The Gingham Giraffe Preschool
234 Southern Boulevard
Chatham, New Jersey 07928
973-635-0033
www.ginghamgiraffe.com

Program:
Class:
Payment:
Enrollment Date:

Child's Name: ____________________ Sex_____ Birthdate:________________
Address: ____
Phone: _________________ Email:______________________________________

Father's Name: ___________________ Mother's Name: ____________________
Address: ________________________ Address: _________________________
cell phone:_______________ cell phone:________________________
Father's Occupation:____
Address: ________________________________ Phone:__________________
Mother's Occupation____
Address: _______________________________ PtPhone: __________________

Persons other than Parent(s) authorized to pick up child and/or contact in case either parent is unavailable...GEOGRAPHICALLY CLOSE PLEASE.
Name __________________________ **Relationship** ____________________
Address: ____
Phone: __________________________Cell Phone: _______________________

Name __________________________ Relationship: ______________________
Address: ____
Phone: _________________________ Cell Phone: _______________________
CHILD'S DOCTOR: _______________**Phone:** ________________________
Address: ____
CHILD'S DENTIST:________________**Phone:** ________________________
Address: ____

In the event of a medical emergency, I authorize the Staff of The Gingham Giraffe Preschool to seek medical care for my child if necessary.
Parent/Guardian Signature: _________________________ Date: __________

I have received the Parent Handbook which contains all School Policies and the NJ Information to Parent's statement. I agree to support the Preschool with tuition payments.
Parent/Guardian Signature: _________________________ Date: __________
Can be signed first day....

The Gingham Giraffe Preschool **973-635-0033** **Medical Form**

Child's name ____ Birthdate __________

IMMUNIZATIONS REQUIRED BY LAW Month/Day/Year

DPT Series 1._____ 2. _____ 3. _____ 4. _____ Booster _____ Booster _____

POLIO Series 1._____ 2. _____ 3. _____ 4. _____ Booster _____ Booster _____

HIB Series 1. _____ 2. _____ 3. _____ 4. _____

HEPATITIS B 1._____ 2. _____ 3.______ 4. _____

MMR Series 1. _____ Booster _____

VARICELLA/VARIVAX 1. _____ 2. _____

PNEUMONIA 1.______ 2.______ 3.______ 4.______

INFLUENZA _____ This is due by Dec.31st, 2011

Is there any reason this child cannot participate in the normal physical activities found in a Preschool program? _______. If yes, please explain________________________________
Is this child currently receiving any therapy? If yes, what type and how frequently?

____

Has the child had any of the following illnesses/conditions? If so, when?

ASTHMA ? _____ DIABETES ? _____ ALLERGIES/Foods? _____
Chicken pox _____ Rheumatic Fever _____ Seizures/convulsions_____
Measles _____ Heart Disease _____ Pneumonia _____

Is this child taking any kind of medication on a regular basis? _______________________
Does any condition warrant any kind of medication to be on the Preschool premises?

____

This child was given a routine medical exam and found to be free of infectious or contagious diseases.
______________________________ Signature of Physician
____Address

I give the Preschool permission to directly contact the above Physician and/or his Staff to clarify any of the above information. PARENT SIGNATURE ________________________DATE_____

Completed form may be mailed: The Gingham Giraffe Preschool 234 Southern Boulevard
Chatham, New Jersey 07928

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

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	

 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider