144 Bartholdi Avenue
Jersey City, NJ 07305
Tel:201-332-9281 Fax: 201-332-9232

The following documents must be submitted with your completed application:

Child's Birth Certificate ☑

Parents' IDs ☑

Updated Physical ☑

Pick-Up Photos (Color) ☑

Leaders of Tomorrow Preschool

144 Bartholdi Avenue
Jersey City, NJ 07305
Tel:201-332-9281 Fax: 201-332-9232

PLEASE BRING THESE ITEMS IN A ZIPLOC BAG LABELED WITH YOUR CHILD'S NAME ON THE FIRST DAY OF THE SUMMER PROGRAM

SUNGLASSES, HATS,

BRING THE FOLLOWING ITEMS IN A ZIPLOC BAG

BOTTLE OF WATER,

THERMOS

COMPLETE SETS OF CLOTHES

BABY WIPES,

SOCKS, SNEAKERS **(NO FLIP FLOPS AND CROCS)**

CRIB SHEETS & BLANKET

SMALL BACKPACK FOR SHEETS,

BLANKETS

PLEASE KEEP IN MIND THAT BLANKETS AND SHEETS MUST GO HOME EVERY FRIDAY AND MUST BE RETURNED TO SCHOOL ON MONDAY

Leaders of Tomorrow Preschool

144 Bartholdi Avenue
Jersey City, NJ 07305
Tel:201-332-9281 Fax: 201-332-9232

SUMMER ENROLLMENT APPLICATION

Date of Enrollment: _____

Child's Full Name: _____ Date of Birth: _____

Mother's Name: _____ Father's Name: _____

Home Address _____ Home Address _____

Phone/Cell # _____ Phone/Cell # _____

Home # _____ Home # _____

MEDICAL INFORMATION

PHYSICIAN'S NAME: _____

ADDRESS: _____

PHONE #: _____ (Clinic)_____ E-MAIL: _____

INSURANCE CARRIER: _____

CUSTODY AND COURT ORDERS

(Court order must be attached if this section is signed by the guardian)

If a biological parent is not included among those persons authorized by the LEGAL GUARDIAN to pick up the child, please sign below and attach a copy of appropriate documents.

Parent/Guardian Signature: _____ Date: _____

By my signature, I attest to the following:

- **The above information is true and correct.**
- **In the event of a medical emergency, I authorize LEADERS OF TOMORROW PRESCHOOL to seek emergency medical care for my child as deemed necessary by the Director and staff.**

Parent/Guardian Signature: _____ Date: _____

PRESCHOOL SUMMER HOURS OF OPERATION

8:00 AM- 4:30 PM Daily for July and August.

The summer program at Leaders of Tomorrow is a private program. The prices are as follows: **Our weekly rate is $350.00 per week per child & $300.00 per child if you have siblings attending. Urban League is accepted if qualified under family size and income.** Breakfast, lunch, and snack are included daily at no additional cost.

It is important that your child be at the center by 8:30am for breakfast. Classroom activities begin at 9:00 am; therefore, your child must be at the center on time to transition and participate in the daily routines and activities. Your child will be marked tardy after 9:00 am. **Habitual lateness will result in your child being withdrawn from out summer program.**

Any child picked up after their scheduled time as per their signed fee agreement will be charged a late fee as outlined below. In addition, as required by New Jersey state law, the CP&P (Child Protection and Permanency) (DYFS) must be called when a child is not picked up an hour after the program's closure without notification by a parent or caregiver.

If the parent(s) or other authorized person(s) fail **to pick up or is late in picking up a child at the time of the center's closing:**

1. All children not picked up by closing time will be supervised by two staff members.
2. The staff persons scheduled to work the late shift will be responsible for the supervision of children present past 4:30 pm. They will notify CP&P and the Jersey City Police Department.
3. Every effort will be made by the center's staff to contact the custodial parent and/ or other persons authorized by the parents to care for the child.
4. A fee of **$5.00 per minute** will be charged for late pick up, i.e., **5 minutes late will be charged $25.00.** The late fee shall be paid at the time of pick-up. This fee is charged to encourage parents to pick up their child on time. Please arrange your schedules accordingly or find an alternate person **(18 years or older)** to pick up your child in a **timely** manner.
5. Whenever the parent or other person(s) authorized by the parent fails to pick up the child one hour **(4:30 pm)** or more after closing time, and provided that Leaders staff members have been unable to make other arrangements for returning the child to his/her parent, a staff member shall call Child Protection and Permanency **(CP&P) 24 hour Child Abuse Hot Line (1800-982-7396)** to seek assistance in caring for a child until his/her custodial parents are available to care for the child.

