Date_____

# Glassboro Child Development Centers
# Preschool Registration Forms

Student's Name: _____
Date of Birth: _____ Current Age: _____ Sex: _____M _____F
Diaper/Pull up Size: _____
Parent's Name: _____
Email: _____

Does your child have any allergies or food restrictions or require medication? ☐ YES ☐ NO
**If yes, GCDC requires documentation** for review prior to enrollment. GCDC may need additional time and resources to develop reasonable accommodations for your student. This may delay enrollment and start date.

**Child Care Resources:** ☐ WFNJ ☐ NJCK ☐ DCP&P
Case Worker: _____ Phone: _____

Please Initial:

## Late Pick-up

_____GCDC School-Age Programs end at 6:00pm. If you are late picking up your child, there will be a cost of $1.00 per minute. Late fees are billed directly through the ProCare account, and an invoice will be automatically generated and emailed to you. For more information regarding our Late Pick-Up Policy, please refer to the Parent Handbook.

## Fees and Costs

_____ Your nonrefundable registration fee of $50 (per child) plus your first week's payment are due at the time of registration. At the time of registration, you are expected to create a ProCare account and pay these fees using the app to complete registration.

_____ Your account is invoiced each Friday (will be sent via email) and your tuition payment is automatically deducted each Sunday. Tuition assistance programs may help cover some of these fees -- please see the back for more information.

## PROCARE Enrollment and Communication App

_____ All families are required to create a ProCare account at time of registration by downloading the ProCare Parent app to their cellphone. *Please note you are not fully registered until your ProCare account is confirmed.* This app is used for all communication, including attendance, payments, weekly/monthly calendars, parent/staff communication and other news.

## Reasonable Accommodations for Children with Special Needs

____ All applicable documentation is to be attached to assist in determining GCDC's ability to reasonably accommodate a child's special needs; the IFSP documents serve as guidance. As a childcare provider we meet the ADA requirements, please note GCDC is not a public school.

## Medication

_____ If your child requires medication, it must be provided 2 days prior to the child's start date, along with medical forms that can be picked up at our main office.

_____ All medications are to be in their original packaging with the pharmacy label with the child's information on it.

## Program Requirements

_____ Students are expected to attend at least 80% of the time (4 days per week).
_____ Students and parents/guardians are expected to participate in surveys and forums that help with the data collection needed for grant reporting throughout the year.
_____ Parents/guardians are expected to participate in family engagement activities at least three times per year.

## Tuition Assistance

_____ Childcare subsidy programs exist to help offset weekly tuition costs if eligible. The following describes the options available:

- NJ State Tuition Assistance: income-based childcare subsidy that requires parents/guardians to work 30+ hours per week, enrolled in 12 semester credits in college or school, or a combination of both. If you work 25-30 hours per week, you may qualify for CCVC/CBC slot at our center. Please email Ms. Itzaida for more information at iromero@gcdckids.net.

***** Please keep in mind that you are responsible for making sure the subsidy contract is up to date and valid.

***** You are responsible for any unpaid fees due to gaps in contract, any assigned mandatory copays, and overage fees. Unpaid fees will result in immediate termination of services.

## Child Release

_____ I certify that the information I've provided about my child's legal parents/guardians is accurate to the best of my knowledge. I understand this will guide pickup authorization and parental communication unless legal documentation is provided to the contrary.
_____ **Both legal parents have equal rights to pick up their child unless we are provided with a court order stating otherwise.** If only one parent is listed on the emergency contact form and no legal documentation has been submitted, we are still obligated to release the child to the other legal parent.
_____ In the absence of a court order, **both parents are presumed to have equal rights** to pick up or access the child, regardless of who enrolled the child. If a parent wishes to restrict the other parent's access, they must provide the center with a **valid, current court order.** The center will retain a copy and enforce it accordingly.
_____ GCDC does not collect or require proof of maternity or paternity at time of enrollment and will rely on parental declarations and documented authorizations of either. Once verbal or written acknowledgement exists of maternity or paternity, GCDC will recognize that individual as a legal parent until provided proof otherwise or until a court document alters parent access.

## Parent Acknowledgement

_____ I understand that once all required documents have been submitted, an enrollment meeting may be scheduled to review application details and finalize next steps before my child may begin.

_____ By signing below, I confirm that the information provided in this GCDC application is complete and accurate to the best of my knowledge.

