# 2019-2020 FORMS CHECKLIST

Review, complete and return the following forms. **Please initial beside each item** indicating you have received, read & completed the information.

***Return this cover sheet with your completed forms.***

| | |
|---|---|
| **Read and keep for your reference** | |
| • Welcome Letter from Allison Tankel | _____ |
| • Parent Handbook – emailed. | _____ |
| • 2019-2020 School Calendar | _____ |
| **Read, complete and return** | |
| • Information to Parents and Acknowledgement Forms | _____ |
| • Student Information Form | _____ |
| • Authorization for Pediatric-Emergency –Medical and / or Surgical Treatment | _____ |
| • Carpool Registration | _____ |
| • Publicity Consent Form | _____ |
| • Dismissal / Late Policy / Walk Policy | _____ |
| • Parent / Child Questionnaire | _____ |
| • Medical Form Letter, Universal Health Care Provider Form and yellow medical card | To be completed by child's physician once per school year;<br>Immunization Card: Only if you are new to school or have received additional vaccinations.<br>_____ |
| • Influenza Vaccine Documentation | _____<br>*Please return Vaccine Documentation by 12/1. |
| • Allergy and Anaphylaxis Emergency Action Plan | _____ *only to be completed if your child has an allergy. |
| • Emergency Medication Administration Authorization form | _____ *only to be completed if your child requires emergency medication to be kept at school. |

Child's Name: _____

Parent Signature: _____ Date: _____

# SUMMIT JCC ELC | 2019-2020 CALENDAR

**2** Labor Day
5 First Day of School
5-6 NOON Dismissal
30 Rosh Hashanah
School Closed

**SEPTEMBER 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | | | | | |

**1** RH School Closed
**8-9** Yom Kippur – Closed
14 Sukkot – Closed
21 Shemini Atzeret-
CLOSED

**OCTOBER 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
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| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | 31 | | |

**5** **Professional Development – Closed**
**7-8** **NJEA Conference Closed**
**12** **Picture Day**
**15** Special Person Day
**27-29** Thanksgiving
Closed

**NOVEMBER 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |

**6** Conference Day
Closed
13 Chanukah
Celebration**
23-31 Winter Recess Closed

**DECEMBER 2019**

| S | M | T | W | Th | F | S |
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| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

**1-3** Winter Recess Closed
**20** M.L. King Day

My Special Guy TBD

**JANUARY 2020**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | |

**14-18** Presidents Day
CLOSED

**FEBRUARY 2020**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |

**MARCH 2020**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

9 Professional Development
CLOSED

**APRIL 2020**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | | |

**6-17** Spring Break/Passover
CLOSED

**MAY 2020**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | | | | | | |

**8** My Special Gal
**25** Memorial's Day
29 Shavout - CLOSED

**JUNE 2020**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | | | | |

**8-12** **NOON Dismissal**
**12** Pre-K Moving Up
12 Last Day of School

**JULY 2020**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | |

**4** Independence Day

**AUGUST 2020**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | | | | | |

** Dismissal at conclusion of program
**Parent/Caregiver Joint Program

*Calendar Subject to Change 1/2019*

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## INFORMATION TO PARENTS AND ACKNOWLEDGEMENT FORM

Dear Parents,

Our staff is dedicated to providing the warm, nurturing environment necessary for young minds and bodies to grow and develop. We are looking forward to a successful school year for your child.

In keeping with New Jersey's child care licensing requirements, we are obligated to provide you, as the parent of a child enrolled in our school, with the informational statement which can be found in our Parent Handbook designed to provide you with an overview of the goals, philosophy, policies and programs offered at the Summit JCC Early Learning Center.

Please read this handbook and statement and if you have any questions, feel free to contact me at allison@summitjcc.org. Once again, we are looking forward to working with both you and your child in the coming year.

Best,
Allison Tankel

Please sign where indicated as acknowledgement of receiving the required Parent Handbook and Information Statement to Parents.

---

**I have read and received a copy of the Parent Handbook including the Information to Parents Document.**
**I have read and received a copy of the Positive Guidance, Discipline Policy in the Parent Handbook.**
**I have read and received a copy of the Expulsion Policy in the Parent Handbook.**
**I have read and received a copy of the Communicable Diseases Management Policy in the Parent Handbook.**
**I have read and received a copy of the Nut Allergy and Healthy Food Guidelines and Policies in the Parent Handbook.**
**I have read and received a copy of the Policy on the Release of Children in the Parent Handbook.**
**I have read and received a copy of the TV/Video Watching Policy in the Parent Handbook.**
**I have read and received information regarding consumer toy recalls (link to our website).**
**I have read and received the Use of Technology and Social Media policy in the Parent Handbook.**

_____
Parent's Signature Date

_____ _____
Parent's Name –Please Print Child's Name – Please Print

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## STUDENT INFORMATION FORM

| | |
|---|---|
| **Child's Name:** | **Date of Birth:** |
| **Home Address:** | **Home Telephone Number:** |
| **Parent/Guardian 1Name:** | **Parent/Guardian 2 Name:** |
| **Place of Business / Address:** | **Place of Business / Address:** |
| **Work Phone:** | **Work Phone:** |
| **Cell Phone:** | **Cell Phone:** |
| **Email:** | **Email:** |
| **Parent/Guardian 1's Email - Should we use this email for weekly school communications: Y or N** | **Parent/Guardian 2's Email - Should we use this email for weekly school communications: Y or N** |

**Local Emergency Contacts:**

| NAME | PHONE | RELATIONSHIP |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

| | |
|---|---|
| **Name of Health Insurance Provider:** | **Address and Phone of Health Insurance Provider:** |
| **Physician Name:** | **Physician Address and Phone number:** |
| **Dentist Name:** | **Dentist Address and Phone number:** |

Allergies/ Special Medical Conditions: _____

_____

***(turn page over):***

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

CHILD'S NAME:_____

If your child is currently receiving any type of special support services, please describe (speech, OT, other).

All information will be held in strict confidence:

_____

_____

_____

_____

_____

_____

_____

Any other important information to know?

_____

_____

_____

_____

Are there any foods your child cannot eat?

_____

_____

_____

_____

Is this your child's first school experience? If no, where did they attend school and for how long?

_____

_____

_____

_____

_____

67 Kent Place Boulevard * Summit, NJ 07901 * 908-277-3919 * allison@summitjcc.org
www.summitjccelc.org

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## AUTHORIZATION FOR PEDIATRIC-EMERGENCY-MEDICAL AND/OR SURGICAL TREATMENT

**EXPLANATION:** In emergency situations when the Early Childhood Director cannot reach a student's parents, the authorization you provide on this sheet will enable medical personnel to administer the required care for your child. We find that Doctors and Hospitals refuse to give treatment regardless of how minor, unless they have a parent's authorization. As you know, time can be a factor in emergency medical situations. This form will assure us that no time would be lost in providing your child with immediate treatment. It is our firm hope that the authorization granted here will never be needed. The granted authorization will be used only where absolutely necessary and after every attempt has been made to contact you, the parent.

**AUTHORIZATION:** In the event my child requires medical care (and the determination thereof shall rest solely with you), I hereby authorize:

1) The Summit Jewish Community Center Early Learning Center Staff to provide emergency medical care and first aid as required. (i.e.: Ice on a bump; antiseptic on a scratch; Band-Aid procedure). The school will not administer medicine. The only exception is emergency medications relating to allergies, such as epi pen or antihistamine (benedryl), or inhalers. The parent to provide the school with a prescriber's authorization form related to any emergency medicine.

2) The Doctor or Doctors and/or Hospital to which he/she may be brought, in an emergency situation, to take and perform all necessary procedures and render any indicated treatment, including the administration of anesthesia, if needed, and the performance of an operation, if in opinion of said Doctor or Doctors the same is necessary, while my child is under the School.

Parent's Signature:_____ Date:_____

Student's Name:_____

**Local Emergency Contacts:**

| NAME | PHONE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |

| | |
|---|---|
| **Name of Health Insurance Provider:** | **Address and Phone of Health Insurance Provider:** |
| **Physician Name:** | **Physician Address and Phone number:** |
| **Dentist Name:** | **Dentist Address and Phone number:** |

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## SUMMIT JCC EARLY LEARNING CENTER

## CARPOOL REGISTRATION

In order to insure the safety of your child, we are requesting that you return this form before the first day of school. Your child will only be dismissed to a parent or the authorized drivers indicated on the daily schedule below.

If for any reason someone other than the scheduled driver will be picking up your child on any given day, please be sure to send a note indicating a change in driver. No child will be dismissed to any other individual without written permission from the parent. **Parents names do not need to be put on this form.**

Child's Name: _____

| | DRIVER'S NAME | PHONE NUMBER (Home / Cell) |
|---|---|---|
| **MONDAY:** | | |
| **TUESDAY:** | | |
| **WEDNESDAY:** | | |
| **THURSDAY:** | | |
| **FRIDAY:** | | |

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## PUBLICITY CONSENT FORM

We are sending you this parental consent form to inform you and to request your permission to use your child's photo/ image, grade level and program name in publicity materials, which may appear in local newspapers, summer program brochures, and on our school website (www.summitjccelc.org) or our synagogue website (www.summitjcc.org). We will not release your child's name. Pursuant to law, we will not release any personally identifiable information without prior written consent from you as parent or guardian. Personally identifiable information includes: student names, photos or images, residential addresses and phone numbers. The SJCC Early Learning Center will never disclose for publicity purposes students' residential addresses, phone numbers, or times of class trips. However, with your written consent, photo/ images and grade level might be used in our publicity materials.

As you are aware, there are potential dangers associated with the posting of personally identifiable information on a website since global access to the Internet does not allow us to control who has access to such information. These dangers have always existed. The law requires that we ask for your written permission to use information about your child.

_____

Student's Name:_____

Parent/ Guardian Signature:_____

Date: _____

**Please read the following options carefully and PLEASE CHECK ONLY ONE :**

_____ 1. I/ We grant permission for use of my/our child's photo or image (NO NAME), grade and program name in local newspapers, social media, program brochures and the school and synagogue website. (FULL ACCESS)

_____2. I/ We grant permission for use of my/our child's photo or image (NO NAME), on the school and /or synagogue website, BUT NOT in local newspapers, or program brochures. (WEBSITE ONLY)

_____3. I/We deny permission for any information about or photo/image of my/our child to be used for any publicity purposes. (NO PUBLICITY).

If you, as parent or guardian, wish to rescind your consent, you may do so at any time in writing by sending a letter to the Director of the School, Allison Tankel. Such rescission will take effect upon receipt by the school.

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## DISMISSAL/LATE POLICY

Dear Parents:

Please read this **VERY IMPORTANT** policy about picking children up late at the end of their class session. This information is also included in the Handbook. After you have read this, please sign at the bottom, and return it to your teacher with all of the other required forms.

Thank you,

Allison Tankel, Early Childhood Director

**Dismissal/Late Policy**: Children are to be picked up promptly at the end of the school session. Please be considerate of our staff and of your child, who is anxious to go home, especially once all of the other children have been picked up. Significant lateness will be subject to a fine which will be charged to the family's account and for payment of which the family will be responsible.

The fee structure for late pickup is as follows:

| Minutes Late | Charge |
|---|---|
| 15-30 | $10.00 |
| Over 30 | $25.00 |

You will be billed and payment will be due within 7 days of the billing date. If the payment is not received within 14 days of the billing date, your child will **not** be permitted to attend any classes until payment in full is received.

I have read the "Dismissal/Late Policy". I acknowledge receipt of this information.

Signature:_____ Date: _____

## WALK PERMISSION SLIP

I give my child, _____ permission to take local walks on school grounds with his / her class throughout the year.