I understand I must drop off my child, _____ at summer camp between 8:00 am- 9:00 am. I further understand that I must pick my child up no later than 4:30 pm (late fee will be charged after 4:30pm).

Parent/Guardian Signature: _____Date: _____

POLICY FOR SICK CHILDREN

1.The child's condition will be evaluated.

2.If we feel it is necessary, we will notify parents.

3.If we cannot reach the parent or guardian, we will call emergency contacts. Please update contact information periodically (every 3 months or sooner) as changes occur.

4.In case of a very high fever, accident, or any illness we feel needs immediate attention, we will take the child to the hospital indicated on your emergency form and continue to try and reach the parent, guardian or emergency contacts.

5.If your child has **a fever of 100.4-degree Fahrenheit or higher, diarrhea and/or vomiting**, we will expect the child to be taken home within the hour**. The child must remain at home for at least a twenty-four-hour period (without medication) and is able to return to school once the temperature returns to 98.6**. Leaders of Tomorrow does not have a "Sick Room" and our facilities are limited to handle all but the most routine problems. The child will be sent back home, if he/she returns within a 24-hour period.

6.Medicine will be given according to guidelines on the Medication Administration Policy, and as per child pediatrician.

7.Children with contagious illnesses, rashes, ringworm, conjunctivitis (pink eye), lesions, of any kind must return with a note from a physician.

8.Absences of three (3) or more days require a physician's note to return to the center.

If is necessary to follow these guidelines to control the spread of illness and to keep all children as healthy and safe as they can possibly be at this learning center.

Parent/Guardian Signature: _____ Date: _____

JEWERLY POLICY

Unfortunately, it is NOT possible for Leaders staff to keep track of your child's jewelry in the event it gets lost, damaged or stolen. Please refrain from bringing your child to school wearing jewelry as Leaders of Tomorrow WILL NOT be responsible for the replacement of any lost, stolen, or damage jewelry.

Parent/Guardian Signature: _____ Date: _____

BLANKET PERMISSION FOR WALKING TRIPS & PLAYGROUND

I hereby give permission for my child _____ to participate in walking trips around the neighborhood and playing at the park.

I understand that the walking route includes no safety hazards, and that the walks will not involve entrance into any facility.

Parent/Guardian Signature: _____ Date: _____

PROPER SHOES FOR PLAYGROUND PLAY

Please be reminded that the children will spend majority of their day playing in the park. Therefore, students are required to wear comfortable shoes appropriate for outdoor activities.

Please **DO NOT** send children in flip flops, crocs or any shoes without an ankle strap. Open toes shoes are not preferred, but with an ankle strap is accepted.

Please keep in mind that we visit different parks in the area and will play in the sprinklers. Children should wear water shoes to be safe while running around in the sprinklers.

Parent/Guardian Signature: _____ Date: _____

LEADERS OF TOMORROW

144 Bartholdi Avenue, Jersey City, NJ 07305
Phone: 201-332-9281 Fax: 201-332-9232 Email: leadersoftomorrowjc@gmail.com

SUMMER PROGRAM FEE AGREEMENT

I. THE FOLLOWING FEE AGREEMENT IS ENTERED INTO BY **LEADERS OF TOMORROW DAYCARE/PRESCHOOL CORP**

and

_____ **for** _____

Parent / Guardian (Print) **Child (Print)**

II. THE PARENT/LEGAL GUARDIAN RESIDES AT _____
Street

_____ _____ _____
City **State** **Zip Code**

III. THE TERMS OF SERVICE FOR THIS AGREEMENT ARE AS FOLLOWS

- **Summer Program Service begins on July 06, 2026, and ends on August 21, 2026.**
- **Summer Program Hours are 8:00 am – 4:30 pm. All children must be picked up before 4:30 pm to avoid late fees.**
- **If a child is picked up after 4:30pm, a late fee of $5.00 per minute will be applied.**
- **All Urban League co-payments are due the first of each month. Private payments are due every Monday of each week.**
- **The cost of the summer program is Three Hundred and Fifty dollars ($350.00) per week per child. Three Hundred dollars ($300) per week per child for (siblings). These rates reflect both private paying and Urban League parents. If payments are not received on time, the child may be terminated from the program.**
- **This agreement can be terminated at any given time with or without written notice.**

