PARTNERS IN LEARNING, INC.

Where Children Learn & Grow Together Since 1999

Therapeutic Learning Center
Turnersville, NJ 08012
856-374-2821

Cherrywood Academy & Private Preschool
Clementon, NJ 08021
856-566-1004

Country Acres Private Preschool
Williamstown, NJ 08094
856-881-0400

Partners in Learning Private Preschool
Northfield, NJ 08225
609-377-8337

Student Information Form

_____ *SY*	**Center: _____**	**Date of Enrollment:_____** **Class: _____**

CHILD	Name of Child	
	Date of Birth	
	Home Address	

		Parent		Parent
GUARDIANS	Name		Name	
	Relationship		Relationship	
	Home Phone		Home Phone	
	Cell Phone		Cell Phone	
	Home Address		Home Address	
	Email Address		Email Address	

WORK INFO	Name of Parent		Name of Parent	
	Name of Business		Name of Business	
	Business Telephone		Business Telephone	
	Business Address		Business Address	
	Occupation		Occupation	

EMERGENCY	***During school hours***, if the school needs to close early or your child needs to be picked up due to illness, please put down the following contact numbers for yourself or an authorized caregiver we would need to call in order of importance. **Please note: People on the list will need to provide a Photo ID at time of pick up and must be 18 years of age or older.**			
	Name of Contact #1		Name of Contact #2	
	Telephone		Telephone	
	Relationship		Relationship	
	Address		Address	

DOCTOR	Child's Doctor	
	Telephone	
	Address	

CUSTODY	Name of Person ***UNAUTHORIZED*** to pick up the Child:_____ If a non-custodial parent is not included among those persons authorized by the custodial parent to pick up the child, please explain below and attach a copy of appropriate court orders.

ER CARE	I have completed the medical emergency permission form, which authorizes Partners in Learning, Inc. to seek emergency medical care for my child, _____ as deemed necessary by the Director or the director's designee. Parent Signature:_____ Date:_____

WALKS

___I give my permission for my child, _____ to participate in walking trips within the center's neighborhood.

___I do not give my permission for my child, _____ to participate in walking trips within the center's neighborhood.

Parent Signature:_____ Date:_____

POLICIES

I attest that all of the information on this application is accurate and that I have received the following information for my home records:

1. Release of Children	☐ Yes	☐ No
2. Emergency Treatment	☐ Yes	☐ No
3. Information to Parents	☐ Yes	☐ No
4. Discipline Policy	☐ Yes	☐ No
5. Communicable Diseases	☐ Yes	☐ No

Parent Signature:_____ Date:_____

ADDITIONAL INFORMATION

What are your child's previous school experiences?_____

Does your child have regular playmates?_____

Does your child suck his thumb or use a pacifier?_____

Is toilet training complete?_____ Was training easy/short, long/difficult or intermittent?_____

Does your child nap?_____ How long?_____ Are there any sleep problems?_____

Are there any restrictions in food or drink?_____

Favorite Foods/Snacks_____

Special Interests_____

Does your child have any specific fears?_____

Has your child had any traumatic experiences?_____

Is your child generally: ____ Cooperative; ____ Shy; ____ Competitive; ____ Aggressive

____ Sensitive; ____ Angry; ____ Happy; ____Defiant; ____ Whines

ADDITIONAL INFORMATION	List other behavior characteristics or special circumstances that will help us understand your child: Please describe how you would like Partners in Learning, Inc. to help your child:

Parent Signature:_____ Date:_____

PARTNERS IN LEARNING, INC.

