

Child Development Centers for Bristol-Myers Squibb  
Back-Up / School-Age Enrollment Materials

## CHECKLIST

- Registration Form
- Developmental History Profile (Infants, Toddlers, Preschool or School-Age)
- Authorization and Consent/Child Release Form
- Policy on Release of Children
- Income Verification Form for Camp Explorations only (For BMS employees only; required only when applying for a reduced tuition fee)
- Universal Child Health Record (Must be completed by a Physician)
- Information to Parents Under the Manual of Requirements for Child Care Centers (New Jersey Only)
- Photograph of Child(ren)
- Photograph(s) of Parent(s) and/or Guardian(s)
- Photograph(s) of Authorized Release Person(s)

### PLEASE NOTE:

A complete set of forms and pictures are required for each child you are registering and must be completed prior to your child's first day at the Child Development Center.

Child Development Centers for Bristol-Myers Squibb  
Central New Jersey and Connecticut

Registration Form

Child's Name: \_\_\_\_\_  
(Last) (First) (Nickname)

Child's Home Address: \_\_\_\_\_

Child's Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Child's Gender: M F

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Other Identifying Marks: \_\_\_\_\_

Names and Ages of Child's Brothers and Sisters: \_\_\_\_\_

\_\_\_\_\_

Child's Physician/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_  
(Last) (First)

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Work Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address via Internet: \_\_\_\_\_

Work Beeper/Cellular Number: \_\_\_\_\_

Home Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home Fax: \_\_\_\_\_



# BRIGHT HORIZONS

## INFANT/TODDLER DEVELOPMENTAL HISTORY

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

What would you like us to call your child? \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Type of birth: \_\_\_\_\_ Complications: \_\_\_\_\_

Age child began sitting: \_\_\_\_\_ crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_

Does child:  pull up  crawl  walk with support

Times child is fussy: \_\_\_\_\_

How do you handle these fussy times? \_\_\_\_\_

### FAMILY INFORMATION

With whom does child reside? \_\_\_\_\_

Who else lives in the home (siblings, extended family, pets)? \_\_\_\_\_

What does child call family members? \_\_\_\_\_

Language spoken at home: \_\_\_\_\_

Are books read in languages other than English? \_\_\_\_\_

Are there words in your home language that we should know? \_\_\_\_\_

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful: \_\_\_\_\_

### HEALTH/ DEVELOPMENT

Serious illnesses or hospitalizations (describe)? \_\_\_\_\_

Any history of colic? \_\_\_\_\_

Special physical conditions, disabilities, or allergies (describe)? \_\_\_\_\_

Is your child presently or ever been diagnosed with a special need? \_\_\_\_\_

If so, is he/she receiving any special services? \_\_\_\_\_

Regular medications? \_\_\_\_\_

## EATING HABITS

Special characteristics or difficulties? \_\_\_\_\_

Special diet: \_\_\_\_\_ Formula: \_\_\_\_\_ Breast Milk: \_\_\_\_\_

Any food allergies? \_\_\_\_\_

Have solid foods been introduced?  yes  no If yes, please identify: \_\_\_\_\_

Favorite foods: \_\_\_\_\_ Foods refused: \_\_\_\_\_

Child eats:  on lap  high chair  other

Child eats with:  spoon  fork  hands  other

## TOILETING/DIAPERING HABITS

Is there frequent diaper rash?  yes  no

Do you use:  oil  powder  lotion  other

Does child wear:  disposable diapers  cloth diapers

Are bowel movements:  regular how often: \_\_\_\_\_

Is there a problem with:  diarrhea  constipation

Is your child toilet trained:  yes  no If yes, when did you begin? \_\_\_\_\_

urination  bowels or  both

What is used at home:  potty-chair  special seat  regular seat

Word used for urination: \_\_\_\_\_ bowel movement: \_\_\_\_\_

Does your child have accidents?  yes  no If yes, how often/when? \_\_\_\_\_

## SLEEPING HABITS

Does child sleep in:  crib  bed  with parents

Does child sleep on:  back  side  stomach

Times child take naps? Times: a.m. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ p.m. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

