

A NAEYC Accredited Early Childhood Program

Carletta Martin-Goldston Ed. S.
Executive Director/Chief Operating Officer

**AUTHORIZATION TO TREAT A MINOR IN
ATTENDANCE AT DAY CARE**

I authorize a licenced physician **at NEAREST Hospital** _____
to evaluate my child, _____ in the event that
he/she is taken ill and or is in an accident. Should treatment be deemed necessary by said
physician, and in the event that I cannot be reached after every reasonable effort has been made,
I authorize such treatment in advance. In such event, the Day Care's Chief Operating Officer or
his/her designee may sign the hospital authorization forms for treatment.

A copy of this authorization maybe considered as valid in lieu of the original. I reserve the right
to revoke the authorization at any time in writing and in the absence of said written revocation,
this authorization shall continue in full force and effect.

Date of last tetanus shot: _____

Allergic reaction: _____

Any other medically important information (diabetic, etc.)

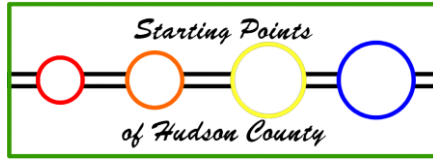
Parent/Guardian Signature and Date

Relationship to child: _____

I may be reached at () _____ During the hours of _____

I may be reached at () _____ During the hours of _____

Authorization to Treat a Minor at Nearest Hospital



A NAEYC -accredited Early Childhood Education Program

Food Allergy Form

To provide the best nutritional environment possible, we need to know what foods, and or beverages, your child is allergic to. This does not include food preferences that your child may have. You need only supply information pertaining to foods that your child is allergic to. This information must be certified by your Childs pediatrician.

Child's Name: _____

Date of Birth _____

My Child does not have any food allergies

Food Allergy

Type of reaction

1. _____

1. _____

2. _____

2. _____

3. _____

3. _____

4. _____

4. _____

5. _____

5. _____

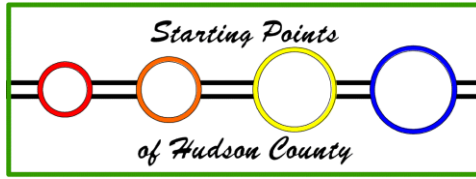
Parent Signature

Date

Doctor's Stamp

Doctor's Signature

Date



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Health Service Release Form

I hereby give permission for Starting Points of Hudson County to provide my child,

_____ with the following services:

Child' Full Name

___ Health Care Treatment as needed

___ Administration of Medication as needed

___ Vision Screening

___ Psychotherapy

___ Hearing Screening

___ First Aid

___ Dental Screening

___ Lead Screening

___ Physical Exams

___ Developmental Screening

Other services needed

Parent's Printed Name

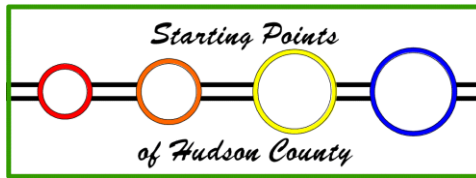
Date

Parent/Guardian Signature

Witnessed by

Administrative Staff Printed Name

Date



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Authorization to release protected Health Information (HIPAA Regulation)

Child's Name: _____

Date of Birth: _____

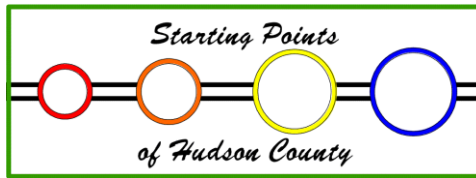
I hereby give Starting Points of Hudson County, permission to release my child's health information to the following individuals:

Name	Relationship to Child
1.	
2.	
3.	
4.	
5.	

Parent/Guardian Print Name

Date

Parent/Guardian Signature



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Permission to Give Over the Counter Medication

I hereby give permission for the nurse at Starting Points of Hudson County Day Care center to administer to my child, _____, the following non-prescription, over the counter, medications in accordance with New Jersey State Law.

Check Box for Permission

- 1. Acetaminophen (aspirin substitutes) for fever of 101 and above or pain.
- 2. Decongestants/Antihistamines (Benadryl) for allergic reactions.
- 3. Cough suppressants – If cough interferes with eating, sleeping, and/or breathing.
- 4. Topical Ointments – for general first aide needs.
- 5. Sunscreen/Sun block -UVB and UVA protection of SPF 15 or higher that is applied to exposed skin.
- 6. Insect repellent.
- 7. I do not wish for any medications to be administered to my child.

Parent/Guardian Printed Name

Date

Permission to Give Over the Counter.....

254 Bartholdi Ave. Jersey City, NJ 07305/PHONE (201) 433-8252/FAX (201) 433-6969/EMAIL sphcnj@verizon.net

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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination:	Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

<input type="checkbox"/> 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 health 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.