Parent Name (Print): _____

Parent Signature: _____

# EMERGENCY AND RELEASE INFORMATION

SITE: _____

| | |
|---|---|
| Child's Name: | |
| Date of Birth: | |
| Address: | |
| | |
| Phone: | |

| Parent 1 Contact Information | |
|---|---|
| Name: | |
| Address (if different): | |
| | |
| Cell Phone: | |
| Email: | |
| Employer: | |
| Work Phone: | |

| Parent 2 Contact Information | |
|---|---|
| Name: | |
| Address (if different): | |
| | |
| Cell Phone: | |
| Email: | |
| Employer: | |
| Work Phone: | |

Is there a court order (custody or restraining order) involving this child? ☐ Yes ☐ No
*(If yes, we must have a copy, complete with judge/clerk's signature and date)*

**In the absence of a court order,* ***both parents are presumed to have equal rights*** *to pick up or access the child, regardless of who enrolled the child. If a parent wishes to restrict the other parent's access, they must provide the center with a* ***valid, current court order.*** *The center will retain a copy and enforce it accordingly.*

**IN THE EVENT OF AN EMERGENCY – PARENTS ARE CONTACTED FIRST.**
**IF PARENTS ARE NOT AVAILABLE, THE PERSONS LISTED BELOW WILL BE CONTACTED IN THE ORDER THEY ARE LISTED. PLEASE NOTE: ONLY THE PERSONS LISTED ON THIS FORM ARE AUTHORIZED TO PICK UP YOUR CHILD.**

**Authorized Pick-Up #1**

Name: _____ Relationship: _____
Phone #: _____ Address: _____

**Authorized Pick-Up #2**

Name: _____ Relationship: _____
Phone #: _____ Address: _____

**Authorized Pick-Up #3**

Name: _____ Relationship: _____
Phone #: _____ Address: _____

**Authorized Pick-Up #4**

Name: _____ Relationship: _____
Phone #: _____ Address: _____

**Authorized Pick-Up #5**

Name: _____ Relationship: _____
Phone #: _____ Address: _____

**Authorized Pick-Up #6**

Name: _____ Relationship: _____
Phone #: _____ Address: _____

# EMERGENCY MEDICAL CARE

*This confidential health record will only be used to ensure the safety of the children in this program. This information will not be shared outside of this Childcare program. Feel free to continue your notes on an attached separate sheet.*

1. If my child requires emergency medical care and I cannot be reached, I give my consent to Glassboro Child Development Centers to obtain the necessary medical care for my child. I agree to pay all of the costs associated with the emergency medical care that my child receives. I understand that every effort will be made to contact me before and after medical care is provided.
2. This information is strictly confidential and will not be shared with anyone without my written consent or in the case of emergency medical care.

Child's Doctor: _____ Insurance Company: _____

Phone: _____ Policy Holder's ID: _____

Last Tetanus: _____ Child's Social Security #: _____

Allergies: _____ **Religious Preference: (optional)** _____

Doctor's Address _____

**Please provide your child's medical history.**

| CONDITION | YES | NO |
|---|---|---|
| Asthma | | |
| Does your child use an inhaler? | | |
| Convulsions/Seizures | | |
| Diabetes | | |
| Ear Infections | | |
| Chicken Pox | | |
| Measles | | |
| German Measles | | |
| Rheumatic Fever | | |
| Mumps | | |
| Corrective Device (glasses, hearing aid, etc.) | | |
| Any significant illnesses or surgeries? | | |
| **If "yes" to any of the above, please provide the date or any further details. | | |

| ALLERGY | YES | NO |
|---|---|---|
| Penicillin | | |
| Insect Stings | | |
| Foods | | |
| Plants | | |
| Hay Fever | | |
| Topical ointments | | |
| Other | | |
| **If "yes" to any of the above, please describe reaction. | | |
| Does your child have an EpiPen®? | | |

**Does your child have any special needs that staff should be aware of?**

- ☐ Child has behavioral /emotional challenges
- ☐ Child has physical disabilities
- ☐ Child has IFSP, IEP, or 504 Plan.

**Special Health Care Needs**

**If yes, the following forms are **required** prior to first date of attendance: the Administration of Medication, Food Allergy Action Plan, and/or Asthma Action Plan as needed. Medical forms are available for pick up at our main office and must be completed and signed by a health care physician.

I understand that this consent will be in effect as of the date of my signing and will continue the duration of my child's enrollment with GCDC programs.

_____

Parent/Guardian Signature Date


# Glassboro Child Development Centers
# Photo Release Form

Please select site of attendance:

| | | | |
|---|---|---|---|
| | Preschool-Main | | HORIZON-Grades 1-2 |
| | Preschool-Ellis | | JURASSIC-Grades 3-8 |
| | RASKEL-Grades PK 3-K | | |

Child's Name: _____
Parent/Guardian Name: _____
Date Completed: _____

I, the undersigned, hereby grant permission to Glassboro Child Development Centers to use photographs, video, or other images of my child for the purposes listed below:

- ☐ Social Media (e.g., Facebook, Instagram, Twitter)
- ☐ GCDC Website and E-newsletters
- ☐ Print Media (newsletters, brochures, flyers, newspapers, etc.)