What does child take to bed? \_\_\_\_\_ mood on awakening: \_\_\_\_\_

What time does child go to bed at night: \_\_\_\_\_ awake in morning: \_\_\_\_\_

Are there any sleep/wake time rituals? If so, please describe. \_\_\_\_\_

## SOCIAL RELATIONSHIPS

Has child had any experience playing with children? If so, please describe. \_\_\_\_\_

Is child:  friendly  aggressive  shy  withdrawn

Reaction to strangers? \_\_\_\_\_

Have you had any previous child care experience?  yes  no If yes, did it meet your needs and expectations? Explain: \_\_\_\_\_

Prefers to play:  alone  in small groups

Favorite toys and activities? \_\_\_\_\_

Is child frightened by:       animals    rough children    loud noises    dark    other

Explain: \_\_\_\_\_

How do you comfort your child? \_\_\_\_\_

How does your child prefer to be held? \_\_\_\_\_

What is your style of disciplining? \_\_\_\_\_

### DAILY SCHEDULE

Please describe by approximate time your child's current daily activities (e.g., awakening, eating, time out of crib, napping, toilet habits, fussy time, bedtime):

MORNING

AFTERNOON

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### PARENTING PHILOSOPHY

Do you have ideas about parenting that would help us to better care for your child as an individual? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you, as a family, hope to get out of this child care experience? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**BRIGHT HORIZONS  
PRESCHOOL/KINDERGARTEN DEVELOPMENTAL HISTORY**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

What would you like us to call your child? \_\_\_\_\_

**DEVELOPMENTAL HISTORY**

Age child began sitting: \_\_\_\_\_ crawling \_\_\_\_\_ walking \_\_\_\_\_ talking \_\_\_\_\_

Any speech difficulties? \_\_\_\_\_

**FAMILY INFORMATION**

With whom does the child reside? \_\_\_\_\_

Who else lives in the home (siblings, extended family members, pets)? \_\_\_\_\_

What does child call family members? \_\_\_\_\_

Language spoken at home: \_\_\_\_\_

Are books read in languages other than English?  yes  no If yes, what language(s)? \_\_\_\_\_

Are there words in your home language that we should know? \_\_\_\_\_

Please tell us about any cultural family customs, rituals or traditions that will help us make your child's experience more meaningful: \_\_\_\_\_

**HEALTH/DEVELOPMENT**

Serious illnesses or hospitalizations (describe): \_\_\_\_\_

Any physical/chronic conditions, disabilities, including allergies? Describe: \_\_\_\_\_

Regular medications: \_\_\_\_\_

Is your child presently or ever been diagnosed with a special need?  yes  no If so, is he/she receiving any special services? Explain. \_\_\_\_\_

**EATING HABITS**

Any food allergies? \_\_\_\_\_

Special diet: \_\_\_\_\_

\_\_\_\_\_

Special characteristics or difficulties? \_\_\_\_\_

\_\_\_\_\_

Favorite foods: \_\_\_\_\_ Foods refused: \_\_\_\_\_

Child eats with:       spoon    fork    hands    other

**TOILETING HABITS**

How does child indicate bathroom needs (include special words)? \_\_\_\_\_

\_\_\_\_\_

Is child reluctant to use the bathroom?    yes    no   If yes, how do you handle? \_\_\_\_\_

\_\_\_\_\_

Does child have accidents?    yes    no   If yes, how often and when? \_\_\_\_\_

\_\_\_\_\_

**SLEEPING HABITS**

Does child become tired or nap during the day (include when and how long)? \_\_\_\_\_

What time does child go to bed at night: \_\_\_\_\_ awake in morning: \_\_\_\_\_

Describe any special characteristics or needs (stuffed animal, story, mood on waking): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are there any sleep/wake time routines? \_\_\_\_\_

\_\_\_\_\_

**SOCIAL RELATIONSHIPS**

How would you describe your child? \_\_\_\_\_

\_\_\_\_\_

Describe any previous experience with children: \_\_\_\_\_

\_\_\_\_\_

Has there been any previous child care experience?    yes    no   If so, did it meet your needs and expectations? \_\_\_\_\_

\_\_\_\_\_

Reaction to strangers: \_\_\_\_\_

Prefers to play alone or in groups? \_\_\_\_\_

Favorite toys and activities: \_\_\_\_\_

\_\_\_\_\_

Fears (e.g., the dark, animals): \_\_\_\_\_

How do you comfort your child? \_\_\_\_\_

How do you discipline your child? \_\_\_\_\_

**DAILY SCHEDULE**

Describe your child's schedule on a typical day:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What would you like your child to gain from the child care experience?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Anything else you would like us to know about your child?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Parent/Guardian's Signature)

\_\_\_\_\_  
(Date)

**The Child Development Centers for Bristol-Myers Squibb  
School Age Care Plan**

Date \_\_\_\_\_ Child's Date of Birth \_\_\_\_\_

Child's Name \_\_\_\_\_  
Last First Middle (Nickname)

Language

What languages does your child speak/understand?  
\_\_\_\_\_

Personal Background

What school does your son/daughter attend?  
\_\_\_\_\_

What is his/her favorite school subject?  
\_\_\_\_\_

Is your son/daughter involved in extra curricular activities? Y N If yes, please list activities (i.e. cheerleading, band...)  
\_\_\_\_\_

What kind of music/groups does your son/daughter like?  
\_\_\_\_\_

What are his/her hobbies? (i.e. collecting cards, beanie babies...)  
\_\_\_\_\_

Does your son/daughter play sports? Y N If yes, please list sport and season (i.e. baseball-Spring)  
\_\_\_\_\_

Does he/she have any favorite professional sports teams? Y N If yes, please list  
\_\_\_\_\_

What does your son/daughter enjoy doing on the weekend?  
\_\_\_\_\_

Who does your son/daughter most enjoy spending time with?  
\_\_\_\_\_

Does your son/daughter have any siblings? Y N If yes, please list names and ages  
\_\_\_\_\_

Has your son/daughter shown interest in dating? Y N If yes, is there anything we should know?  
\_\_\_\_\_

Routines

Is there anything we should know about your son/daughter with regard to:

Eating: \_\_\_\_\_

Sleeping: \_\_\_\_\_

Bathroom Issues: \_\_\_\_\_

Other: \_\_\_\_\_

Behavior

Is your son/daughter friendly? \_\_\_\_\_ aggressive? \_\_\_\_\_ shy? \_\_\_\_\_ withdrawn? \_\_\_\_\_

How does your son/daughter get along with adults?  
\_\_\_\_\_

What does he/she enjoy doing with you or other adults?  
\_\_\_\_\_

How does he/she react to frustration?  
\_\_\_\_\_

Separation

Has your child ever been separated from you for a long period of time?  
\_\_\_\_\_

How does your child react to being left by you?  
\_\_\_\_\_

Are there special routines that might make the day easier for your child?  
\_\_\_\_\_

Physical Background

Has your child had any serious illness, operations, or accidents since birth?  
\_\_\_\_\_

What health problems has your child had in the past?  
\_\_\_\_\_

What health problems does your child have now? Any physical disabilities?  
\_\_\_\_\_

Any allergies? Food? \_\_\_\_\_  
Medication? \_\_\_\_\_  
Other? \_\_\_\_\_

How severe? \_\_\_\_\_

Does your child take any medicine regularly? If so, what? \_\_\_\_\_

Has your child ever been hospitalized? If so, why and when?

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Does your child have any recurring chronic illness or health problems (such as asthma or frequent earaches)?

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Does your child have a disability that has been diagnosed (such as cerebral palsy, seizure disorder, developmental delay)?

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Do you have any concerns about your child's health?

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Development
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Does your child have any problems with talking or making sounds? Please explain:

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Does your child have any problems with walking, running, or moving? Please explain:

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Does your child have any problems seeing? Please explain:

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Does your child have any problems hearing? Please explain:

---

Does your child have any problems using his/her hands (such as with puzzles, drawings, small building pieces)? Please explain:

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Do you have any concerns about your child's development?

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Parent's Signature

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Date

---

Parent's Signature

---

Date

## BRIGHT HORIZONS AUTHORIZATION AND CONSENT / CHILD RELEASE

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child, \_\_\_\_\_. If I cannot be reached, I understand that the emergency contacts listed below will be called. However, I hereby authorize Bright Horizons to call an ambulance to transport my child to a hospital or medical facility and to secure for my child the necessary medical treatment. I understand the staff in the child care Center/School is trained in the basics of first aid and CPR and I authorize them to give my child first aid. In the best interests of my child, I realize any member of the teaching staff assigned responsibility for the care and education of my child may view my child's health information, as well as state licensors to ensure compliance.

