Registration Form

Child's Information

Full name: _____ Nickname: _____

Date of birth: _____ Place of birth: _____ Sex: M☐F☐

Home street address: _____ City: _____ Zip: _____

Parent/Guardian's Information

Mother/Guardian's name: _____ SS#: _____

Home street address: _____ City: _____ Zip: _____

Home telephone: _____ Cell/beeper: _____

Company name: _____ Work telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Father/Guardian's name: _____ SS#: _____

Home street address: _____ City: _____ Zip: _____

Home telephone: _____ Cell/beeper: _____

Company name: _____ Work telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Sibling(s) name(s) and age(s): _____

Child's Pediatrician: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Allergies: _____

Medical problems: _____

Emergency Contacts and others authorized to pick-up child if parent is unavailable:

Contact/Pick-up name: _____ Telephone: _____
Address: _____ Relationship: _____

Contact/Pick-up name: _____ Telephone: _____
Address: _____ Relationship: _____

Contact/Pick-up name: _____ Telephone: _____
Address: _____ Relationship: _____

I understand that for registration to be valid I must present upon enrollment:

1. Complete all informational forms.
2. Present the following documentation from the child's physician or health provider:
   - Proof and results of the child's recent physical exam (no more than 1 year old from date of first class).
   - Health history
   - Proof of the immunization as required by the New Jersey State Dept. of Health.

I understand that my child cannot attend The Magic Garden School until the immunizations are up to date.

Signature: _____ Date: _____

Printed name: _____

Magic Garden School & Earl Learning Center
113 Fern Avenue, Wharton, NJ 07885
Telephone: (973) 361-4167 Fax: (973) 361-0761
Tax ID: 47-394-1111

Permissions For Health Care

Child's Name: _____ Date: _____

Child's Pediatrician: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Child's Dentist: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZED ADULTS In the event of an emergency, please indicate your name and the telephone number where you and at least one other authorized person can be reached who are authorized to make judgments concerning the above child's health care.

Mother/Guardian's name: _____ Telephone: _____

Father/Guardian's name: _____ Telephone: _____

Alternate's name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

Alternate's name: _____ Telephone: _____

Address: _____ City: _____ State: _____ Zip: _____

FIRST AID

In the event of an emergency, I authorized the staff to provide any first aid care deemed necessary for my child.

Signature: _____ Date: _____

Printed name: _____

EMERGENCY CARE

In the event of an emergency in which I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child.

Signature: _____ Date: _____

Printed name: _____

HEALTH RECORD TRANSFER

In the event of an emergency, I hereby authorize the transfer of my child's health record to the local hospital.

Signature: _____ Date: _____

Printed name: _____

MEDICAL INSURANCE INFORMATION (information below should pertain to your child)

Policy Holder Name: _____ Address: _____

Insurance Company: _____ ID#: _____

Group Name: _____ Group Number: _____

Student SSN: _____ Policy Holder SSN: _____

Information about Your Child (Nursery and older)

Child's full name: _____ Nickname: _____
Date of birth: _____ Sex: M☐F☐

1. What is your child's current sleeping schedule? Morning wake-up_____ Evening bedtime: _____

Daily Naps: _____

2. What upsets or frightens your child? _____

_____

3. What does your child find soothing or comfortable? _____

_____

4. What toys/activities make him/her happy? _____

_____

5. What are some of your child's interests? _____

_____

6. List food your child likes to eat: _____

7. ALLERGIES – Any food or liquids to avoid? Please list and explain reactions, cautions, etc._____

_____

8. When does your child usually have bowel movements? _____
    a. What does your child call the bowel movements? _____
    b. What does your child call urination: _____

9. Has your child attended any other child/preschool program? _____ If yes, why did he/she stop attending? _____

10. Do you have any particular concerns that our staff should know? (Please say "None" if none.)

_____

11. Does your child have any special needs? _____ If yes, please describe (attach information if more space is needed). _____

_____

12. Use the space below for any other information you may wish to share about your child: _____

_____

_____

Signature: _____ Date: _____

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Printed name: _____

Information about Your Child (Infants & Toddlers, Page 1 of 2)

Child's full name: _____ Nickname: _____

Date of birth: _____ Sex: M☐ F☐

1. What is your child's current sleeping schedule? Morning wake-up _____ Evening bedtime: _____

Daily Naps: _____

2. Is your child sleeping through the night? Yes No If not, when does s/he usually wake up at night?

_____

3. What upsets or frightens your child? _____

_____

4. What does your child find soothing or comfortable? _____

_____

5. How does your child react to strangers? _____
6. Is your child using a cub, a bottle, or both? _____
7. Are you breastfeeding? _____ If yes, at what time(s)? _____
8. At what times does your child receive a bottle each day? How many ounces at each feeding? _____