IV. THE PARENT/GUARDIAN ALSO AGREES TO THE FOLLOWING:

IMPLEMENTATION OF TERMS OF SERVICE	INITIALS
• All payments must be received on the first Monday of every week. **If payments are not received on time, the child will be terminated from the program. NO exceptions.**	_____
• Leaders of Tomorrow accepts payments by cash, Zelle or money order, only.	_____
• A late penalty of ($5.00) dollars per minute will be applied when the child is picked up. after 4:30 pm as indicated in this Agreement.	_____
• Tuition payment is required, regardless of illnesses, vacations, holidays, or any other cause-of-absence from the preschool program.	_____
• All terms in this Agreement remain in force until parental and/or administrative withdrawal ends summer program enrollment.	_____

LEADERS OF TOMORROW

144 Bartholdi Avenue, Jersey City, NJ 07305

Phone: 201-332-9281 Fax: 201-332-9232 Email: leadersoftomorrowjc@jmail.com

SUMMER PROGRAM FEE AGREEMENT

V. THE UNDERSIGNED ASSERTS THAT HE/SHE HAS READ, UNDERSTOOD, AND AGREED TO ALL TERMS, PROCEDURES AND POLICIES STATED IN THIS FEE AGREEMENT.

Parent/Guardian Signature	**Date**
Parent/Guardian Signature	**Date**
Ms. Widnelia M. Avila (Nelly) **Director of Early Childhood Education**	**Date**

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 (es):

☐ 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 all 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 this 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 Member 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 member 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 or reduced priced meals. 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 to 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 this 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

Leaders of Tomorrow

Day Care / Preschool
144 Bartholdi Avenue
Jersey City, NJ 07305
Tel: 201-332-9281 Fax: 201-332-9232

IMPORTANT MEDICAL DOCUMENTS:
MUST BE COMPLETED BY PHYSICIAN AND PARENT/GUARDIAN PRIOR TO REGISTRATION.

This packet includes:

- Consent for Emergency Medical Treatment
- Universal Child Health Record
- Asthma Action Plan
- Food Allergy Action Plan
- Seizure Action Plan
- Early Childhood Health History Questionnaire

CONSENT FOR CHILD'S EMERGENCY MEDICAL TREATMENT & TRANSPORT

I, _____, hereby give my consent for emergency medical treatment of

my son/daughter _____ to any duly licensed medical doctor, while under the care of the Leaders of Tomorrow. This medical care may include physical examinations and any necessary tests, which in the opinion of the physician are deemed necessary and/or advisable. This does not include the right to perform surgical operations without any further consent, except in the case of an emergency when an effort has been made to locate me.

IN THE EVENT THAT AN EMERGENCY OCCURS, I AUTHORIZE LEADERS OF TOMORROW TO SEEK EMERGENCY MEDICAL CARE FOR MY CHILD AS DEEMED NECESSARY BY THE DIRECTOR AND/OR TRANSPORT MY CHILD TO BAYONNE HOSPITAL BY AMBULANCE.

Child's Name_____

Mother/Guardian
Signature_____

Home Address_____

Home Phone Number_____ Work Phone Number_____

Cell Phone Number_____

Father/Guardian
Signature_____

Home Address_____

Home Phone Number_____ Work Phone Number_____

Cell Phone Number_____

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

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

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

FARE Food Allergy Research & Education

FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

Name: _____ D.O.B.: _____

Allergy to: _____

Weight: _____ lbs. Asthma: ☐ **Yes (higher risk for a severe reaction)** ☐ **No**

NOTE: Do not depend on antihistamines or inhalers (bronchodilators) to treat a severe reaction. USE EPINEPHRINE.

