



www.newgenerationlearningcenter.com  
 info@newgenlc.com  
 60 River Road, East Hanover  
 973-434-2404 (office)

## REGISTRATION FORM

<b>CHILD</b>	Name of Child	
	Date of Birth	
	Mother's Name	
	Father's Name	
	Home Address	
	Home Phone	
	Allergies	

<b>WORK</b>		MOTHER	FATHER
	Name of Business		
	Business Address		
	Work Phone		
	Cell Phone		
	Email Address		
	Driver's License #		

Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.

<b>EMERGENCY</b>		CONTACT#1	CONTACT #2
	Name		
	Phone		
	Relationship		
	Address		

Choose your program:  5 days  4 days  3 days  2 days

Full day Program

Half day Program

Drop off time:

Pick up time:



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## ENROLLMENT FORM

Child's name: \_\_\_\_\_

Start Date: \_\_\_\_\_

### **Tuition Schedule and Billing Policies**

I am responsible for the following fees and I agree to abide by the billing policies as outlined in the Policies and Procedures Handbook.

Monthly tuition: \_\_\_\_\_

Security deposit: \$500 (is required to secure your spot. This deposit will be applied to your first month's tuition.)

Early drop off or late pick up (if not pre-arranged): \$20 per 15 minutes

Registration fee:

Late payment fee: monthly payments are due by the 5<sup>th</sup> of the month. Late payments will incur a daily fee equaling 2% monthly rate.

Bounced check fee: \$25 for each bounced check.

There are **NO DEDUCTIONS, REBATES OR MAKE-UP DAYS** due to illness, absences, inclement weather or school closings. However, you are entitled to **5** business days of vacation each year, from September to September. These days **MUST** be used within that period, as they **DO NOT** carry over. No reimbursement will be provided. If the child was absent for more than 5 consecutive business days and there is a doctor's notice preventing him/her from attending daycare, we will credit you 50% of that time 2 times per school year, not more. Discount will be applied towards your next payment.

If Child Custody Agreement is in place:

- Parents must provide the center with a copy of the agreement and update it when necessary.
- If any changes of visitation schedule occur that would affect pick-ups, school should be notified immediately.
- One parent must be responsible for payments (guarantor).

**Mother's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_

**Father's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Print Name: \_\_\_\_\_

**CHILD CARE EMERGENCY CONTACT INFORMATION AND CONSENT FORM**

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

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

Parent/Guardian #1 Name: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Parent/Guardian #2 Name: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**EMERGENCY CONTACTS** (to whom child may be released if guardian is unavailable)

Name #1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Name #2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**CHILD'S PREFERRED SOURCES OF MEDICAL CARE**

Physician's name: \_\_\_\_\_

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

Dentist's name: \_\_\_\_\_

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

Hospital name: \_\_\_\_\_

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

Ambulance Service: \_\_\_\_\_

Telephone: \_\_\_\_\_

**(Parents are responsible for all emergency transportation**

**charges) CHILD'S HEALTH INSURANCE**

Insurance Plan: \_\_\_\_\_ ID # \_\_\_\_\_

Subscriber's Name (on insurance card): \_\_\_\_\_

**SPECIAL CONDITIONS, DISABILITIES, ALLERGIES, OR MEDICAL EMERGENCY INFORMATION**

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

**PARENT/GUARDIAN CONSENT AND AGREEMENT FOR EMERGENCIES:**

As parent/guardian, I consent to have my child receive first aid by facility staff and, if necessary, be transported to receive emergency care. I will be responsible for all charges not covered by insurance. I consent for the emergency contact person listed above to **ACT ON MY BEHALF** until I am available. I agree to review and update this information whenever a change occurs and at least every 6 months.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# STATE OF NEW JERSEY HEALTH HISTORY AND APPRAISAL

IMMUNIZATION REGISTRY NUMBER

Name of Child (Last, First, M.I.) \_\_\_\_\_ Date of Birth (Mo/Day/Yr) \_\_\_\_\_ Sex  Male  Female

**PARENT OR GUARDIAN** NAME \_\_\_\_\_ TELEPHONE NO. \_\_\_\_\_  
ADDRESS \_\_\_\_\_

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/Yr	5th Dose Mo/Day/Yr	LEAD SCREENING	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT, indicate in corner box)							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV) <i>If oral vaccine, indicate (OPV) in corner box</i>							
MEASLES, MUMPS, RUBELLA (MMR)						<b>Document below single antigen vaccine receipt, serology titers, or varicella disease history</b>	
HAEMOPHILUS B (HIB)**							
HEPATITIS B						Hepatitis B	Date: _____ Titer: _____
VARICELLA						Varicella	Date: _____ Titer: _____
PNEUMOCOCCAL CONJUGATE **						Measles	Date: _____ Titer: _____
MENINGOCOCCAL						Mumps	Date: _____ Titer: _____
HEPATITIS A ***						Rubella	Date: _____ Titer: _____
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							
OTHER							

Provisional admission attached–Date Granted: \_\_\_\_\_  Medical exemption attached  Religious exemption attached

HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR	HISTORY	YEAR
FOOD ALLERGIES		DIABETES		LYME DISEASE		JUVENILE RHEUMATOID ARTHRITIS	
NON-FOOD/NON-DRUG ALLERGIES		INFLUENZA (FLU)		MONONUCLEOSIS		AUTISM SPECTRUM DISORDERS	
		OTHER		NEUROMUSC. DISORDER		HEMATOLOGICAL DISORDERS	
ASTHMA		DRUG ALLERGIES		CHRONIC OTITIS MEDIA		ADD/ADHD	
CONGENITAL DISORDER		HEART DISEASE		AUTO IMMUNE DISORDERS		CONCUSSION/TBI	
CONVULSIVE DISORDER		HEPATITIS		STREP INFECTIONS			

**HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments**

Grade/Age																					
Date																					
Height																					
Weight																					
BMI***																					
Blood Pressure																					
VISION	With correction	R																			
		L																			
		BOTH																			
	Without correction	R																			
		L																			
		BOTH																			
	Muscle Balance																				

Color Perception	Date	Results																		
HEARING	Date																			
	Pure Tone	R																		
L																				

BIENNIAL SCOLIOSIS SCREENING \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_ Date \_\_\_\_\_  
(Beginning at Age 10)  
Referred for abnormal result

TB Screening (Mantoux or IGRA Test)	Date	Date	Chest X-Ray	Date	Result	Medication Reactor No Rx <input type="checkbox"/>
Tested	_____	_____		_____	Normal _____ Abnormal _____	Date Started _____
Read	_____	_____		_____	_____	Date Completed _____
Mantoux Result (MM) or IGRA Result	_____	_____		_____	_____	

# 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) <span style="float: right;">(First)</span>		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth / /
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>			
Signature/Date		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination:		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Abnormalities Noted:	Weight (must be taken within 30 days for WIC)		
	Height (must be taken within 30 days for WIC)		
	Head Circumference (if <2 Years)		
	Blood Pressure (if ≥3 Years)		

<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS					
Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

<input type="checkbox"/> <b>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.</b>	
Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

## PARENT RECEIPT OF INFORMATION:

- Information to Parents Document
- Policy on the Release of Children
- Positive Guidance and Discipline Policy
- Policy on Methods of Parental Notification
- Policy on Communicable Disease Management
- Expulsion Policy
- Policy on the Use of Technology and Social Media

*I have read and received a copy of the information/policies listed above.*

Child(ren)'s Name:

\_\_\_\_\_

Parent/Guardian's Name:

\_\_\_\_\_

Signature

Date

# Photographs, Videos and Interviews

*(Please sign one)*

I give permission for my child to be photographed, videotaped and/or interviewed for the promotion of New Generation Learning Center. I also give permission for my child's work to be published on any advertising media. This may include and is not limited to New Generation Learning Center Facebook, Instagram posts, website or any internet or print media, and will remain the property of New Generation Learning Center.

This consent is intended to release all personnel from any claim arising out of the use of such photograph, video and/or interview.

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I give permission for my child's **WORK ONLY**, to be published on any advertising media, I **do not** give permission to post any photos or videos of my child. I understand that my child will be cropped out or hidden in any photos.

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I DO NOT give permission for my child's work, photos or videos to be published on any print or advertising media.

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## NEW GENERATION LEARNING CENTER SICK POLICY

If a child exhibits any of the following symptoms, the child should not attend the center. If such symptoms occur at the center, the child will be removed from the group, and parents will be called to take the child home.

- Severe pain or discomfort
- Acute diarrhea
- Episodes of acute vomiting
- Elevated oral temperature of 100.4 degrees Fahrenheit
- Lethargy
- Severe coughing
- Yellow eyes or jaundiced skin
- Red eyes with discharge
- Infected, untreated skin patches
- Difficult or rapid breathing
- Skin rashes in conjunction with fever or behavior changes
- Skin lesions that are weeping or bleeding
- Mouth sores with drooling
- Stiff neck

To ensure the health and safety of all children and staff at the New Generation Learning Center, we have strict guidelines regarding illness:

1. **Fever:** A child must be fever-free (without the aid of Children's Tylenol/Motrin) for 24 hours with a temperature below 100.4°F / 38.0°C before returning to childcare.
2. **Vomiting:** If your child vomits, you will be contacted immediately to pick them up. Your child must stay home for 24 hours after the last episode of vomiting.
3. **Sore Throat/Strep Throat:** Children with strep throat must be on antibiotics for 48 hours and be fever-free before returning.
4. **Coughs, Colds, and Runny Nose:** Children should stay home with a persistent, hacking cough or green/yellow mucus/phlegm.
5. **Rashes/Pink Eye:** Children with conditions like lice, ringworm, or pink eye should remain home until treated and no longer contagious.

If your child becomes ill at the center, we will promptly notify you to arrange for pickup. For the well-being of everyone, sick children cannot return to daycare until they are fully recovered, typically 24-48 hours depending on the illness. Please provide a doctor's note upon return to ensure clearance for your child to rejoin us.

Parent signature: \_\_\_\_\_ Child's name \_\_\_\_\_

## What to bring

Please LABEL everything with your child's first and last name!

Infant	Young toddlers	Potty trained and up
Bibs (3-4)	Bibs (1-2)	
Diapres/pull ups		
Wipes		
Diaper rash cream (if needed)		
2(two) fitted crib sheets		One fitted crib/cot sheet
All premade bottles, at least two nipples, one extra empty bottle just in case	premade bottles (if needed)	
pacifier s	pacifiers (if needed)	
swaddling blankets*	thin blanket	
2-3 sets of change of clothes	change of clothes (if potty training 2-3 changes!)	one change of clothes
water bottle/thermos (lidded, non-spill)		
		Sunscreen/bug spray

## What not to bring

Please do not allow your children to bring any toys or candy to daycare.

Any valuables that could be lost or could be safety hazard for students

Fancy clothing/shoes that cannot get stained/ruined.

**New Generation Learning Center is not responsible for any loss or damage to personal property, with your childkids' clothing etc. that happened during normal learning and exploration activities.**