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I have read the Parent Handbook online and know at any time I can see it on the website www.partnersinlearningnj.org or request a printout. I understand the policies in the Parent Handbook including but not limited to:

Please check off:

_____ Screening and Referral Policy (added 8/6/18)
_____ Environmental Rating Scale Policy (added 8/6/18)
_____ Home Language Policy
_____ Information to Parents Disclosure
_____ Reporting Child Abuse Policy
_____ Hot Lines for Domestic Abuse (added 8/20/20)
_____ Student Requirements Letter (revised 8/29/22)
_____ Guidelines for Exclusion from the Program (revised 11/12/24)
_____ Health, Nutrition, and Safety Policies and Procedures
_____ Management of Communicable Diseases
_____ Medication Administration
_____ Life Sustaining Equipment Policy
_____ Parent Notification/Tadpoles
_____ Parent Signatures (added 1/26/25)
_____ Television, Computer and Video Equipment Usage in Center
_____ Policy on Television/Electronic Viewing at Home
_____ Policy on Use of Technology & Social Media
_____ Discipline & Positive Guidance Policy (rev 8/6/18)
_____ Discontinuation of Enrollment Policy (rev 8/5/19)
_____ Policy on Release of Children
_____ Easing Separation Anxiety (added 8/6/18)
_____ Drop Off and Pick Up Policy
_____ Authorized and Unauthorized Pick-Ups
_____ Parental Custody Agreement/Order (added 8/6/18)
_____ Emergency Lockdown Procedure
_____ Emergency Procedure Plan
_____ Emergency Procedure Requirements
_____ Video Camera/Surveillance on School Grounds @CWA
_____ Daycare Sign-Up Policy
_____ Daycare Cancellation Policy
_____ NJ Car Seat Law

Child's Name:_____

Both Parents/Guardians are required to read the handbook and sign this form

Parent's Name:_____		Parent's Name:_____
Relationship:_____		Relationship:_____
Signature:_____		Signature:_____
Date:_____		Date:_____

PARTNERS IN LEARNING, INC.

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Dear Parents/Guardians,

Partners in Learning is a non-profit organization and applies for grants. In many grant applications, funders will ask for specific demographic information to be eligible for funding. Please know that this private information we are requesting will be kept confidential are reporting on demographic data globally.

We are asking you to fill out and return this form. This is voluntary and confidential. Names are not needed.

Thank you so much for your help! We will let you know if we receive the grants!

Lori Lorenzetti
Director of Behavior Health:Staff Support Services
Fundraising Coordinator

Per attending child from your household:

1. Gender

____Male
____Female
____Other: _____
____Prefer not to answer

2. Age (Years)

____0-3
____3-5
____5-7
____7-9
____9-12
____12-15
____15-17

3. Ethnicity

____African American
____Hispanic American
____Caucasian
____Bi-or multi-racial
____Native American
____Asian American/Pacific Islander
____Other: _____
____ Prefer not to answer

4. Is the child to be enrolled diagnosed with a disability? **YES / NO**

If "yes," please specify the diagnosis_____

5. How many individuals reside in the home? _____

Parent/Guardian Information:

6. What is the total annual household income before taxes?

_____$0-$9,999
_____$10,000-$24,999
_____$25,000-$49,999
_____$50,000-$74,999
_____$75,000-$99,999
_____$100,000-$124,999
_____$125,000-$149,999
_____$150,000-$174,999
_____$175,000-$199,999
_____$200,000 and up

_____Prefer not to answer

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Authorization Pick-Up List

Please complete this form with the names of individuals that you authorize our school staff to release your child to for transport in the event that you are not able to do so yourself. Any person not on this list can be added by written documentation only. NO PHONE CALLS WILL BE ACCEPTED. Written documentation must be signed by the parent and can be done in person or sent via fax to the school. After a written note is completed, those persons will be added to the list.

Please note: People on the list will need to provide a Photo ID at time of pick up and must be 18 years of age or older.

Parent's Name:_____		Parent's Name:_____
Relationship:_____		Relationship:_____
Cell #:_____		Cell #:_____
Work #:_____		Work #:_____

Name: _____

Phone: _____

Relationship: _____

Name: _____

Phone: _____

Relationship: _____

Name of Child:_____

Name of Parent_____

Parent Signature:_____ Date:_____

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Photography Permission Form

I, _____ give permission for Partners in Learning, Inc. to photograph and/or video tape my child _____.

