Prince of Peace Preschool
Explore Discover Learn

Prince of Peace Preschool is requesting copies of Vision and Hearing screenings for all preschool children. All information collected by Prince of Peace Preschool will be held in strictest confidence.

Child's Full Name_____ Male ___ Female ___

Child's Date of Birth: _____ Child's Age:_____

Parent or Guardian's Full Name: _____
Please Print

Option 1:

I, _____, have attached a copy of _____
(Please Print Name)
screening (S) to Prince of Peace Preschool in which my child attends.

_____ _____
Signature of Parent or Guardian Date

Option 2:

I,_____, will not be providing vision and/or
(Please Print Name)
hearing screening results to Prince of Peace Preschool at this time.

_____ _____
Signature of Parent or Guardian Date

Option 3:

☐ Vision and hearing assessments are included on my child's health form.

_____ _____
Signature of Parent or Guardian Date

PERSONAL HISTORY FORM

Last Name: _____ First Name: _____

What should we call your child? _____

Birth Date: _____ List siblings and their ages:_____

_____

Has your child previously attended a playgroup, nursery school, or Sunday School? __ YES __ NO

Please list schools or playgroup: _____

_____

With what does your child especially like to play? _____

Does your child stay with other adults such as a regular baby sitter, grandparent, etc? __ YES __ NO

Does your child speak plainly, so that others besides those at home can understand? __ YES __ NO

Is any language other than English used at home? __ YES __ NO What language? _____

Does your child have any special fears? __ YES __ NO If so, please describe: _____

_____

If there is anything else you would like us to know about your child that would help us to understand them better? (Please Print below)

_____

_____

_____

_____

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What would you like your child to gain from our preschool this year?

_____

_____

_____

Do you have a home church? _____
If not, would you like Pastor Holliday to contact you about Prince of Peace? _____

_____ _____

Guardian Signature Date

This information is considered confidential and will be kept on file in the classroom

EMERGENCY INFORMATION

(please print)

STUDENT	Name of Child
	Home Address
	Phone #(s)

Does the student have any health problems, allergies, etc? __ YES __ NO Please specify _____

_____

Does the student receive medication? __ YES __ NO Please specify _____

_____

Local Physician's Name _____ Phone _____

	GAURDIAN	GUARDIAN
GUARDIAN	Name	Name
	Home Address	Home Address
	Home Phone #(s) Cell #	Home Phone #(s) Cell #

	GUARDIAN	GUARDIAN
WORK	Employer	Employer
	Address	Address
	Phone # Cell #	Phone # Cell #

List two nearby relatives or friends we may call if parents or guardian cannot be reached.

	Name Contact #1	Name Contact #2
EMERGENCY	Phone # Cell #	Phone # Cell #
	Relationship	Relationship
	Address	Address

In case of accident or serious illness where I cannot be reached, I hereby authorize the school to make whatever arrangements seem necessary for the care of my child.

Signature of Guardian_____ Date _____

Mulitcultural Form

Name _____

Email _____

Phone _____

Where is your family from ancestrally?

Do you practice a form of religion? If so, what do you practice?

Which languages do you speak?

List any special holidays/celebrations you observe.

Would you like to share your ansestry with our students? If so, what can you share?

- Cultural traditions
- Books
- Traditional clothing
- Dance
- Holidays/celebrations

Prince of Peace Preschool

Community Involvement Form

POPPS is participating in a state-wide quality improvement plan (QIP) called Grow NJ Kids. As part of this initiative, we are asked to pole the parents on community organizations to which they belong and community organizations in which they are leaders. Examples of these organizations are PTAs, Boy Scouts, Girl Scouts, Mental Health Organizations, Rotary Clubs, pool clubs, Environmental organizations, Church committees, CCD teacher, Food pantry volunteer etc. If you would like to share this information with us, please complete the following form. Thank you!!

Name of Organization	Leadership role

Prince of Peace Preschool

Consent to photograph , film or videotape a student

Last Name_____

As the parent/guardian of a child/children at Prince of Peace Preschool, I agree to the following:

- I understand that my child(ren) whose name(s) are listed below may be photographed or recorded during normal school hours, fieldtrips, or other activities.
- I understand that these photographs or recordings may be used in newsletters, school displays our website, child(ren)'s portfolios, social media, promotional material or another publication.
- I understand that the child(ren)'s name will not be used at any time.
- I understand that since the permission in publications is voluntary, neither the child(ren) or I will receive financial compensation.
- I understand that if I do not grant permission my child(ren) may be asked to step out of some photos.

The following are the names of my children attending Prince of Peace Preschool:

_____

_____

_____

( ) I confirm that I have read and understand the above, and agree to have my child(ren)'s photos or recordings posted on the Prince of Peace Preschool website or the Prince of Peace Lutheran Church website, social media pages, newsletters or other publications. I further agree that participation in any publication and website produced by Prince of Peace Preschool confers no rights of ownership whatsoever. I release Prince of Peace Preschool and Prince of Peace Lutheran Church, its directors, board members, and employees from liability for any claims by me or a third party in connection with my participation or the participation of the undersigned minor child(ren). I further understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I understand that there is no payment for me or my child(ren)'s participation.

( ) I do not grant permission at this time.

Name (please print) _____

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

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	

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.