

**PLEASE READ THE FOLLOWING CAREFULLY. YOUR SIGNATURE BELOW WILL
ACKNOWLEDGE ACCEPTANCE OF THESE TERMS.**

YWCA Central New Jersey Early Childhood Learning Center Program Fees

All fees are due and payable on the first day of each month. We send out invoices as a courtesy. Please note that the fees are due the first day of every month regardless of whether or not you have received a physical invoice. If your fees are not paid during the first week of the month, your child/ren will be subject to termination from the program. Teachers and Administrative Staff are not able or allowed to negotiate fees or payment schedules. You must contact the Finance Administrator at 908-756-3500, ext. 121 to make payment arrangements.

If there are any circumstances that require your child to be absent for more than 1 week, it is very important that you call Renee Daniels at 908-756-3500, ext.129 as soon as possible. Making an adjustment after the fact is very difficult, and we expect full payment unless arrangements have been made. We want to accommodate any unusual circumstances, but you must give us the opportunity to do so.

The Early Childhood Learning Center operates from 6am to 7pm. Should your child arrive earlier than scheduled or remain later than scheduled, you will be billed for those additional hours of care according to our regular fee schedule.

If your child remains after regular closing time, we will attempt to locate the parent/guardian and the emergency contact, but it is your responsibility to alert us to unusual circumstances. In the event that we are unable to locate anyone, local authorities and/or DYFS will be called for assistance.

I HAVE READ AND UNDERSTAND THE PROCEEDING INFORMATION REGARDING THE YWCA'S PAYMENT POLICIES, UNSCHEDULED EXTENDED CARE, AND LATE PICKUP.

PARENT SIGNATURE

DATE

CHILD'S NAME

OFFICE USE ONLY

_____ SSBG

_____ CATH CHAR/ 4C'S/ DYFS

_____ FULL PAY

YWCA of CENTRAL NEW JERSEY CHILDREN'S PROGRAMS HEALTH FORM

CHILD'S NAME _____ DOB _____ SEX _____ AGE _____

MOTHER/GUARDIAN'S NAME _____ PHONE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER/GUARDIAN'S NAME _____ PHONE _____

HOME ADDRESS _____ CITY _____ STATE _____ ZIP _____

IF NOT AVAILABLE IN AN EMERGENCY, NOTIFY:

NAME _____ ADDRESS _____ PHONE _____

HEALTH HISTORY (GIVE APPROXIMATE DATES)

	DATE		DATE		DATE
FREQUENT EAR INFECTIONS		HEART DISEASE/DEFECTS		CONVULSIONS	
DIABETES		BLEEDING/CLOTTING DISORDERS		MUMPS	
HYPERTENSION		MONOUCLEOSIS		MEASLES	
CHICKEN POX		GERMAN MEASLES		HAYFEVER	
IVY POISONING		INSECT STINGS		ASTHMA	

OPERATIONS OR SERIOUS ILLNESSES (DATES): _____

DISABILITIES OR CHRONIC RECURRING ILLNESSES: _____

ANY SPECIFIC ACTIVITIES TO BE ENCOURAGED OR LIMITED BY PHYSICIAN: _____

DIETARY MODIFICATIONS: _____

OTHER DISEASES OR DETAILS OF ABOVE: _____

DENTIST NAME: _____ PHONE: _____

PHYSICIAN NAME: _____ PHONE: _____

DO YOU CARRY FAMILY MEDICAL/HOSPITAL INSURANCE? _____

IF SO, INDICATE CARRIER _____ POLICY # OR GROUP _____

YWCA of CENTRAL NEW JERSEY CHILDREN'S PROGRAMS HEALTH FORM

CHILD'S NAME _____

THIS HEALTH HISTORY IS CORRECT AS FAR AS I KNOW AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED ACTIVITIES EXCEPT AS NOTED.

EMERGENCY AUTHORIZATION:

I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE PROGRAM DIRECTOR TO ORDER X-RAYS, ROUTINE TESTS, AND TREATMENT FOR MY CHILD IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY. I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE PROGRAM DIRECTOR TO HOSPITALIZE MY CHILD IN ORDER TO SECURE PROPER TREATMENT, AND TO ORDER INJECTION AND/OR ANESTHESIA, AND/OR SURGERY IN MY ABSENCE FOR MY CHILD AS NAMED ABOVE, THIS FORM MAY BE PHOTOCOPIED FOR USE.

SIGNATURE OF PARENT OR GUARDIAN _____ DATE _____

THIS SECTION IS TO BE COMPLETED BY LICENSED PHYSICIAN

VACCINES

DATES OF MOST RECENT IMMUNIZATIONS

1. DAPHNIA	1.
2. PETRUSES OR WHOOPING COUGH	2.
3. TETANUS	3.
4. DIPHTHERIA	4.
5. INTERCEPT POLIO	5.
6. MEASLES	6.
7. MUMPS	7.
8. RUBELLA	8.
9. OTHER	9.

TUBERCULIN TEST GIVEN: YES / NO (circle one) * IF YES: NEGATIVE / POSITIVE (circle one)

DATE TUBERCULIN TEST GIVEN: _____

I have examined the above applicant. In my opinion, the applicant's condition does _____ does not _____ preclude his/her participation in an active program.

- The applicant is under the care of a physician for the following condition(s):

- Current medications include: _____
- Explanation of any reported loss of consciousness or convulsions: _____
- Does applicant have epilepsy? Yes _____ No _____
- Does applicant have diabetes? Yes _____ No _____

RECOMMENDATIONS AND RESTRICTIONS WHILE PARTICIPATING AT PROGRAM

- Any dietary restrictions: _____
- Any allergies (food, plants, insects, etc.): _____

Licensed Physician's Signature: _____ **Date:** _____

Address: _____ **Phone:** _____