Extremely reactive to the following allergens: _____

THEREFORE:

☐ If checked, give epinephrine immediately if the allergen was LIKELY eaten, for ANY symptoms.

☐ If checked, give epinephrine immediately if the allergen was DEFINITELY eaten, even if no symptoms are apparent.

FOR **ANY** OF THE FOLLOWING:

SEVERE SYMPTOMS

LUNG
Shortness of breath, wheezing, repetitive cough

HEART
Pale or bluish skin, faintness, weak pulse, dizziness

THROAT
Tight or hoarse throat, trouble breathing or swallowing

MOUTH
Significant swelling of the tongue or lips

SKIN
Many hives over body, widespread redness

GUT
Repetitive vomiting, severe diarrhea

OTHER
Feeling something bad is about to happen, anxiety, confusion

OR A COMBINATION of symptoms from different body areas.

1. **INJECT EPINEPHRINE IMMEDIATELY.**
2. **Call 911.** Tell emergency dispatcher the person is having anaphylaxis and may need epinephrine when emergency responders arrive.

- Consider giving additional medications following epinephrine:
  - » Antihistamine
  - » Inhaler (bronchodilator) if wheezing
- Lay the person flat, raise legs and keep warm. If breathing is difficult or they are vomiting, let them sit up or lie on their side.
- If symptoms do not improve, or symptoms return, more doses of epinephrine can be given about 5 minutes or more after the last dose.
- Alert emergency contacts.
- Transport patient to ER, even if symptoms resolve. Patient should remain in ER for at least 4 hours because symptoms may return.

MILD SYMPTOMS

NOSE
Itchy or runny nose, sneezing

MOUTH
Itchy mouth

SKIN
A few hives, mild itch

GUT
Mild nausea or discomfort

FOR **MILD SYMPTOMS** FROM **MORE THAN ONE** SYSTEM AREA, GIVE EPINEPHRINE.

FOR **MILD SYMPTOMS** FROM **A SINGLE SYSTEM** AREA, FOLLOW THE DIRECTIONS BELOW:

1. Antihistamines may be given, if ordered by a healthcare provider.
2. Stay with the person; alert emergency contacts.
3. Watch closely for changes. If symptoms worsen, give epinephrine.

MEDICATIONS/DOSES

Epinephrine Brand or Generic: _____

Epinephrine Dose: ☐ 0.1 mg IM ☐ 0.15 mg IM ☐ 0.3 mg IM

Antihistamine Brand or Generic: _____

Antihistamine Dose: _____

Other (e.g., inhaler-bronchodilator if wheezing): _____

_____

PATIENT OR PARENT/GUARDIAN AUTHORIZATION SIGNATURE DATE PHYSICIAN/HCP AUTHORIZATION SIGNATURE DATE

FORM PROVIDED COURTESY OF FOOD ALLERGY RESEARCH & EDUCATION (FARE) (FOODALLERGY.ORG) 5/2018

Asthma Treatment Plan – Student

(This asthma action plan meets NJ Law N.J.S.A. 18A:40-12.8) (Physician's Orders)

PACNJ Pediatric/Adult Asthma Coalition

Sponsored by American Lung Association. in New Jersey

NJ Health New Jersey Department of Health

(Please Print)

Name	Date of Birth	Effective Date
Doctor Phone	Parent/Guardian (if applicable) Phone	Emergency Contact Phone

HEALTHY (Green Zone)

You have *all* of these:
- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work, exercise, and play

And/or Peak flow above _____

Take daily control medicine(s). Some inhalers may be more effective with a "spacer" – use if directed.

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Advair® HFA ☐ 45, ☐ 115, ☐ 230	2 puffs twice a day
☐ Aerospan™	☐ 1, ☐ 2 puffs twice a day
☐ Alvesco® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Dulera® ☐ 100, ☐ 200	2 puffs twice a day
☐ Flovent® ☐ 44, ☐ 110, ☐ 220	2 puffs twice a day
☐ Qvar® ☐ 40, ☐ 80	☐ 1, ☐ 2 puffs twice a day
☐ Symbicort® ☐ 80, ☐ 160	☐ 1, ☐ 2 puffs twice a day
☐ Advair Diskus® ☐ 100, ☐ 250, ☐ 500	1 inhalation twice a day
☐ Asmanex® Twisthaler® ☐ 110, ☐ 220	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Flovent® Diskus® ☐ 50 ☐ 100 ☐ 250	1 inhalation twice a day
☐ Pulmicort Flexhaler® ☐ 90, ☐ 180	☐ 1, ☐ 2 inhalations ☐ once or ☐ twice a day
☐ Pulmicort Respules® (Budesonide) ☐ 0.25, ☐ 0.5, ☐ 1.0	1 unit nebulized ☐ once or ☐ twice a day
☐ Singulair® (Montelukast) ☐ 4, ☐ 5, ☐ 10 mg	1 tablet daily
☐ Other	
☐ None	