These images may be used for informational, promotional, and educational purposes, and may be published in print or digital formats. I understand that my child's full name will not be used unless I give specific written consent.
I understand that I may revoke this consent at any time in writing, but that revocation will not affect any use already made prior to the revocation.

Consent Options (please check one):

- ☐ I give permission for my child's image to be used as indicated above.
- ☐ I do not give permission for my child's image to be used.

Signature of Parent/Guardian: _____ Date: _____
Parent/Guardian Contact Information:

Phone: _____ Email: _____

# BLANKET PERMISSION SLIP

Note: A specific Permission Slip will be given to you for every trip. In the event that we have not received a completed form, or your child was absent at the time the forms were distributed, this Blanket Permission Slip Form will be used along with your verbal permission.

When signed below, this form allows your child to participate in the following activities and services offered by Glassboro Child Development Centers:

- Supervised activities at the center
- Supervised walks around the neighborhood
- Emergency treatment by a physician or dentist in their office or at a hospital (as determined by qualified personnel or the EMT in Glassboro).

Permission is given for all the activities and services specified above by signing this form. My child is in good health and can participate in the normal activities of the GCDC programs. Furthermore, any conditions or special needs that may require special accommodations are described below.

Child's Name: _____

Parent/Guardian Signature: _____

Parent/Guardian Name: _____

Relationship to Child: _____

Date: _____

# PARENT HANDBOOK /POLICY RECEIPT ACKNOWLEDGEMENT

Dear Parent:

In keeping with New Jersey's child care center-licensing requirements we are obligated to provide you, as the parent of a child enrolled at our center, with this statement as well as other policies attached.

Please read the policies and if you have any questions, feel free to contact us at 856-881-3331.

Sincerely,

Joan E. Dillon, Executive Director

---

## Please complete and return this portion to the center. (Please print)

I, _____, have received the following policies for Glassboro Child Development Centers, outlined in the parent handbook for my child's program:

___ Administration of Medication
___ Breastfeeding *(Preschool Only)*
___ Communicable Diseases
___ Completion of Assessment
___ Diapering
___ Fee Policies
___ Hand Washing Guidelines
___ Information to Parents
___ Nutrition and Physical Activity
___ Parent Grievance
___ Right to Refuse Services
___ Screen Time
___ Supervision of Children
___ Toilet Training
___ Visiting Consultants/Therapists
___ Attendance *(Preschool Only)*
___ Discipline/Expulsion
___ Communication/Notification
___ Dental Health *(Preschool Only)*
___ Family Engagement
___ Transportation
___ Inaccessibility to Toxic Substances
___ Late Pick Up
___ Parent/Family Code of Conduct
___ Release of Children
___ Safe Sleep *(Preschool Only)*
___ Screening/Referral *(Preschool Only)*
___ Transition (*Preschool Only*)
___ Use of Technology and Social Media

I agree to abide by the above policies AND other procedures contained in the parent handbook.

_____
Parent/Guardian signature

_____
Date

_____
Agency Witness

Names of child/children:
_____

_____

_____

**** THIS PAGE MUST BE RETURNED BEFORE YOUR CHILD ENTERS OUR PROGRAM.**

7/2024

# Additonal Child Information

Child's Name: _____
Parent/Guardian Name: _____
Date Completed: _____

**Sleeping**

1. What is your child's current sleep schedule?
   AM wake-up: _____ PM Bedtime: _____ Naps:_____
2. Is your child sleeping throughout the night? ☐ Yes ☐ No
3. Are there any specific bedtime routines? _____
4. Does your child sleep with a special blanket, toy, and "lovey" or pacifier? ☐ Yes ☐ No
   If yes, explain: _____
5. Does your child sleep on his/her back or stomach? _____
   *If your child is younger than 4 months old, your child will always be put in the crib on his/her back. If your child is between 4 and 10 months old, you must provide a doctor's note to allow our staff to place the child in a different position when placed in the crib. PLEASE NOTE: We prohibit pillows/soft bedding and require snug-fitting sheets for infants to reduce the risk of suffocation.

**Social and Emotional Development**

1. Has your child attended childcare before? ☐ Yes ☐ No
2. Is there anything we should know about your child's play with other children, by themselves, any concerns?
3. What kinds of activities does your child enjoy? Are there any activities that your child avoids?
   _____
4. Does your child have any siblings? _____
5. Who lives at home? _____
6. Does your child have any favorite songs or games that comfort them?
   _____
7. What are your expectations and hopes for your child at the center?
   _____
8. Is there anything regarding your family, extended family, or child that you would like to share with us?
   Any other questions or concerns that you would like to share?
   _____
   _____
   _____

**Feeding/Food Preferences**

1. What is your child's feeding schedule?
   a. Mealtimes
      Morning: _____
      Midday: _____
      Afternoon: _____
   b. Formula: _____ How many ounces? _____
   c. Any additional information you'd like us to know: _____
   _____
2. Does your child have any favorite snacks? _____
   _____
3. Does your child have any specific food preferences? (vegetarian, vegan, gluten-free, etc.)
   _____

4. Does your child have any favorite foods? Food they dislike? Refuse to eat?

_____

5. Does your family follow any cultural or religious dietary practices? (halal, kosher, no pork, etc.)

_____

6. Are there any traditional or special foods that you would like to share with the class during celebrations or events? _____

_____

_____

7. Do you celebrate any cultural holidays or festivals that include specific food customs?

_____

_____

_____

Any other information you'd like to share with us:

_____

_____

_____

_____

*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.

