Christian Pentecostal After School & Full Day Child Care Services
613-615 Nye Avenue, Irvington NJ 07111 - **Telephone: (973) 399-0004 - Fax: (973) 399-3331**
Divine Direction Learning Center - 219-223 Orange Avenue, Irvington NJ 07111 - Telephone: (862) 955-3450-
Christian Pentecostal After School – 1442B Springfield Avenue, Irvington NJ 07111 - Telephone: (973) 375-0605
Little Hearts Learning Center I 631 E. Front Street, Plainfield NJ 07060
Little Hearts Learning Center Learning Center II 400 Cleveland Av, Plainfield NJ 07060 - Telephone: Telephone: (908) 755-7555

After Schools: 141-181 Montgomery Avenue; 787 Grove Street; 46 Mt. Vernon Avenue;
844 Chancellor Avenue; 1 University Place; 1324 Springfield Avenue
Deborah F. Simpkins, Executive Director

REGISTRATION DOCUMENTS

(*FULL DAY PRESCHOOL*)

The following list of documents are required for your child(ren) to be enrolled at Christian Pentecostal After School/Full Day facilities:

☑ **Enrollment Form**
(Enrollment Information – (2 pages): **Medical Emergency Release/Treatment Form** (1 page) and **Authorization to Pick-Up Child** (1 page.) *Must be filled out completely, signed and dated.*

☐ **Infant Notification Letter (0 – 12 months of age)**

☑ **Child and Adult Care Food Program ELIGIBILITY APPLICATION (Meal Form)**

☑ **Universal Health Record (Must Be Completed and Signed by Doctor or Clinic PRIOR TO start date**

☑ **Immunization Record including Flu Shot vaccination (prior to start date)**

☑ **Copy of Birth Certificate or document validating that student(s) is/are qualified residents.**

☑ **Copy of child(ren)'s Social Security Card**

Items required for the 1st day of school:

Infants & Toddlers:
- ⇨ Diapers/Pull-Ups – 1 full package (you will be notified when supply is low)
- ⇨ 1 box of baby wipes – at least 80 – 100 count
- ⇨ Any cream, powder, mylicon etc. that you wish to use
- ⇨ 2 changes of clothing *(t-shirt, sleeper, outfit and socks)*

Careful attention should be made to maintain current sizes left at school!

Return a full-set when a soiled set is sent home!

- ⇨ 2 sheets (crib size)

Preschoolers:
- ➲ Change of Clothes *(complete set including underwear and socks)*
- ➲ 2 Sheets (crib size)
- ➲ Proper outerwear for outside play and walks.

CPAS @1442B Springfield Av
(Head Office) 613-615 Nye Avenue, Irvington NJ 07111
Telephone: (973) 399-0004 - Fax: (973) 399-3331
Deborah F. Simpkins, Executive Director

Start Date: _____

Site: _____

PRESCHOOL ENROLLMENT FORM (FORMA DE LA INSCRIPCIÓN)

Email address: _____

Child's Full Name (Nombre completo del niño/s) _____

Birth Date (Cumpleaños) _____ **SS#** (Número de Seguridad Social): _____

Home Address (dirección) _____

Home Phone Number (Teléfono casero) _____

PARENT/GUARDIAN EMPLOYMENT INFO (INFORMACION DE EMPLEADO DEL PADRE)

Father's Name (Nombre del padre) _____

Employer/Address/Phone
(Patrón/dirección/teléfono): _____

Cell Phone (Numero de 1elular) _____ **Work Hours** (Horas del trabajo):_____

Mother's Name (Nombre de la madre): _____

Employer/Address/Phone
(Patrón/dirección/teléfono): _____

Cell Phone (Numero de cellular): _____ **Work Hours** (Horas del trabajo): _____

Parent's Marital Status (circle one):	**Married**	**Seperated**	**Divorced**	**Single**	**Widow/er**
Estado civil del padre (Círculo uno):	Casado	Separado	Divorciado	Solo	viuda/viudo

Child Lives With (Niño vivo con): _____

If Divorced, Who Has Legal Custody (Si está divorciado, que tiene custodia legal): _____

May the Non-Custodial Parent Pickup Child (¿Puede el niño no-de la custodia de la recogida del padre?): _____

The Child Will Be Released Only To Those People On This Form And The Following:
Lanzarán al niño solamente a esa gente en esta forma y el siguiente:

Name & Phone (Nombre y teléfono): _____

Name & Phone (Nombre y teléfono): _____

DISCLOSURE: TUITION IS DUE EVERY WEEK once your child is enrolled at the CPAS or DDLC facilities!

