

# Joyful Noise Nursery School & Daycare - SUMMER ENROLLMENT APPLICATION

Name Of Child:	Birthdate:	Enrollment Date:
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<b>PARENT/GUARDIAN INFORMATION</b>	<i>Please check the box (<input type="checkbox"/>) to indicate the primary residence of the child listed above.</i>			
	<input type="checkbox"/> PARENT/GUARDIAN # 1		<input type="checkbox"/> PARENT/GUARDIAN # 2	
	Name:		Name:	
	Relationship:		Relationship:	
	Cell Phone:		Cell Phone:	
	Home Phone:		Home Phone:	
	Home Address:		Home Address:	
	Employer Name:		Employer Name:	
	Employer Phone:		Employer Phone:	
	Employer Address:		Employer Address:	
E-Mail Address:		E-Mail Address:		

<b>EMERGENCY CONTACTS</b>	Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.					
	Contact Name #1:		Contact Name #2:		Contact Name #3:	
	Relationship:		Relationship:		Relationship:	
	Cell Phone:		Cell Phone:		Cell Phone:	
	Home Phone:		Home Phone:		Home Phone:	
	Employer Phone:		Employer Phone:		Employer Phone:	

<b>CUSTODY</b>	Name of person PROHIBITED from picking up your child:	
	If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to this effect for the center to maintain a copy on file, and to comply with the terms of the court order.	

<b>PERMISSIONS</b>	<input type="checkbox"/> I give permission for my child to participate in <b><u>WALKING TRIPS</u></b> within the center's neighborhood, using routes that pose no known safety hazards to children, with the understanding that the walk involves no entrance into another facility unless otherwise indicated.	<input type="checkbox"/> I <b><u>DO NOT</u></b> permission for my child to participate in <b><u>WALKING TRIPS</u></b> within the center's neighborhood, using routes that pose no known safety hazards to children, with the understanding that the walk involves no entrance into another facility unless otherwise indicated.
	<input type="checkbox"/> I give permission for my child to be <b><u>PHOTOGRAPHED</u></b> during normal daycare hours, field trips, or activities and understand that photographs may be used in promoting child care services, either in print or on the Internet.	<input type="checkbox"/> I <b><u>DO NOT</u></b> give permission for my child to be <b><u>PHOTOGRAPHED</u></b> during normal daycare hours, field trips, or activities and understand that photographs may be used in promoting child care services, either in print or on the Internet.

RECEIPT OF POLICIES

I (we) attest that all of the information on this application is accurate, and that I (we) have received the following information:

- Center Policies and Procedures
- Information to Parents Document
- Policy on the Expulsion of Children from Enrollment
- Policy On The Use Of Technology And Social Media
- Policy On The Management Of Illnesses/Communicable Diseases
- Policy On The Release Of Children
- Policy on the Methods of Parental Notification of Injuries (if applicable)
- Other: \_\_\_\_\_
- Other: \_\_\_\_\_

MEDICAL INFORMATION

Child's Health Care Provider:	
Health Care Provider Phone:	
Health Care Provider Address:	
Name Of Insurance Company/Hmo:	
Group #:	
Identification #:	
Subscriber's Name On Insurance Card:	
Known Allergies (including medication):	
Medication My Child Is Taking:	
List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information For Emergency Situations:	

HEALTH STATEMENT

As the parent/guardian of the above named child, I certify that he/she is in good physical health and may participate in the normal activities of the program and has no conditions or specific needs that require specific accommodations, unless otherwise indicated in the medical information provided above or an attached Universal Health Record or a Care Plan for Children with Special Health Needs.

Parent/Guardian Initials: \_\_\_\_\_

EMERGENCY TREATMENT

As the parent(s)/ legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified.

Parent/Guardian Initials: \_\_\_\_\_

Parent/Guardian Signature #1:	Date:	Parent/Guardian Signature #2:	Date:

Name of Child:	Birthdate:
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**SUMMER OF EXPLORATION, ENRICHMENT & FUN**

**9:00AM - 1:00PM**

Circle your choices:

<b>Session 1: 6/24 - 6/28</b>		<b>Pirates &amp; Mermaids</b>
Full Week	Partial Week	Total Due Session 1: _____
M - F	T - Th	
\$240	\$160	

<b>Session 2: 7/1 - 7/3 ( NO Thurs/Fri)</b>		<b>Fourth of July - USA!</b>
Partial Week		Total Due Session 2: _____
M/T/W		
\$160		

<b>Session 3: 7/8 - 7/12</b>		<b>Fairytale Forest</b>
Full Week	Partial Week	Total Due Session 3: _____
M - F	T - Th	
\$240	\$160	

<b>Session 4: 7/15-7/19</b>		<b>Broadway Bound</b>
Full Week	Partial Week	Total Due Session 4: _____
M - F	T - Th	
\$240	\$160	

<b>Session 5: 7/22 - 7/26</b>		<b>Around Town</b>
Full Week	Partial Week	Total Due Session 5: _____
M - F	T - Th	
\$240	\$160	

<b>Session 6: 7/29 - 8/2</b>		<b>Frozen</b>
Full Week	Partial Week	Total Due Session 6: _____
M - F	T - Th	
\$240	\$160	

<b>Session 7: 8/5 - 8/9</b>		<b>Out of this World</b>
Full Week	Partial Week	Total Due Session 7: _____
M - F	T - Th	
\$240	\$160	

<b>Session 8: 8/12 - 8/16</b>		<b>Carnival!</b>
Full Week	Partial Week	Total Due Session 8: _____
M - F	T - Th	
\$240	\$160	

**Total Due :** \_\_\_\_\_

**Tuition for Summer Programs is NON - REFUNDABLE and NON - TRANSFERABLE.**

**Each participant will be allowed one free change after that there will be a change fee of \$15.00.**

Name of Child:	Birthdate:
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**SUMMER**

**DAYCARE**

Circle your choices:

**7:30AM - 5:30PM**

<b>JUNE 1 WEEK ONLY (6/24 - 6/28)</b>		<b>NEW STUDENTS ONLY</b> **current students this week is included in June tuition**
<b>3 DAY RATE</b> \$250	<b>4 DAY RATE</b> \$290	<b>5 DAY RATE</b> \$312

<b>JULY (7/1 - 7/31)</b>		
<b>3 DAY RATE</b> \$995	<b>4 DAY RATE</b> \$1,160	<b>5 DAY RATE</b> \$1,245

<b>AUGUST (8/1 - 8/31) **closed the week of 8/26-8/30</b>		
<b>3 DAY RATE</b> \$995	<b>4 DAY RATE</b> \$1,160	<b>5 DAY RATE</b> \$1,245

<b>DAYCARE CHOOSE OPTION:</b>		
<b>3 DAY</b>	<b>4 DAY</b>	<b>5 DAY</b>

<b>DAYCARE PREFERENCE OF DAYS:</b>				
<b>M</b>	<b>T</b>	<b>W</b>	<b>TH</b>	<b>F</b>

**Registration Fee of \$75.00 & June Payment Due at Registration  
(Current daycare families no payment needed)**

# 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 ( ) -	
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>					
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)	
<b>IMMUNIZATIONS</b>			<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____		
MEDICAL CONDITIONS					
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Medications/Treatments • List medications/treatments:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Limitations to Physical Activity • List limitations/special considerations:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Equipment Needs • List items necessary for daily activities		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Allergies/Sensitivities • List allergies:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:		<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached		Comments	
Emergency Plans • 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	
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					