# Glassboro Child Development Centers

| **INDIVIDUAL PERMISSION FOR MEDICATION OR HEALTH CARE PROCEDURE** | |
|---|---|
| Child's Name: | Date of Birth: |
| Allergy/Medical Condition: | Name of Medication/Procedure: |
| Reason for administering medication:<br>☐ Cold<br>☐ Teething<br>☐ Rash<br>☐ Sore Throat<br>☐ Ear Infection<br>☐ Injury<br>☐ Other: _____<br><br>Known Allergies: _____<br>_____ | ☐ Prescription *(need doctor's approval)*<br>☐ Non-prescription<br><br>_____<br>Healthcare Provider's Name:<br><br>_____<br>Provider Signature:<br><br>_____<br>Phone Number: Date: |
| Amount to be administered: _____<br>Times to be administered: _____<br>Dates to be administered: _____<br>Refrigeration necessary? ___Yes ___No | Doctor's Office Stamp: |
| Special Instructions: | Possible Adverse Reactions: |

I, _____, authorize the administration of medication for my child, _____, to receive the above medication, according to the directions and cautions, from the Child Care Director or the Child Care Director Designee. I confirm that I have given at least one dose of medication without any evidence of side effects or adverse reactions. I understand that it is my responsibility to provide the medication in its original container labelled with my child's full name. I also agree to supply the appropriate measuring device needed to give an accurate dose of the medication. I authorize the Director or Director Designee to contact the pharmacist or healthcare provider for more information about this drug if necessary. I also give permission to the Director or Director Designee to contact the health care provider regarding my child's health if necessary.

Signature of Parent/Guardian: _____ Date: _____

**OFFICE USE ONLY:**

- ☐ Is all the information above complete?
- ☐ Has the medication been made inaccessible to children?
- ☐ Is the medication in the original container with the prescription label on it?
- ☐ Does the information on the label match the child's information?
- ☐ Is the date on the prescription current?
- ☐ Is the name of the drug/instructions/dose/schedule on the label match what is outlined above?

# Glassboro Child Development Centers

Amount of Medication Provided: _____ Expiration Date: _____

Parent Signature: _____ Date: _____

Director/Designee Signature: _____ Date: _____

Amount of Medication returned to parent: _____

Parent Signature: _____ Date: _____

Director/Designee Signature: _____ Date: _____

## Administration Log

| Date | Time | Reactions Observed | Staff Initials |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

# Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

○ I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/ monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.

○ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

_____

Parent or guardian's signature

_____

Date

Child's Name:_____

Child's date of birth:_____

If child was born 3 or more weeks prematurely, # of weeks premature:_____

Child's primary physician:_____

# Demographic Information Sheet

Today's date: _____

Child's name (first/middle/last): _____

Child's date of birth (MM/ DD/YYYY): _____ / _____ / _____

If child was born premature, # of weeks premature: _____

Child's gender: ○ Male ○ Female

Child's race/ethnicity: _____

Child's birth weight (pounds/ounces): _____

Parent/primary caregiver's name (first/middle/last): _____

Relationship to child: _____

Street address: _____

City: _____

State/province: _____ ZIP/postal code: _____

Home telephone: _____ Work telephone: _____

Cell/other telephone: _____

E-mail address: _____

Child's primary language: _____

Language(s) spoken in the home: _____

ASQ-3™

Child's primary care physician: _____

Clinic/location/practice name: _____

Clinic/practice mailing address: _____

City: _____

State/province: _____ ZIP/postal code: _____

Telephone: _____ Fax: _____

E- mail address: _____

Please list any medical conditions that your child has: _____

_____

Please list any other agencies that are involved with your child/ family:

_____

_____

**Program Information**

Child ID #: _____

Date of admission to program: _____

Child's adjusted age in months and days (if applicable): _____

Program ID #: _____

Program Name: _____

# Strengthening Families

***These next few questions are about you and your household. They will be used to help program staff understand the needs of people and families they are serving, and improve service provision. Remember, your responses to this survey are confidential.***

