Pilgrim Preschool

Glen Ridge Congregational Church
195 Ridgewood Avenue Glen Ridge NJ 07028
973.743.5596 Ext 13
www.pilgrimpreschoolnj.com
Karen Nisenson, Director
knisensonpps@gmail.com
Glen Ridge Congregational Church Tax ID: 22-1487206

Registration Information

Please answer each question. Any changes or updates should be provided to the Director as soon as possible.

Please check your choice in the boxes below:

1. **2.5-year-old program**: 3 or 5 days/week (Child must be 2.5 by October 1)

   ☐ a. 8:30–12:30* (Monday – Friday) ***8:30-11:30 until 1/2/2025, when we add lunch.***

   ☐ b. 8:30–12:30* (Tuesday, Wednesday, Thursday); ***8:30-11:30 until 1/2/2025, when we add lunch.***

2. **3-year-old program – choose 1:** (Child must be 3 by October 1)

   ☐ a. 5 mornings 8:30 – 12:30

   ☐ b. 5 mornings and 3 afternoons 8:30 – 12:30 and 8:30 – 2:30 (Tues, Wed, Thurs)

   ☐ c. 5 mornings and 5 afternoons 8:30 -2:30 (Mon – Fri)

3. **Pre-K program:** (Child must be 4 years old by October 1) ***5 days/week only***

   ☐ a. 5 mornings and 3 afternoons 8:30 – 12:30 and 8:30-2:30 (Tues, Wed, Thurs)

   ☐ b. 5 mornings and 5 afternoons 8:30 – 2:30 (Mon – Fri)

Child's Name: _____

Child likes to be called: _____

Birth date: _____

Primary address:

_____

Preferred telephone: _____

Preferred email: _____

Parent/Guardian Information

1. Name: _____

   Address: _____

   Telephone: _____

   Cell Phone: _____

   Business Name/Address/Telephone _____

   _____

2. Name: _____

   Address/Home Telephone: _____

   _____

   Cell phone: _____

   Business Name/Address/Telephone: _____

   _____

Siblings/Other Household Members

Names/Ages/Relationship: _____

Languages spoken to and by the child: _____

Physician's Name/Address/Telephone: _____

_____

☐ My child has been vaccinated in compliance with New Jersey's Department of Health guidelines. (Please check)

Is your child able to participate in all activities at Pilgrim Preschool? _____

_____

Any concerns? _____

Are there any conditions or accommodations needed?

(Speech/OT/Allergies): _____

Signature of parent or guardian: _____

Date: _____

A registration fee of $100 is required. 10% deposit is not due at this time. Checks (payable to Pilgrim Nursery School) or Zelle are our payment options.

Zelle info: Pilgrim Nursery School <lorrainebrownpps@gmail.com>

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	IMMUNIZATION 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	LEAD SCREENING *(Not Required)* TEST DATE	RESULT
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)					[5] Document below single antigen vaccine receipt, serology titers, or Varicella disease history		
HAEMOPHILUS B (HIB) [2]							
HEPATITIS B [3]					Hepatitis B	DATE:	TITER:
VARICELLA [4]					Varicella	DATE:	TITER:
PNEUMOCOCCAL CONJUGATE [2]					Measles	DATE:	TITER:
INFLUENZA [6]					Mumps	DATE:	TITER:
OTHER, SPECIFY:					Rubella	DATE:	TITER:

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

IMM-8
OCT 08

(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 ENROLLED (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04
(5) MMR single antigen receipt requries MO/DAY/YR, serologies require titers, and varicella disease history requires MO/YR.
(6) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months - 59 Months)

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.

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Licensing Information to Parents Form

Dear Parent,

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

The state 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 Central Registry Hotline (877) NJABUSE/(877) 652-2873.

Please read this statement carefully and, if you have any questions, feel free to contact me at 973.743.5596 Ext 13.

Sincerely,

Karen Nisenson

Karen Nisenson, Director

……

Please complete and return this portion to Pilgrim Preschool. 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 Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children and Families.

