above to my child.

Known Adverse Reactions (if any):

_____

This authorization is effective for the duration of the 2026 summer session.

Parent/Guardian Signature: _____ Date: _____

Allergy and Medication Information

If your child has a medically diagnosed allergy, food allergy, medication need, or other medical condition, please send the following required paperwork to the school:

- Physician-completed and signed medical action plan (Allergy/Anaphylaxis Plan, Asthma Treatment Plan, or other condition-specific plan)
- Parent/Guardian signature on all required forms
- Medication Authorization Form (if medication will be kept or administered at school)
- Non-expired medication labeled by the pharmacy, if applicable

If your child no longer has the condition or no longer needs emergency medication, please provide a physician's note so their health record can be updated.

Please feel free to use the attached emergency care plans related to food allergies/anaphylaxis and/or asthma (located at the end of this document).

Walking Permission

N.J.A.C. 3A:52 requires parental permission for trips around the Katz JCC building, including but not limited to: walking to the gym and fitness areas, for creative classes, indoor and outdoor pools for swimming, playground areas, the Social Hall, and other designated areas for participation in a variety of programs.

N.J.A.C. 3A:52 requires us to specifically notify you that we have a swimming pool on the premises and that children may be participating in activities near water two or more feet in depth.

I give permission for my child to walk on the grounds of the Katz JCC.

I understand that my child will participate in activities throughout the Katz JCC building, and that my child will also participate in activities located near water two or more feet in depth. **Safety Permitting**

Parent/Guardian Signature: _____ Date: _____

Photo Permission

☐ YES, I give permission for my child's photo and name to be used in social media, marketing materials, and other public facing content.

☐ NO, I do not give permission for my child's photo and name to be used in any marketing materials, social media, or other public facing content. I understand that my child will be excluded from some photos to the best of the school's ability, and that reasonable efforts will be made to ensure they are not included in any media.

Parent/Guardian Signature: _____ Date: _____

Acknowledgment of Inclusive Support Services

Our preschool is committed to providing a meaningful, inclusive learning environment for all children. As part of this commitment, our program utilizes a collaborative team that may include Board Certified Behavior Analysts (BCBAs), Occupational Therapists (OTs), Registered Behavior Technicians (RBTs), and other qualified professionals. These professionals provide proactive classroom consultation, participate in classroom activities, model strategies, and offer recommendations that support all children and enhance the overall classroom environment. As a regular part of our inclusive program, these professionals may be present in and out of classrooms throughout the school year.

If, at any time, individualized concerns are identified that may warrant further screening, discussion, or additional support for your child, you will be contacted directly to discuss those concerns, any recommendations, and appropriate next steps.

☐ I acknowledge that I have read and understand that this preschool provides classroom-based consultation and support from qualified professionals as part of its inclusive educational program. I understand that these professionals may be present in my child's classroom, participating in classroom activities and collaborating with staff to support the learning environment. I also understand that I will be contacted directly should any individualized concerns regarding my child arise.

Parent/Guardian Signature: _____ Date: _____

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 ☐ 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, Vaccine Preventable Diseases Program at 609-826-4860. 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.nj.gov/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.