Remember to rinse your mouth after taking inhaled medicine.

If exercise triggers your asthma, take_____ ____ puff(s) ____minutes before exercise.

CAUTION (Yellow Zone)

You have *any* of these:
- Cough
- Mild wheeze
- Tight chest
- Coughing at night
- Other:_____

If quick-relief medicine does not help within 15-20 minutes or has been used more than 2 times and symptoms persist, call your doctor or go to the emergency room.

And/or Peak flow from_____ to_____

Continue daily control medicine(s) and ADD quick-relief medicine(s).

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	2 puffs every 4 hours as needed
☐ Xopenex®	2 puffs every 4 hours as needed
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 4 hours as needed
☐ Duoneb®	1 unit nebulized every 4 hours as needed
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 4 hours as needed
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Increase the dose of, or add:	
☐ Other	

- **If quick-relief medicine is needed more than 2 times a week, except before exercise, then call your doctor.**

EMERGENCY (Red Zone)

Your asthma is getting worse fast:
- Quick-relief medicine did not help within 15-20 minutes
- Breathing is hard or fast
- Nose opens wide • Ribs show
- Trouble walking and talking
- Lips blue • Fingernails blue
- Other:_____

And/or Peak flow below _____

Take these medicines NOW and CALL 911.
Asthma can be a life-threatening illness. Do not wait!

MEDICINE	HOW MUCH to take and HOW OFTEN to take it
☐ Albuterol MDI (Pro-air® or Proventil® or Ventolin®)	4 puffs every 20 minutes
☐ Xopenex®	4 puffs every 20 minutes
☐ Albuterol ☐ 1.25, ☐ 2.5 mg	1 unit nebulized every 20 minutes
☐ Duoneb®	1 unit nebulized every 20 minutes
☐ Xopenex® (Levalbuterol) ☐ 0.31, ☐ 0.63, ☐ 1.25 mg	1 unit nebulized every 20 minutes
☐ Combivent Respimat®	1 inhalation 4 times a day
☐ Other	

Triggers

Check all items that trigger patient's asthma:

- ❑ Colds/flu
- ❑ Exercise
- ❑ Allergens
  - ○ Dust Mites, dust, stuffed animals, carpet
  - ○ Pollen - trees, grass, weeds
  - ○ Mold
  - ○ Pets - animal dander
  - ○ Pests - rodents, cockroaches
- ❑ Odors (Irritants)
  - ○ Cigarette smoke & second hand smoke
  - ○ Perfumes, cleaning products, scented products
  - ○ Smoke from burning wood, inside or outside
- ❑ Weather
  - ○ Sudden temperature change
  - ○ Extreme weather - hot and cold
  - ○ Ozone alert days
- ❑ Foods:
  - ○ _____
  - ○ _____
  - ○ _____
- ❑ Other:
  - ○ _____
  - ○ _____
  - ○ _____

This asthma treatment plan is meant to assist, not replace, the clinical decision-making required to meet individual patient needs.

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REVISED MAY 2017

Permission to Self-administer Medication:

☐ This student is capable and has been instructed in the proper method of self-administering of the non-nebulized inhaled medications named above in accordance with NJ Law.

☐ This student is not approved to self-medicate.

PHYSICIAN/APN/PA SIGNATURE_____ DATE____

Physician's Orders

PARENT/GUARDIAN SIGNATURE_____

PHYSICIAN STAMP

Make a copy for parent and for physician file, send original to school nurse or child care provider.