1. Sex: ◯ A. Male ◯ B. Female ◯ C. Gender non-conforming/non-binary ◯ D. Prefer not to answer

2. Age (in years):_____

3. Primary Language Spoken at Home:

◯ A. English ◯ C. Creole ◯ E. Arabic G. Other:_____
◯ B. Spanish ◯ D. Mandarin ◯ F. Russian

4. Race/Ethnicity (Please choose as many as apply):

◯ A. Native American or Alaskan Native
◯ B. Asian
◯ C. Black or African American
◯ D. African National/ Caribbean Islander
◯ E. Hispanic or Latino
◯ F. Middle Eastern
◯ G. Native Hawaiian/Pacific Islander
◯ H. White (Non-Hispanic/ European American)
◯ I. Multi-racial
◯ J. Other_____

5. Relationship Status:

◯ A. Married
◯ B. Partnered
◯ C. Single-never married
◯ D. Divorced
◯ E. Widowed
◯ F. Separated

6. Family Housing:

◯ A. Own
◯ B. Rent
◯ C. Shared housing with relatives/friends
◯ D. Homeless
◯ E. Temporary (shelter, temporary with friends/relatives)

7. Total Family Income:

◯ A. $0 - $10,000
◯ B. $10,001 - $20,000
◯ C. $20,001 - $30,000
◯ D. $30,001 - $40,000
◯ E. $40,001 - $50,000
◯ F. $50,001 - $60,000
◯ G. More than $60,001

8. Highest Level of Education:

◯ A. No formal education
◯ B. Elementary
◯ C. Junior high school
◯ D. Some high school
◯ E. High school diploma or GED
◯ F. Trade/Vocational training
◯ G. Some college
◯ H. 2-year college degree (Associate's)
◯ I. 4-year college degree (Bachelor's)
◯ J. Advanced degree

9. Which, if any, of the following do you or your family currently receive? (Check all that apply)

◯ A. Supplemental Nutrition Assistance Program (SNAP/ foodstamps)
◯ B. Social Security Disability Income (SSDI)
◯ C. Medicaid
◯ D. Earned Income Tax Credit (EITC)
◯ E. Temporary Assistance for Needy Families (TANF)
◯ F. Head Start/Early Head Start Services
◯ G. Unemployment Benefits
◯ H. State Health Insurance (including children's health insurance)
◯ I. Supplemental Security Income (SSI)
◯ J. None of the above
◯ K. Other

*This survey was developed by the FRIENDS National Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.*

***Please tell us about the children living in your household.***

10. CHILD #1 ◯ A. Male ◯ B. Female ◯ C. Gender non-conforming/ non-binary ◯ D. Prefer not to answer

11. Date of Birth:_____

12. This child lives in my house: ◯ Yes ◯ No

13. What is your relationship to this child?

◯ A. Birth parent ◯ D. Foster parent ◯ G. Other relative

◯ B. Step-parent ◯ E. Grand/Great-grandparent ◯ H. Other

◯ C. Adoptive parent ◯ F. Sibling

14. CHILD #2 ◯ A. Male ◯ B. Female ◯ C. Gender non-conforming/ non-binary ◯ D. Prefer not to answer

15. Date of Birth:_____

16. This child lives in my house: ◯ Yes ◯ No

17. What is your relationship to this child?

◯ A. Birth parent ◯ D. Foster parent ◯ G. Other relative

◯ B. Step-parent ◯ E. Grand/Great-grandparent ◯ H. Other

◯ C. Adoptive parent ◯ F. Sibling

18. CHILD #3 ◯ A. Male ◯ B. Female ◯ C. Gender non-conforming/ non-binary ◯ D. Prefer not to answer

19. Date of Birth:_____

20. This child lives in my house: ◯ Yes ◯ No

21. What is your relationship to this child?

◯ C. Birth parent ◯ D. Foster parent ◯ G. Other relative

◯ D. Step-parent ◯ E. Grand/Great-grandparent ◯ H. Other

◯ C. Adoptive parent ◯ F. Sibling

22. CHILD #4 ◯ A. Male ◯ B. Female ◯ C. Gender non-conforming/ non-binary ◯ D. Prefer not to answer

23. Date of Birth:_____

24. This child lives in my house: ◯ Yes ◯ No

25. What is your relationship to this child?

◯ A. Birth parent ◯ D. Foster parent ◯ G. Other relative

◯ B. Step-parent ◯ E. Grand/Great-grandparent ◯ H. Other

◯ C. Adoptive parent ◯ F. Sibling

*This survey was developed by the FRIENDS National Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.*

# PROTECTIVE FACTORS SURVEY



**Part I.** Please ***circle*** the number that describes how often the statements are true for you or your family. The numbers represent a scale from 1 to 7 where each of the numbers represents a different amount of time. The number 4 means that the statement is true about half the time.