_____ _____

Parent's signature Date

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## PARENT-CHILD QUESTIONNAIRE

In order to assist us in getting to know your child, please complete the following form as fully as possible. If you need additional space, please use the other side of the street. The information you provide will help the teachers in planning a good program for your child.

CHILD's NAME: _____

Please list your child's strengths:

Please list your areas where your child can improve:

How does your child learn best? (i.e. visual, auditory, tactile)

What kind of group activity (ies) has your child enjoyed? (School, playgroup, etc).

67 Kent Place Boulevard * Summit, NJ 07901 * 908-277-3919 * allison@summitjcc.org
www.summitjccelc.org

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

PARENT-CHILD QUESTIONNAIRE (CONTINUED)

CHILD'S NAME:_____

How do you see your child in relationship to others of a similar age?

Please describe your child's relationship with adults:

Please list other members of your household (siblings, grandparents, pets etc)

What are your child's favorite activities?

What are your child's least favorite activities?

Is your child potty-trained?

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

Dear Parents:

You will find medical forms which should be completed by your child's doctor, and returned by **July 1, 2019**. The forms can be mailed directly to the above address, or dropped off at the Early Learning Center office.

**What we need:**

- We need all parents to have their pediatrician complete the **Universal Health Care Provider Form** from a well visit that was conducted within the past 12 months.

- If your child is new to the school, we will also need you **to complete the attached immunization card**. Please advise your pediatrician's office that they must complete the **immunization form**.

  We also need **a child's immunization history with the doctor's signature and seal.** If your child is returning to our school and has received **additional vaccinations** this past year, we will need an updated immunization card to be completed.

- Influenza Vaccine needs to be administered to all children ages 6 months to 59 months by December 1st. Please have your doctor complete the form upon the vaccination.

Please note, if your child attended our Summer Fun Program for the first time this year and you submitted all the required medical information, you do not need to complete a new medical form if the well visit exam was conducted within the past year.

Sincerely,

Allison Tankel

**67 Kent Place Boulevard * Summit, NJ 07901 * 908-277-3919 * allison@summitjcc.org**
**www.summitjccelc.org**

*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<br>☐ Date Next Immunization Due: _____ |
|---|---|

### MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>• List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>• List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>• List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>• List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>• List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>• List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>• List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>• List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ 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.

**This form must also be filled out** in addition to submitting proof of vaccinations.

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

# Summit JCC ELC Food Allergy & Anaphylaxis Emergency Action Plan

Place Child's Picture Here

Name:_____ D.O.B:_____ Teacher:_____
ALLERGY TO:_____
Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

## STEP 1: TREATMENT

**Symptoms:** Give Checked Medication**:
**(To be determined by physician authorizing treatment)

| | | |
|---|---|---|
| If a food allergen has been ingested, but no symptoms: | Epinephrine | Antihistamine |
| Mouth Itching, tingling, or swelling of lips, tongue, mouth | Epinephrine | Antihistamine |
| Skin Hives, itchy rash, swelling of the face or extremities | Epinephrine | Antihistamine |
| Gut Nausea, abdominal cramps, vomiting, diarrhea | Epinephrine | Antihistamine |
| Throat† Tightening of throat, hoarseness, hacking cough | Epinephrine | Antihistamine |
| Lung† Shortness of breath, repetitive coughing, wheezing | Epinephrine | Antihistamine |
| Heart† Thready pulse, low blood pressure, fainting, pale, blueness | Epinephrine | Antihistamine |
| Other† _____ | Epinephrine | Antihistamine |
| If reaction is progressing (several of the above areas affected), give | Epinephrine | Antihistamine |

The severity of symptoms can quickly change. †Potentially life-threatening.

**DOSAGE**

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: _____ ) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ at _____

3. Emergency contacts:

Name/Relationship Phone Number(s)

a. _____ 1.)_____ 2.) _____

b. _____ 1.)_____ 2.) _____

c. _____ 1.)_____ 2.) _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

Parent/Guardian
Signature_____
Date_____

Doctor's
Signature_____
Date_____

Use for Prescriber's Address Stamp

**LOCATION OF EPINEPHRINE:**

_____ With Teacher

_____ Main Office

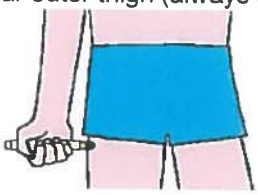
## Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions

Remove GREY caps labeled "1" and "2". Place RED rounded tip against outer thigh, press down hard. Hold for 10 seconds, then remove.

## EPiPEN® Auto-Injector and EpiPEN Jr.® Auto-Injector Directions

- First, remove the EpiPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)

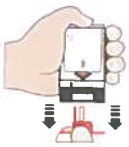


- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove EpiPEN Auto-Injector and massage the area for 10 more seconds

EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

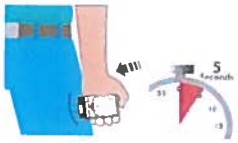
## Auvi-Q ™ (epinephrine injection USP)

Remove the outer case of Auvi-Q. This will automatically activate the voice instructions.






Pull off RED safety guard



Place black end against outer thigh, press firmly, hold for 5 seconds

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

# Summit JCC ELC Emergency Medication Administration Authorization Form

Dear Parents:

The Summit JCC ELC will only administer medication in an emergency situation. Please complete and return the attached form (s). Please note the following:

- Medication administration forms must be completed and signed by your child's health care provider and stamped with their office stamp.
- Parental signature is required as well authorizing administration of the prescribed medication.
- Medication must be in the original container as dispensed by the pharmacy with the child's name on the affixed label.
- Any over-the-counter medication must be unopened, in the original box.

If you have any questions, please let us know.

67 Kent Place Boulevard * Summit, NJ 07901 * 908-277-3919 * allison@summitjcc.org
www.summitjccelc.org

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## Summit JCC ELC Emergency Medication Administration Authorization Form

Name of Student: _____ Date of Birth: _____

This order is valid only for school year (current) _____ including the summer camp if applicable.

**This form must be completed fully in order for the school to administer the required emergency medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of medication.**

• Prescription medication must be in a container labeled by the pharmacist or prescriber.

• Over the counter medication, when prescribed, must be in the original sealed container with the label intact. •

### Prescriber's Authorization

Condition for which medication is being administered: _____

Medication Name: _____ Dose: _____ Route: _____

Time/frequency of administration: _____

Relevant side effects: ____None expected / Or specify: _____

Prescriber's Name/Title: _____

(Type or Print)

Telephone: _____ Fax: _____

Address:

_____

_____

Use for Prescriber's Address Stamp

Prescriber's Signature: _____ Date:_____

(Original signature or signature stamp ONLY)

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### PARENT/GUARDIAN AUTHORIZATION

I/We request the school to administer the medication as prescribed. I/We certify that I/We have legal authority to consent to medical treatment for the student named above, including the administration of medication at school.

Parent/Guardian Signature: _____ Date: _____

Home Phone: #: _____ Cell Phone #: _____

Allison Tankel, Early Childhood Director
Amy Weinstock, School Administrator

## INFLUENZA VACCINE DOCUMENTATION

The New Jersey Health Commissioner has mandated that all children ages six (6) months to fifty-nine (59) months attending preschool must have received at least one (1) dose of the influenza vaccine between September 1st and December 31st of each year. This rule is mandatory throughout the State of New Jersey. The Summit JCC Early Learning Center as part of its requirements must collect proof of immunization once it occurs.

_____ has received at least one dose of the

Influenza vaccine on _____.

(date)

Physician's Name_____

Physician's Signature

_____

**PLEASE RETURN TO SCHOOL BY DECEMBER 1, 2019.**

67 Kent Place Boulevard * Summit, NJ 07901 * 908-277-3919 * allison@summitjcc.org
www.summitjccelc.org