EPILEPSY FOUNDATION · epilepsy therapy project
STRONGER TOGETHER

Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____

JERSEY CITY PUBLIC SCHOOLS
EARLY CHILDHOOD DEPARTMENT
346 CLAREMONT AVENUE
JERSEY CITY, NEW JERSEY 07305
(201) 915-6078

EARLY CHILDHOOD HEALTH HISTORY QUESTIONNAIRE

Student's Name _____ Date of Birth _____

Parents/Guardian _____ Daytime Phone Number_____

Child's Doctor _____ Cell/Emergency Number_____

Prenatal

Were you sick during your pregnancy? Yes_____ No _____
If yes, please explain _____
Full term _____ Premature _____ Complications_____
What type of delivery did you have? Normal _____ C-Section _____

Neonatal

How much did your baby weigh at birth? _____
Was your baby sick in the first few days of life? Yes _____ No _____
If yes, please explain _____

Developmental Milestones (age at which the child)

Sat up _____ Crawled _____ Walked _____ Talked _____ Toilet Trained _____

Health Problems

Has your child ever had any of the following?

	Yes	No	Age		Yes	No	Age
Heart disease	___	___	___	Seizure/Convulsion	___	___	___
Fainting	___	___	___	Diabetes	___	___	___
Kidney Disease	___	___	___	Ear Infections	___	___	___
Sickle Cell	___	___	___	Lead Poisoning	___	___	___
Hearing Problem	___	___	___	Learning Problem	___	___	___
Vision Problem	___	___	___	Broken Bones	___	___	___
Surgery	___	___	___	Asthma	___	___	___

Explain any "yes" answers and list any other health problems.

_____

_____

_____

CONTINUED ON NEXT PAGE>>>>>>>>>>>

Activity restrictions specified by MD (note required) _____

Hospitalizations

Has your child ever been hospitalized for any reason? Yes _____ No _____
Reason for hospitalization _____ How many days? _____ Year _____
Reason for hospitalization _____ How many days? _____ Year _____

Asthma

Has your child ever had asthma? Yes _____ No _____
How often does your child have asthma attacks? _____
What triggers your child's asthma? _____
Has your child used asthma medicine in the past 2 years? Yes _____ No _____
If yes, please indicate medicine used _____

Allergies

To food? Yes _____ No _____ To medicine? Yes _____ No_____

If yes, please list things child is allergic to and indicate symptoms:

_____

_____

Anaphylaxis? Yes _____ No _____ Epipen? Yes _____ No _____

Medications

Does your child take any prescription medicine at home? Yes _____ No _____
If yes, please list medicine(s) _____

_____

Will your child be taking prescription medicine at school? Yes _____ No _____
If yes, what medicine(s)? _____

Parents/Guardian Signature: _____ Date_____

I GIVE PERMISSION TO SHARE THIS INFORMATION WITH STAFF MEMBERS INVOLVED IN MY CHILD'S CARE AND EDUCATION.

Parents/Guardian Signature: _____ Date_____

Reviewed by:_____ Date_____

Child's Recent Photo:

LEADERS OF TOMORROW

Authorized Pick-Up List

(Must be 18+ years old and Picture ID is required)

Teacher/Teacher's Assistant: _____

Child's Name: _____ D.O.B: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Allergies/Food Restrictions: _____

Medications: _____ EPI Pen (Y/N): _____

Child's Doctor: _____ Phone #: _____

Doctor's Address: _____ City: _____ State: NJ Zip: _____

Mother's Picture:

Mother Contact Information:

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Work Address: _____

Work Phone: _____ Email: _____

Father's Picture:

Father's Contact Information:

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Employer: _____

Work Address: _____

Work Phone: _____ Email: _____

Please turn over to authorize contacts for pick-up →

The following authorized persons can pick up my child on my behalf:

Authorized Contact's Picture
Name:
Home Phone:
Cell Phone:
Relationship:

Authorized Contact's Picture
Name:
Home Phone:
Cell Phone:
Relationship:

Authorized Contact's Picture
Name:
Home Phone:
Cell Phone:
Relationship:

Authorized Contact's Picture
Name:
Home Phone:
Cell Phone:
Relationship:

Authorized Contact's Picture
Name:
Home Phone:
Cell Phone:
Relationship:

Authorized Contact's n Picture
Name:
Home Phone:
Cell Phone:
Relationship: