Ogden Junior Preschool
Alternate Pick-Up Authorization Form

For your child's protection we are unable to release him/her to any nonauthorized person. This includes family members, babysitters and parents of classmates. Please give this careful consideration as the release policy is strictly enforced in an effort to keep all our children safe.

Child's name: _____

Class/Teacher: _____

Authorized Alternates for Pick-Up:

Name: _____
Relationship: _____
Phone number: _____
Cell phone number: _____

Name: _____
Relationship: _____
Phone number: _____
Cell phone number: _____

Name: _____
Relationship: _____
Phone number: _____
Cell phone number: _____

Parent Signature: _____ Date: _____

Ogden Junior Preschool
Enrollment Questionnaire

Please fill out this brief questionnaire and return it during the Meet and Greet. It will not be shared with anyone other than your child's teacher.

Name_____Class/Teacher_____

1. Is your child toilet trained? Yes____No____In process_____

2. Has your child been cared for by others (Nanny, day care, babysitters)?

3. Does your child have a "lovie" or a special way they calm themselves?

4. What are your child's favorite activities?

6. Are there any medical issues that we should know of?

7. Does your child have allergies diagnosed by a doctor? If yes, please explain.

8. Has your child met their milestones? If no, please explain.

9. Is your child receiving any services such as speech therapy, occupational therapy, or early intervention?

10. Anything else we should know?

Ogden Junior Preschool
EMERGENCY CARD

Child's Name:
Child's Class/Teacher:
Address/Phone:
Parents Names:
Mom cell: Dad Cell:
Contact #1:
Phone:
Contact#2:
Phone:
List Allergies:

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	