I understand that my child's photographs/video will be used in school and for promotional purposes which may include pamphlets, brochures and/or on our website at www.partnersinlearningnj.org.

I, _____ do not give permission Partners in Learning, Inc. to photograph and/or video tape my child _____.

I understand that I may change my decision at any time.

Parent Signature:_____ Witness:_____

Date:_____ Title:_____

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Dear Parents:

We are so happy to have your child attending our program! They will learn so many new and wonderful things.

There are a few mandatory immunization requirements. Per the NJ State Commissioner of Health & Senior Services, every child 12 months through 59 months of age enrolling in or attending a licensed child-care center on or after September 1, shall have received at least **one dose of Pneumococcal Conjugate Vaccine (PCV) on or after their first birthday**. Please check with your doctor if you are not sure of this date. If your child's immunizations do not fall under this new regulation, a new immunization of PCV is required.

If your child is **under** the age of 5 as of Sept. 1, they must also receive at least **one dose of the flu vaccination by December 31.** Prior to December 31, your child may start school if s/he has not had the flu vaccine yet. We will need a current shot record submitted after the Influenza Vaccine has been given. **If your child does not receive the flu vaccine by December 31, your child will not be permitted to return to our center**, per state guidelines, until documentation has been provided that the shot has been given or written explanation for exclusion of the shot has been submitted.

If you enroll your child between January 1 and March 31, your child may not start until the flu vaccination is given and documentation is submitted.

PIL is keeping on record COVID-19 Vaccination cards, so please submit your child's copy if applicable.

Per the State of NJ, children cannot start unless we receive a completed packet which includes all health documents.

If you have any questions, please do not hesitate to call me at 856-374-2821.

Sincerely,
Kelley L. Dinardo
Kelley L. Dinardo
Administrative Coordinator

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Immunization Record Form
ATTACH HERE

All medical forms must be completed in full, signed, dated and stamped by your child's doctor.

As a condition of enrollment in the program, except for any immunizations for which parents are using a religious/medical exemption for, all medical forms, including a current shot record, must be returned to the school before your child's start date.

Your child must have had a physical 1 year prior to todays's date to admission to school.
The Universal Child Health Record form must be updated annually.

_____ If your child has a religious or medical exception for immunizations, please check this line ***and*** submit a letter of exception with your child's Universal Health Record form.

If your child has received the COVID-19 Vaccinations, please include a copy of their card.

_____ **My child has *not* received the COVID-19 Vaccinations**

Name of Child:_____

Parent Signature:_____

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	

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Care Plan for Children with Special Health Needs

I have received the Care Plan for Children with Special Health Needs form and have determined that this form

____ Does apply to my child

_____ Does not apply to my child

Name of Child:_____

Parent Signature:_____

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

	Today's Date
Child's Full Name	Date of Birth
Parent's/Guardian's Name	Telephone No. **( )**
Primary Health Care Provider	Telephone No. **( )**
Specialty Provider	Telephone No. **( )**
Specialty Provider	Telephone No. **( )**
Diagnosis(es)	
Allergies	

ROUTINE CARE

Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects

List medications given at home:

NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: _____

Classroom Activities: _____

Naptime/Sleeping: _____

Toileting: _____

Outdoor or Field Trips: _____

Transportation: _____

Other: _____

Additional comments: _____

_____

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

_____

_____

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

_____

_____

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

_____

_____

_____

SUGGESTED SPECIAL TRAINING FOR STAFF

_____

_____

_____

Health Care Provider Signature	Date

PARENT NOTES (OPTIONAL)

_____

_____

_____

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.

