Faith Lutheran Nursery School
1801 Grand Central Avenue
Lavallette, NJ 08735
(732)-793-6972

Child's Name_____Date of Birth_____

Home Address:_____Phone:_____

City, State, and ZIP: _____

	Father	Mother
Name:	_____	_____
Type of employment:	_____	_____
Name of Employer:	_____	_____
Address of Employer:	_____	_____
Employer's Telephone:	_____	_____
Cell Phone:	_____	_____
Email Address:	_____	_____

OTHER CHILDREN IN FAMILY

NAME: _____ AGE: ____ NAME: _____ AGE: ____

NAME: _____ AGE: ____ NAME: _____ AGE: ____

In case of Emergency, please contact the following:

(1)_____
(Name) (Phone)

(2)_____
(Name) (Phone)

If none of the above can be reached, I hereby authorize the Nursery School Staff to take appropriate emergency action for the safety of my child. _____
(Initial)

AUTHORIZED STUDENT PICK-UP LIST

(1)_____
(Name) (Relationship) (Phone)

(2)_____
(Name) (Relationship) (Phone)

SCHEDULE AND FEES

Non-refundable $35.00 Registration Fee Received _____

DAYS	9-11:30	9-12:30	9-3pm
MONDAY	____	____	_____
TUESDAY	____	____	_____
WEDNESDAY	____	____	_____
THURSDAY	____	____	_____
FRIDAY	____	____	_____

2 DAYS		
9-11:30	$1890.00 per year	$189.00 per month
9-12:30	$2170.00 per year	$217.00 per month
9-3:00	$3150.00 per year	$315.00 per month
3 DAYS		
9-11:30	$2380.00 per year	$238.00 per month
9-12:30	$2780.00 per year	$278.00 per month
9-3:00	$3900.00 per year	$390.00 per month
4 DAYS		
9-11:30	$2900.00 per year	$290.00 per month
9-12:30	$3380.00 per year	$338.00 per month
9-3:00	$4500.00 per year	$450.00 per month
5 DAYS		
9-11:30	$3350.00 per year	$335.00 per month
9-12:30	$3910.00 per year	$391.00 per month
9-3:00	$4950.00 per year	$495.00 per month

The yearly tuition is divided into ten equal payments, September through June, due the first week of each month.

Parents Signature_____

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 ☐ 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