Child's Health Insurance Provider: \_\_\_\_\_  
 Name of Insured: \_\_\_\_\_ Policy Number: \_\_\_\_\_

To ensure children's safety, Bright Horizons will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below as undersigned by the parent/guardian.

By signing this form, I understand that Bright Horizons will not release my child to any other person unless I notify the Center/School in advance, following the guidelines listed below:

- If the person (spouse, relative, friend) picking up my child is listed on this form, I must notify the Center/School verbally.
- If the person picking up my child is **NOT** listed on this form, I must notify the Center/School in writing.
- Photo identification will be required of any person picking up my child.

**Child's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Day Phone #: \_\_\_\_\_

City/Town & Zip: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Day Phone #: \_\_\_\_\_

City/Town & Zip: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Day Phone #: \_\_\_\_\_

City/Town & Zip: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

4. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Day Phone #: \_\_\_\_\_

City/Town & Zip: \_\_\_\_\_ Evening Phone #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

\_\_\_\_\_  
 (Parent/Guardian's Signature) (Date)

\_\_\_\_\_  
 (Parent/Guardian's Signature) (Date)

## Child Development Centers for Bristol-Myers Squibb

### Policy on the Release of Children

At the Child Development Centers for Bristol-Myers Squibb, the safety and security of your child(ren) is our most fundamental responsibility. As a result, each child will be released only to the child's parent(s) or to persons whose names are listed on the Consent for Child Release Form contained in your registration materials. You must advise the Center's Director in advance, in writing, if an alternate or person not listed on the original form is to be authorized to pick up your child. For the safety of each child, photographic identification will be required of all authorized persons picking up children. Please understand that we will not release your child without written preauthorization and we will not accept oral authorization for pick up by individuals who are not preauthorized.

In the event that an unplanned pick up of your child by a previously authorized person becomes necessary, a telephone authorization for the release of your child(ren) to an alternate person will require the use of your personal Bright Horizons ID code to verify identity. A telephone authorization can only be accepted as parental consent to release a child to a person previously authorized on the Consent for Child Release. No additions to this form can be made by phone.

If a non-custodial parent has been denied access, or granted limited access, to a child by a court order, the Center must secure documentation to that effect, maintain a copy on file, and comply with the terms of the court order.

All families are required to pick up their child(ren) and exit the Child Development Center by 6:30 pm each evening. If the parent(s) or person(s) authorized by the parent(s) fails to pick up a child by 6:30 pm, the Center will ensure that

- The child is supervised at all times;
- Staff members attempt to contact the parent(s) or person(s) authorized by the parent(s) on the Emergency Information Form in the registration packet; and
- An hour or more after closing time, and provided that other arrangements for releasing the child to his/her parent(s) or person(s) authorized by the parent(s) have failed and the staff members cannot continue to supervise the child at the Center, the staff member will call the Department of Child and Families' 24 hour Child Abuse Hotline (800-792-8610 in New Jersey or 800-842-2288 in Connecticut) to seek assistance in caring for the child until the parent(s) or person(s) authorized by the child's parent(s) is able to pick up the child.

Policy on the Release of Children (Continued)

If the parent(s) or person(s) authorized by the parent(s) appears to be physically and/or emotionally impaired to the extent that, in the judgment of the Director and/or staff member, the child would be placed at risk of harm if released to such an individual, the Center will ensure that

- The child may not be released to such an impaired individual;
- Staff members attempt to contact the child's other parent or an alternative person(s) authorized by the parent(s); and
- If the Center is unable to make alternative arrangements, a staff member shall call the Department of Child and Families' 24 hour Child Abuse Hotline (800-792-8610 in New Jersey or 800-842-2288 in Connecticut) to seek assistance in caring for the child.

I have read and understand the Policy on Release of Children.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Name Printed

Child Development Centers for Bristol-Myers Squibb  
Central New Jersey and Connecticut

Income Verification Form  
(For Bristol-Myers Squibb Employees Only)

Tuition is set on a sliding scale depending on your annual family income. Annual family income includes the adjusted gross income from each parent/guardian who lives with the child and child support received each year (Form 1040; Form 1040AA; Form 1040EZ).

If you filed separately, a copy of tax returns from each parent/guardian who lives with the child must be submitted. Employees who recently joined the company may submit a copy of their last pay stub or offer letter. If for some reason your family income substantially changes below or above your current income, please let the center director know in writing.

If you do not provide verification of income, your tuition will be set at the highest level.

Adjusted Gross Income for Parent #1 (If filed jointly or separately)	\$ _____
Adjusted Gross Income for Parent #2 (If filed separately)	\$ _____
Child Support Per Year	\$ _____
TOTAL	\$ _____

I certify that all information on this form and the attached documentation is complete and true.

BMS Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Other Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\*\*\*

Center Use Only

Income verified by Child Development Centers for Bristol-Myers Squibb:

High: \_\_\_\_\_

Middle: \_\_\_\_\_

Low: \_\_\_\_\_

# UNIVERSAL CHILD HEALTH RECORD

American Academy of Pediatrics  
New Jersey Chapter

Endorsed By:  
New Jersey Department of  
Health & Senior Services

New Jersey Academy of  
Family Physicians

## SECTION 1: TO BE COMPLETED BY PARENTS

Child's Name (Last)	(First)	Date of Birth
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 2: 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**       Immunization Record Attached  
 Date Next Immunization Due:

### MEDICAL CONDITIONS

Chronic Medical Condition/Related Surgeries • List medical conditions/ongoing surgical concerns:  Medications/Treatments • List medications/treatments:  Limitations to Physical Activity • List limitations/special considerations:  Special Equipment Needs • List items necessary for daily activities:  Allergies/Sensitivities • List Allergies:  Special Diet/Vitamin & Mineral Supplements • <u>List dietary specifications:</u>	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached  <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached  <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached  <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached  <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached  <input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments:  Comments:  Comments:  Comments:  Comments:  Comments:  Comments:
Behavioral Issues/Mental Health Diagnosis • <u>List behavioral/mental health issues/concerns:</u>	<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		
Other:			Dental		
Other:			Developmental		
Other:			Scoliosis		

Name, Address, Phone & Fax 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 childcare 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, this 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 and Senior Services, Immunization Program at 609-588-7512.
  - 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 childcare setting.
  - a. If the child has a complex medical condition, a special care plan should be completed and attached. Note any significant medical conditions or major surgical history.
  - b. Medications - List any ongoing medications. Include any medications given at home if they might impact the child's health while in childcare, (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 induce information for the parent and childcare provider as to dosage, route, frequency, and possible side effects. Many childcare providers may likely 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](http://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 and some other programs. This section may be optional for routine childcare settings but 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 was normal.
  - For lead screening state if the blood sample was capillary' or venous.
  - For PPD enter millimeters of in duration, 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.
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.

## The Child Development Centers at Bristol-Myers Squibb Information To Parents

Under provisions of the Manual of Requirements for Child Care Centers (N.J.A.C. 10:122), every licensed child care center in New Jersey must provide to parents of enrolled children written information on parent visitation rights, State licensing requirements, child abuse/neglect reporting requirements and other child care matters. The center must comply with this requirement by reproducing and distributing to parents this written statement, prepared by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children and Families (DCF). In keeping with this requirement, the center must secure every parent's signature attesting to his/her receipt of the information.

\* \* \* \* \*

Our center is required by the State Child Care Center Licensing law to be licensed by the Office of Licensing, Child Care & Youth Residential Licensing, in the Department of Children and Families (DCF). A copy of our current license must be posted in a prominent location at our center. Look for it when you're in the center.

To be licensed, our center must comply with the Manual of Requirements for Child Care Centers (the official licensing regulations). The regulations cover such areas as: physical environment/life-safety; staff qualifications, supervision, and staff/child ratios; program activities and equipment; health, food and nutrition; rest and sleep requirements; parent/community participation; administrative and record keeping requirements; and others.