| | Never | Very Rarely | Rarely | About Half the Time | Frequently | Very Frequently | Always |
|---|---|---|---|---|---|---|---|
| 1. In my family, we talk about problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. When we argue, my family listens to "both sides of the story." | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. In my family, we take time to listen to each other. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. My family pulls together when things are stressful. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. My family is able to solve our problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Part II.** Please *circle* the number that best describes how much you agree or disagree with the statement.

| | Strongly Disagree | Mostly Disagree | Slightly Disagree | Neutral | Slightly Agree | Mostly Agree | Strongly Agree |
|---|---|---|---|---|---|---|---|
| 6. I have others who will listen when I need to talk about my problems. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 7. When I am lonely, there are several people I can talk to. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8. I would have no idea where to turn if my family needed food or housing. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 9. I wouldn't know where to go for help if I had trouble making ends meet. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 10. If there is a crisis, I have others I can talk to. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 11. If I needed help finding a job, I wouldn't know where to go for help. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

*This survey was developed by the FRIENDS National Center for Community-Based Child Abuse Prevention in partnership with the University of Kansas Institute for Educational Research & Public Service through funding provided by the US Department of Health and Human Services.*

**Part III.** This part of the survey asks about parenting and your relationship with your child. For this section, please focus on the child that you hope will benefit most from your participation in our services. Please write the child's age or date of birth and then answer questions with this child in mind.

**Child's Age _____ or DOB ___ ___ ___**

| | Strongly Disagree | Mostly Disagree | Slightly Disagree | Neutral | Slightly Agree | Mostly Agree | Strongly Agree |
|---|---|---|---|---|---|---|---|
| 12. There are many times when I don't know what to do as a parent. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 13. I know how to help my child learn. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 14. My child misbehaves just to upset me. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

**Part IV.** Please tell us how often each of the following happens in your family.

| | Never | Very Rarely | Rarely | About Half the Time | Frequently | Very Frequently | Always |
|---|---|---|---|---|---|---|---|
| 15. I praise my child when he/she behaves well. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 16. When I discipline my child, I lose control. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 17. I am happy being with my child. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 18. My child and I are very close to each other. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 19. I am able to soothe my child when he/she is upset. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 20. I spend time with my child doing what he/she likes to do. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

# 2026 NEW JERSEY CHILD AND ADULT CARE FOOD PROGRAM
# ELIGIBILITY APPLICATION

**NAME(S) & AGE(S) OF ENROLLED PARTICIPANT(S)**

*(Name)* *(Age)* *(Name)* *(Age)*

***OPTIONAL:*** *RACIAL/ETHNIC IDENTITY OF PARTICIPANT*

**Check one ETHNIC identity:**

☐ Hispanic or Latino ☐ Not Hispanic or Latino

**Mark one or more RACIAL identity (ies):**

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian or Other Pacific Islander ☐ White

## *Enrollment Information*

***Check ( ✓ ) each day*** *the above participant is enrolled for care, the* ***hours of care*** *each day, and the* ***meal type(s)*** *served:*

| *DAYS OF CARE:* | *MON* | *TUES* | *WED* | *THURS* | *FRI* | *SAT* | *SUN* |
|---|---|---|---|---|---|---|---|
| *HOURS OF CARE:* | | | | | | | |
| *Swing / Rotating Shifts: (If Applicable)* | ___ ___ | ___ ___ | ___ ___ | ___ ___ | ___ ___ | ___ ___ | ___ ___ |

*MEAL TYPES SERVED:* ☐ ***BREAKFAST*** ☐ ***A.M. SUPPLEMENT*** ☐ ***LUNCH*** ☐ ***P.M. SUPPLEMENT*** ☐ ***DINNER***

## CHILD DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

**OPTION 1A: BENEFICIARIES of Supplemental Nutrition Assistance Program (SNAP)** *(formerly Food Stamps)*, **Temporary Assistance for Needy Families (TANF), or Food Distribution Program on Indian Reservations (FDPIR)**

If you are now receiving SNAP, TANF or FDPIR for this child, complete **one** of the following numbers:

**SNAP CASE #** _____ *OR* **TANF CASE #** _____ *OR* **FDPIR CASE #** _____

**OPTION 1B: FOSTER CHILD**

If you are applying for a foster child, check the box and list any personal income which has been identified by specific category such as clothing, school fees, allowances, etc.:

☐ **FOSTER CHILD** **INCOME $** _____

## ADULT DAY CARE FOOD PROGRAM PARTICIPANTS ONLY

**OPTION 2: BENEFICIARIES of SNAP, FDPIR, SSI or Medicaid**

If you are now receiving SNAP, SSI, FDPIR or Medicaid complete **one** of the following numbers:

**SNAP #** _____ *OR* **FDPIR CASE #** _____ *OR* **SSI CASE #** _____ **OR MEDICAID CASE #** _____

**OPTION 3: HOUSEHOLD ELIGIBILITY - COMPLETE IF YOU DID NOT COMPLETE OPTION 1A, OPTION 1B, OR OPTION 2**

*Complete the following information: Household Members, Social Security Numbers and Income.*

| NAMES OF ALL OTHER HOUSEHOLD MEMBERS: (*Related and Unrelated*) | **MONTHLY INCOME** *(Complete One Or More - Before Deductions)* | | | | |
|---|---|---|---|---|---|
| | **Monthly** (Gross Earnings) Wages/Salary | **MONTHLY** SOCIAL SECURITY PENSIONS RETIREMENT | **MONTHLY** UNEMPLOYMENT WORKER'S COMPENSATION | **MONTHLY** WELFARE CHILD SUPPORT ALIMONY | **Monthly** Any Others Income |
| 1. | $ | $ | $ | $ | $ |
| 2. | $ | $ | $ | $ | $ |
| 3. | $ | $ | $ | $ | $ |
| 4. | $ | $ | $ | $ | $ |
| 5. | $ | $ | $ | $ | $ |
| 6. | $ | $ | $ | $ | $ |
| 7. | $ | $ | $ | $ | $ |
| 8. | $ | $ | $ | $ | $ |
| 9. | $ | $ | $ | $ | $ |
| 10. | $ | $ | $ | $ | $ |
| **TOTAL NUMBER IN HOUSEHOLD** *(INCLUDE ENROLLED PARTICIPANT):* _____ | | | | | |
| **TOTAL GROSS HOUSEHOLD INCOME:** | | | | | $ _____ |

**ADULT HOUSEHOLD MEMBER SIGNATURE and LAST FOUR DIGITS of SOCIAL SECURITY NUMBER:** *(See Privacy Act Statement below)*

An Adult Household Member must sign and date this form and list the last four (4) digits of his or her Social Security Number.

If you do not have a social security number, mark the box - ☒ "I do not have a Social Security Number".

**PENALTIES FOR MISREPRESENTATION:** I certify that all of the above information is true and correct and that the Food Stamp, TANF, SSI, or Medicaid Number of the enrolled participant is correct, or that a income is reported. I understand that this information is being given for the receipt of Federal funds issued to the day care center based on the information I provide. I understand that CACFP officials may verify thi information, and that deliberate misrepresentation may result in the participant losing meal benefits, and I may be prosecuted under the applicable State and Federal laws. ***An Adult Household Membe must complete the following:***

Signature: _____ Address: _____

Print Name: _____ City: _____ State: _____ Zip Code: _____

Date: _____ Phone Number: _____

**Last four (4) digits of Social Security Number:** * * * - * * * - _____ ☐ **I do not have a Social Security Number**

**PRIVACY ACT STATEMENT:** The National School Lunch Act requires that, unless the participants' Case Number is provided, you must include the Social Security Number of the adult household member signing the application or indicate that the household membe does not have a Social Security Number. Provision of a Social Security Number is not mandatory, but if a Social Security Number is not given or an indication is not made that the signer does not have such a number, the participant cannot be determined eligible for free o reduced priced menus. The Social Security Numbers may be used to identify you for verifying the correctness of information stated on the application. These verifications may include audits, and investigations and may include contacting employers to determine income, contacting Food Stamp or TANF office to determine current certification for receipt of Food Stamps or TANF benefits, contacting the State Employment Security office to determine the amount of benefits received and checking the documentation produced by household members t verify the amount of income received. These efforts may result in a loss or reduction of benefits, administrative claims or legal actions if incorrect information is reported. These acts must be told to all household members whose Social Security Numbers are reported on thi form.

Determination: Free _____ Reduced _____ Paid _____

Signature of Determining Official: _____ Date _____

**TOTAL MONTHLY INCOME $** _____

*Conversion factors to figure monthly income: Weekly x 4.33*
*Twice a month x 2*
*Every 2 weeks x 2.15*

**2025-2026 CHILD AND ADULT CARE FOOD PROGRAM LETTER TO PARENT/PARTICIPANT**

*Dear Parent/Participant:*

*Our agency depends on Child and Adult Care Food Program funds to provide meals at no separate charge to all participants. Complete information is necessary in order to receive the maximum funds available through the United States Department of Agriculture. The information will serve as documentation that our enrolled participants are eligible for the Child and Adult Care Food Program. You may complete and submit one CACFP eligibility application for all participants from the same household that are enrolled for care with our agency.*

*Household members include everyone in your household (such as grandparents, other relatives, or friends who live with you) who share income and expenses. You must include yourself and all children who live with you. You also may include foster children who live with you. Once properly categorized for free or reduced price benefits, whether through income or by providing a current SNAP, FDPIR, or TANF case number (SNAP, FDPIR, SSI, or Medicaid case number for Adult Day Care Participants), you will remain eligible for those benefits for 12 months. You should notify us, however, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within those eligibility standards.*