_____

9. Does your child take formula, whole milk, skim, or other? _____
10. What special instructions do you have for preparing the formula? _____

_____

11. Are there any special instructions concerning bottle feeding? _____

_____

12. Does your child eat baby food or table food? _____
13. List the foods your child is now eating:
    a. Vegetables: _____
    b. Fruits: _____
    c. Juices: _____
    d. Meats: _____
14. List any allergies or restrictions: _____

_____

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Information about Your Child (Infants & Toddlers, Page 2 of 2)

Child's full name: _____ Nickname: _____

15. Is your child now eating finger foods? _____ If yes, list them: _____

_____

16. List any other foods your child is now eating: _____

17. Where does your child spend his/her waking hours (crib, playpen, floor, etc.)? _____

_____

18. What toys/activities make him/her happy? _____

_____

19. When does your child usually have bowel movements? _____

_____

20. Has your child begun potty training? _____ If yes, describe the routine: _____

_____

What does your child call the bowel movements? _____

What does your child call urination: _____

21. Has your child attended any other child/preschool program? _____ If yes, why did he/she stop attending? _____

22. Do you have any particular concerns that our staff should know? (Please say "None" if none.)

_____

23. Does your child have any special needs? _____ If yes, please describe (attach information if more space is needed). _____

_____

24. Use the space below for any other information you may wish to share about your child: _____

_____

_____

Signature: _____ Date: _____

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Printed name: _____

Individual Permission for Medication or Health Care Procedure

Child's name: _____

Dates to be administered: From: _____ To: _____

Child's condition requiring the medicine:

Cold: _____ Sore throat: _____ Rash: _____

Teething: _____ Ear infection: _____ Injury: _____

Other: _____

Explanation for Injury or Other: _____

_____

Name of medication: _____

(One medication per sheet)

Prescription: _____ Non-prescription: _____

Doctor's approval required: _____

Amount to be administered: _____

Time(s) to be administered: _____

Refrigeration necessary: Yes No

Special Instructions: _____

Possible adverse reactions: _____

Parent/guardian signature: _____

Date(s) Administered	Time(s) Administered	Adverse Reactioin Observed	Staff's Initials

Staff check-off:

Is all of the above information complete?
Is the prescription date current?
Has medication been placed out of reach of children?
Is the child's name on the container?

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Is the medication in the original container with the prescription label on it?
Is the name of the drug/procedure, dos, and schedule on the label the same as the instructions given by the parent?

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I give permission to The Magic Garden School to take my child _____
(print child's name)

on walks around the neighborhood. I understand that they will be walking on the sidewalk with their class and their teachers.

_____ _____
Signature of Parent/Guardian Date

_____
Printed name of Parent/Guardian

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Dear Parent,

Through the year we anticipate taking some wonderful photographs of your children. With your permission, we would like to use some of them in our submissions to the press, advertisements, our facebook page and brochures. If you feel comfortable with this arrangement, please sign the agreement below.

I, _____, agree to allow The Magic Garden School & Early Learning Center to use photographs of my child, _____ _____, in their news releases and/or promotional materials.

Signed: _____

Printed name: _____

Date: _____

The Magic Garden School & Early Learning Center
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Dear Parents:

In keeping with the New Jersey's child care center licensing requirements, we are obliged to provide you, as the parents of a child enrolled at our center, with this informational statement.

The statement highlights, among other things, your right to visit and observe our center at any time without having to secure prior permission; the center's obligation to be licensed and to comply with licensing standards, and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's Division of Youth and Family Services (DYFS).

Also enclosed in this packet are our school's Discipline Policy, Expulsion Policy, Child Release Policy, and a copy of our health requirements including Illnesses and Communicable diseases.

Please read these statements carefully and, if you have any questions, feel free to contact us anytime at: 973-361-4167.

Sincerely,

The Magic Garden School & Early Learning Center

Please complete and return this portion to the center. (Please Print)

Name of Child: _____

Name of Parent(s): _____

I have read and received a copy of the Information to Parents statement prepared by the Bureau of Licensing in the Division of Youth and Family Services. I have also read and received a copy of the school's Discipline Policy, Expulsion Policy, Child Release Policy, and Health Requirements including Illnesses and communicable diseases.

Signature: _____ Date: _____

Signature: _____ Date: _____

SUBMIT FORM