NEW GENERATION LEARNING CENTER

www.newgenerationlearningcenter.com
info@newgenlc.com
60 River Road, East Hanover

973-434-2404 (office)
973-908-1398 (cell)

REGISTRATION FORM

CHILD	Name of Child	
	Date of Birth	
	Mother's Name	
	Father's Name	
	Home Address	
	Home Phone	
	Allergies	

		MOTHER	FATHER
WORK	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.

		CONTACT#1	CONTACT #2
EMERGENCY	Name		
	Phone		
	Relationship		
	Address		

Choose your program: ☐ 5 days ☐ 4 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 5th 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: _____

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			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	

CH-14 SEP 08 Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

All policies and procedures are outlined in the Parent Handbook and at https://www.newgenerationlearningcenter.com

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 Genius Kids. I also give permission for my child's work to be published on any advertising media. This may include and is not limited to Genius Kids Facebook, Instagram posts, website or any internet or print media, and will remain the property of Genius Kids.
This consent is intended to release all personnel from any claim arising out of the use of such photograph, video and/or interview.

_____

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.

_____

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

_____

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
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination *(If Td or DT, indicate in corner box)*					
Tdap					
POLIO – INACTIVATED POLIO VACCINE (IPV) *If oral vaccine, indicate (OPV) in corner box*					
MEASLES, MUMPS, RUBELLA (MMR)					
HAEMOPHILUS B (HIB)**					
HEPATITIS B					
VARICELLA					
PNEUMOCOCCAL CONJUGATE **					
MENINGOCOCCAL					
HEPATITIS A ***					
HPV (HUMAN PAPILLOMAVIRUS) ***					
OTHER					
OTHER					

LEAD SCREENING	
Test Date	Result

Document below single antigen vaccine receipt, serology titers, or varicella disease history

Hepatitis B	Date:	Titer:
Varicella	Date:	Titer:
Measles	Date:	Titer:
Mumps	Date:	Titer:
Rubella	Date:	Titer:

☐ 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															
VISION With correction L															
VISION With correction BOTH															
VISION Without correction R															
VISION Without correction L															
VISION Without correction BOTH															
VISION Muscle Balance															
HEARING Date															
HEARING Pure Tone R															
HEARING Pure Tone L															

Color Perception Date Results

BIENNIAL SCOLIOSIS SCREENING (Beginning at Age 10)

	Date	Date	Date	Date	Date
Referred for abnormal result	☐	☐	☐	☐	☐

TB Screening (Mantoux or IGRA Test)

	Date	Date
Tested		
Read		
Mantoux Result (MM) or IGRA Result		

Chest X-Ray

	Date	Result: Normal	Result: Abnormal

Medication
Reactor No Rx ☐
Date Started _____
Date Completed _____

**REQUIRED FOR DAY/CHILD CARE ENROLLEES (2 Months-5th Birthday Only) ***Not Required

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.

Genius Kids is not responsible for any loss or damage to personal property, with your childkids' clothing etc. that happened during normal learning and exploration activities.