Our center must have on the premises a copy of the Manual of Requirements for Child Care Centers and make it available to interested parents for review. If you would like to review our copy, just ask any staff member. Parents may secure a copy of the Manual of Requirements by sending a check or money order for \$5 made payable to the "Treasurer, State of New Jersey", and mailing it to: NJ Department of Children and Families, Office of Licensing, Publication Fees, PO Box 657, Trenton, NJ 08646-0657.

We encourage parents to discuss with us any questions or concerns about the policies and program of the center or the meaning, application or alleged violations of the Manual of Requirements for Child Care Centers. We will be happy to arrange a convenient opportunity for you to review and discuss these matters with us. If you suspect our center may be in violation of licensing requirements, you are entitled to report them to the Office of Licensing toll free at 1 (877) 667-9845. Of course, we would appreciate your bringing these concerns to our attention too.

Our center must have a policy concerning the release of children to parents or people authorized by parents to be responsible for the child. Please discuss with us your plans for your child's departure from the center.

Our center must have a policy about administering medicine and health care procedures and the management of communicable diseases. Please talk to us about these policies so we can work together to keep our children healthy.

Our center must have a policy concerning the expulsion of children from enrollment at the center. Please review this policy so we can work together to keep your child in our center.

Parents are entitled to review the center's copy of the Office of Licensing's Inspection/Violation Reports on the center, which are issued after every State licensing inspection of our center. If there is a licensing complaint investigation, you are also entitled to review the Office's Complaint Investigation Summary Report, as well as any letters of enforcement or other actions taken against the center during the current licensing period. Let us know if you wish to review them and we will make them available for your review.

Our center must cooperate with all DCF inspections/investigations. DCF staff may interview both staff members and children.

Our center must post its written statement of philosophy on child discipline in a prominent location and make a copy of it available to parents upon request. We encourage you to review it and to discuss with us any questions you may have about it.

Our center must post a listing or diagram of those rooms and areas approved by the Office for the children's use. Please talk to us if you have any questions about the center's space.

Our center must offer parents of enrolled children ample opportunity to assist the center in complying with licensing requirements; and to participate in and observe the activities of the center. Parents wishing to participate in the activities or operations of the center should discuss their interest with the center director, who can advise them of what opportunities are available.

Parents of enrolled children may visit our center at any time without having to secure prior approval from the director or any staff member. Please feel free to do so when you can. We welcome visits from our parents.

Our center must inform parents in advance of every field trip, outing, or special event away from the center, and must obtain prior written consent from parents before taking a child on each such trip.

Our center is required to comply with the New Jersey Law Against Discrimination (LAD), P.L. 1945, c. 169 (N.J.S.A. 10:5-1 et seq.), and the Americans with Disabilities Act (ADA), P.L. 101-336 (42 U.S.C. 12101 et seq.). Anyone who believes the center is not in compliance with these laws may contact the Division on Civil Rights in the New Jersey Department of Law and Public Safety for information about filing an LAD claim at (609) 292-4605 (TTY users may dial 711 to reach the New Jersey Relay Operator and ask for (609) 292-7701), or may contact the United States Department of Justice for information about filing an ADA claim at (800) 514-0301 (voice) or (800) 514-0383 (TTY).

Our center is required to periodically review the Department of Law and Public Safety (DLPS), Division of Consumer Affairs (DCA), unsafe children's products list, make the list accessible to staff and parents, and ensure that items on the list are not at the center. The list is available at [www.state.nj.us/lps/ca/recall/recalls.htm](http://www.state.nj.us/lps/ca/recall/recalls.htm). Internet access may be available at your local library. For more information call the DLPS, DCA, toll-free at 1(800) 242-5846.

Anyone who has reasonable cause to believe that an enrolled child has been or is being subjected to any form of hitting, corporal punishment, abusive language, ridicule, harsh, humiliating or frightening treatment, or any other kind of child abuse, neglect, or exploitation by any adult, whether working at the center or not, is required by State law to report the concern immediately to the State Child Abuse Hotline, toll free at 1 (877) NJ ABUSE. Such reports may be made anonymously. Parents may secure information about child abuse and neglect by contacting: DCF, Office of Communications and Legislation at (609) 292-0422 or go to [www.nj.gov/dcf](http://www.nj.gov/dcf) and select Publications.

I certify that all information provided on this sheet is acceptable to me and has my full authorization. I understand that it is my responsibility to update Center staff should any information change.

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_