1. **PAYMENTS are due on FRIDAY of the week PRIOR to (before) service. If payment is not received by MONDAY of the week of service, a $10.00 per day LATE FEE will be applied to your account.**
2. **Payment, IN FULL, is due as long as your child *is enrolled* in CPAS or DDLC, even if your child *does not* attend for a full week**

*****Note: The $100.00 Registration Fee is non-refundable** _____**Initial**

AUTHORIZATION TO PICK-UP CHILD (*La AUTORIZACION DE TOMAR A NIÑO*)

Please print all information (Escriba en letra separada por favor toda la información)

Child's Name (Nombre del niño): _____

Child's Classroom (Salón de clase del niño): _____

Parent/Guardian's Name (Nombre del padre y/o tutor legal: _____

Home Phone # (#Teléfono de la casa): _____

Cell Phone # (#Teléfono de celular): _____

Other Number I can be reached in an emergency (Otro número que pueda ser localizado en una emergencia):

_____

The following persons are authorized to pick up my child *(Autorizo a las personas siguientes a recoger a mi niño)*

No other person is authorized to pick-up my child. ***(No se autoriza a ninguna otra persona a recoger a mi niño.)***

PLEASE PRINT NAMES OF AUTHORIZED PERSONS AND TELEPHONE #: _____

(POR FAVOR ESCRIBA LOS NOMBRES DE LAS PERSONAS AUTORIZADAS Y TELEFONO #: _____

Name of Person Autorized to Pick-up child daily
(Nombre de las personas autorizadas que puede recoger el niño): _____

Address *(Dirección)*: _____

Relationship to Child *(Relación al Niño)*: _____ Telephone *(Teléfono)* # _____

When parent cannot be reached, list at least one person who may be contacted in an emergency:
(Cuando el padre no puede ser alcanzado, lista por lo menos una persona que puede ser contactado por una emergencia):

(1) Name *(Nombre)*: _____ Telephone *(Teléfono)* #: _____

Address *(Dirección* _____

Name *(Nombre)*: _____ Telephone *(Teléfono)* #: _____

Address *(Dirección)*: _____

(2) Name *(Nombre)*: _____ Telephone *(Teléfono)* #: _____

Address *(Dirección)*: _____

SIGNATURE *(FIRMA)*: _____ **DATE *(FECHA)*:** _____

AUTHORIZED PERSON MUST SHOW ID IN ORDER TO PICK-UP CHILD
(LA PERSONA AUTORIZADA DEBE PRESENTAR UNA IDENTIFICACIÓN PARA PODER RECOGER AL NIÑO)

7/2013

MEDICAL EMERGENCY RELEASE / TREATMENT FORM

(En caso de EMERGENCIA/ FORMA para MÉDICOS para TRATAMIENTO)

Child's Last Name (Apellido del niño) _____ First (Nombre) _____ Middle Initial (Inicial) _____ Date of Birth (Fecha de nacimiento) _____

Parent/Guardian's Name (Nombre del padre/del tutor legal): _ _____

Address (Dirección): _____ Home Phone: _____ (Teléfono casero)

_____ Cell Phone: _____ (Número de celular)

Name of Employer: _____ (Nombre del patron) Work Phone: _____ (Teléfono del trabajo)

IN CASE OF EMERGENCY (*EN CASO DE EMERGENCIA*) CALL/CONTACT :

Name (Nombre): _____ Phone (Teléfono) #: _____

Address (Dirección): _____

MEDICAL INFORMATION (*INFORMACIÓN MÉDICA*):

Existing medical problems (Problemas médicos existentes): _____ Allergies to food/medicine (Alergias a alimento y/o medicina): _____

Medicine/s child is taking (Medicinas que el niño esta tomando): _____

Child's Doctor/Clinic Name (Nombre del doctor/de la clinica del niño):_____ Phone (Teléfono) #: _____

Choice of Hospital if necessary (Opción del hospital si es necesario) : _____ Phone (Teléfono) #: _____

Date of child's last tetanus shot (La fecha de la vacuna del tétanos):_____ Medicaid #, if applicable: _____

Medical Insurance Co (Seguro médico Co): _____ ID (Identificación) #: _____

Subscriber's Name (Nombre del suscriptor): _____

It is understood that every effort will be made to notify me or _____at _____before such action is taken, but if not possible to locate me or the above person, the uninsured expense of this service will be accepted by me.

I authorize the child care provide to arrange transportation in case of emergency or acute illness and to arrange for possible medical and/or surgical care at (1) the closest hospital available in case of dire emergency or (2) the hospital of my choice.

(Se entiende que se hará el esfuerzo de notificar me al _____ yo o del _____antes de que se tome acción, pero si no posible localizar a me o a la persona antedicha, el costo sin seguro de este servicio será aceptado por mí.)

(Autorizo el cuidado de niño proporciono para arreglar el transporte en caso de urgencia o la enfermedad aguda y para arreglar para médico posible y/o cuidado quirúrgico en (1) el hospital más cercano disponible en caso de emergencia calamitosa o (2) el hospital de mi opción.)

Parent/Guardian's Signature (Firma del padre/ tutor legal):_____ **Date (Fecha):** _____

THE SCHOOL MUST BE NOTIFIED OF ANY CHANGES

SE DEBE NOTIFICAR LA ESCUELA DE CUALQUIER CAMBIO

2/2012

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:

Abnormalities Noted:

Results of physical examination normal? ☐Yes ☐No

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