*The income that you report must be the total gross income received by all members of your household.*

*The "Eligibility Income Scale" for reduced-price meals is included in this letter for your information. If your income is less than or equal to these reduced- priced standards, the participant is eligible for free or reduced-price meals from the Child and Adult Care Food Program, which means increased reimbursement for our center and increased nutritional benefits for the participant.*

*Please complete, sign and return the form so that our center may receive maximum reimbursement. We cannot approve a form that is not complete, so be sure to read the instructions carefully and fill out all required information. This form will be placed in our files and treated as confidential information. Your cooperation is vital and appreciated.*

*In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.*

*Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339.*

*To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint-Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to USDA by:*

1. ***mail:***
   *U.S. Department of Agriculture*
   *Office of the Assistant Secretary for Civil Rights*
   *1400 Independence Avenue, SW*
   *Washington, D.C. 20250-9410; or*
2. ***fax:***
   *(833) 256-1665 or (202) 690-7442; or*
3. ***email:***
   *program.intake@usda.gov*

*This institution is an equal opportunity provider.*

Glassboro Child Development Centers | (856) 881-3331

***(Name of Day Care Center)*** | ***(Day Care Center Phone Number)***

***New Jersey Department of Agriculture Child and Adult Care Food Program*** | ***Phone Number 609-984-1250***

---

**TO APPLY, YOU MUST COMPLETE ONE OF THREE OPTIONS**.

1. List the Name of the participant *(First and Last Names)*.
2. Complete the Days, Hours of Care, and the meal types served to the enrolled participant. *(One time requirement for Adult Day Care participants.)*

**Option 1A or 1B - CHILD CARE PARTICIPANTS ONLY:**

**If you receive SNAP, TANF, or FDPIR** benefits for the participant, list the SNAP, TANF or FDPIR Case Number and Sign and Date the form.

If you are applying for a **Foster Child** who is under the legal responsibility of the welfare agency or court, Check the Box and Sign and Date the form.

*A FOSTER CHILD'S PERSONAL USE INCOME is defined as follows:*

*a) Funds received from a welfare agency, which can be identified for personal use of the child. Where funds provided by the welfare agency are specified by the agency, i.e., funds for shelter and care; special needs funds; and funds for personal needs such as clothing, school fees, allowances, etc., only those funds that can be identified as personal use funds shall be considered as income.*

*b) Money received in hand from any source. This includes, but is not limited to, funds received from trust accounts, monies provided by the child's family for personal use and earnings from employment other than occasional or part-time (e.g., paper routes, baby-sitting).*

**Option 2 – ADULT CARE PARTICIPANTS ONLY:**

**If you receive SNAP, FDPIR, SSI or Medicaid** benefits for the participant, indicate the SNAP, FDPIR, SSI or Medicaid Case Number and Sign and Date the form.

**Option 3 – CHILD CARE AND ADULT PARTICIPANTS:**

**If you do not receive** SNAP, TANF, FDPIR, SSI or Medicaid benefits for the participant, you must complete:

3. Names of all *(Related or Unrelated)* household members
4. List the household income *(Monthly Gross Earnings)* for each household member.
5. Total number in household *(1 + #3 above)*.
6. Total the gross income of all household members.
7. Sign, Print and complete the full address of the Adult Household Member signing the application.
8. Date the form and complete the telephone number of Adult Household Member signing the application.
9. List the last four (4) digits of the social security number for the Adult Household Member signing the application or indicate that the Adult Household Member signing the application does not possess a social security number.

**ELIGIBILITY INCOME SCALE - Effective From July 1, 2025 to June 30, 2026**

| HOUSEHOLD SIZE | REDUCED | | |
|---|---|---|---|
| | ANNUAL | MONTHLY | WEEKLY |
| 1 | $20,346 - $28,953 | $1,697 - $2,413 | $ 393 - $ 557 |
| 2 | $27,496 - $39,128 | $2,293 - $3,261 | $ 530 $ 753 |
| 3 | $36,646 - $49,303 | $2,889 - $4,109 | $ 668 - $ 949 |
| 4 | $41,796 - $59,478 | $3,484 - $4,957 | $ 805 - $1,144 |
| 5 | $48,946 - $69,653 | $4,080 - $5,805 | $ 943 - $1,340 |
| 6 | $56,096 - $79,828 | $4,676 - $6,653 | $1,080 - $1,536 |
| 7 | $63,246- $90,003 | $5,272 - $7,501 | $1,218 - $1,731 |
| 8 | $70,396 - $100,178 | $5,868 - $8,349 | $1,355 - $1,927 |
| **Each Additional Family Member** | **+10,175** | **+848** | **+196** |