Parent/Guardian Signature	Date

Important: *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*

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Parental Authorization/Permission Slip for Emergency Treatment

PARENT(S) NAME: _____

Parent(s) Address _____

_____

CHILD'S NAME: _____

Age _____ Date of Birth _____

Address _____

_____

MEDICAL INFORMATION:

Existing Medical Problems _____

Allergies _____

Medicine(s) Child is taking _____

Medicine(s) Child is allergic _____

Child's Doctor _____

Name ***Telephone***

INSURANCE:

Company/HMO _____

Group Number _____

Identification Number _____

Last tetanus shot _____

I (we) state that we are the parent(s)/guardian(s) having legal custody of the above child and attest that the information above is correct. I (we) authorize the above child care center director or directors designee to obtain emergency treatment for my child. I consent to an x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

The following steps will be followed in an emergency

1. The parent/guardian will be contacted immediately.
2. The child's physician will be contacted.
3. There will be an attempt to contact you through all of the emergency persons listed on the child's application form.
4. If we cannot contact you or your child's physician, we will do any or all of the following. (a) Call for emergency paramedic assistance/transportation. (b) Call another physician (c) Have the child transported to an emergency hospital in the company of a staff member.
5. The center will not be responsible for complications that may occur as a result of false information given at the time of enrollment.

Parent Signature: _____

Date of Signature: _____ Date Permission Terminated: _____

Witness: _____ Date of Signature: _____

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Allergy Questionnaire

Child's Name:_____

What type of allergies does your child have?

_____

_____

_____

What is the severity of reaction if he/she should come in contact with these allergens?

_____

_____

If a food allergy (i.e. peanut), will your child have an allergic reaction if he/she touches the food or just through ingestion?

_____

_____

What actions must be taken if your child has an allergic reaction?

_____

_____

_____

Does your child require an epi-pen / inhaler / medication?

_____

If yes, a doctor's note must be submitted if you require the school to maintain medication on the premises.

Other information you would like the teachers to know:

_____

_____

Parent Signature:_____ Date:_____

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Training of Life Sustaining Equipment

Before administering a health care procedure associated with a child's health condition, such as the use of a blood glucose monitor, nebulizer, or epinephrine pen, the center shall ensure that all staff members who administer the procedure are taught to do so by the child's parent or another appropriately trained person.

_____ Does apply to my child.

To be completed by staff and parent:

I, _____ certify that I have been trained accordingly on the usage and

administration of _____ by _____.

_____ Does not apply to my child

Name of Child:_____

Parent Signature:_____ Date:_____

Staff Signature:_____ Date:_____

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Dear Parents/Guardians:

Please keep the Medication Authorization Form in case medication needs to be disbursed during the school year. This form must be completed by you and your child's doctor and returned to the center before any medication can be disbursed. Additional forms can be found online on our website, partnersinlearningnj.org.

Thank you.

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MEDICATION AUTHORIZATION FORM

TO BE COMPLETED BY THE HEALTH CARE PROVIDER:

Name of Child _____ Date of Birth _____

Medication/Strength _____

Dosage to be Given _____ Time to be Given _____

Route of Administration _____ Diagnosis _____

Side Effects _____

Duration of Order (no longer than duration of school year)_____

Doctor's Signature/Stamp/Date:_____

TO BE COMPLETED BY PARENT/GUARDIAN: I hereby give consent for the following:

_____ Center staff may administer the medication to my child according to the physician's directions above.

_____ The Center's Director has my permission to contact the physician should there be any questions or concerns regarding this medication. I understand that this medication must be delivered to school personnel by the parent/guardian and that students are NOT to transport medication unless it is an approved emergency medication. I understand that this medicine must be in the original, labeled container. The medication provided must match the physician's order. I hereby release the Center, their agents, and employees from any and all liability that may result from my child taking this medication.

Parent/Guardian Signature: _____ Date _____

Parent/Guardian Phone: Home _____ Cell _____ Work _____

Center Director Signature: _____ Date _____