Signature: _____ Date: _____

OOL: 4/11/13

Parent Receipt of Information Form

1. **Pilgrim is required to notify parents immediately in the event of one of these events:**
    1. Injury to the head or face
    2. A bite that breaks the skin
    3. Fall from a height greater than the height of the child
    4. Injury requiring professional medical care

A telephone call will be made to one of the Immediate Contacts in your child's file and a written report will be sent home

2. Pilgrim no longer refrigerates lunches so please include an ice pack in your child's lunchbox. All thermoses and drink containers must be labeled with your child's name/date. Children's lunches are required to follow general nutritional best practices (low sodium, no trans-fats, low sugar, etc). If your child's lunch contains items that are outside of nutritional best practices, we are required to have you sign that you are aware of the matter and are authorizing the teacher to allow your child to eat the lunch.

3. The teachers often take walks around the GRCC property. If an off-site walking trip is planned, you will be notified to provide permission.

4. In the event of a medical emergency, Pilgrim Preschool will seek life-saving medical care for any child.

Please turn over or see below!!!

The following policies are found by clicking on the "Parent's Corner" tab located on the Pilgrim website: www.pilgrimpreschoolnj.com.

- □ Information to Parents Document
- □ Policy on the Release of Children
- □ Policy on Methods of Parental Notification
- □ Policy on Communicable Disease Management
- □ Expulsion Policy
- □ Policy on the Use of Technology and Social Media

I have read and received a copy of the information/policies listed above.
Child(ren)'s Name:_____

Parent/Guardian Name:_____

Signature: _____ Date:_____

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Special Information

Dear Parent/Guardian,

The staff at Pilgrim Preschool wants to provide the best possible experience for your child. Our purpose is to have our program meet your child's developmental needs. Communication between you and your child's teacher allows us to be partners. We are professionals and consider all information to be confidential.

Child's Name: _____ Date: _____

1. Tell us a little about your child (temperament, energy level, special abilities, difficulties:
   _____
   _____
2. Please list/describe all childcare/school experiences your child has had so far:
   _____
3. What are your child's interests/favorite activities (characters, pets, animals, music, books, sports?)
   _____
   _____
4. Tell us about any concerns you have regarding your child (fears, separation, socializing, language, toileting, food). It would be especially helpful if you would notify us of any recent or impending "major" life events occurring in your family (birth of a sibling, loss of a close family member, sudden development of fear, etc.)
   _____
   _____
5. Does your child have other childcare, playgroup or scheduled activities on a regular basis?
   _____
   _____
6. Pilgrim Preschool needs to have immediate notification of any custody or medical issues regarding your child:
   _____
   _____
7. Feel free to share your expectations and concerns:
   _____
   _____

_____
Parent/Guardian Signature

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Pick Up Authorization Form

Dear Parent/Guardian,

As mandated by the State of New Jersey Department of Children and Families (Office of Licensing), our center may only release children to the child's parent(s) or person authorized by the parents. They may take the child from the center and assume responsibility for the child as part of the daily dismissal or in an emergency if the parent cannot be reached.
Parents/guardians are required to read the enclosed "Policy on Release of Children" which may also be found on our school website at www.pilgrimpreschoolnj.com.

For the safety and welfare of your child, we ask that you list any and all adults (18 yearsof age and older) who are authorized to pick up your child. This may include any family members, extended family members, baby-sitters, nannies or their alternates. If someone other than those listed here will be picking up your child (i.e., for a playdate), you must send **WRITTEN** notification.

We will be asking the pick-up person to sign your child out daily.

Thank you.

Child's name: _____

Name	Telephone/Address	Relationship to child

_____

Parent or Guardian/Date

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Immediate Contact Information

Child's Name: _____ DOB: _____

Any medical alerts (allergy, medications, etc.):

_____

_____

Address: _____

Parent/Guardian Name(s): _____

Call First

Name/Relationship: _____

Phone Number: _____

Call Second

Name/Relationship: _____

Phone Number: _____

Call Third

Name/Relationship: _____

Phone Number: _____