Child Data Form

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

Home Address: _____

Mailing Address (if different from above): _____

Child's Primary Language: _____

Child's Physician: _____ _____
(name) (phone #)

Allergies: _____

Religious Observances/Restrictions (dietary, etc.): _____

Parent/Legal Guardian Information

Name: _____ Relationship to Child: _____

Authorized to Pick Up Child? ☐ Yes ☐ No

Address (if different from above): _____

Home Phone Number: _____ Work Phone Number: _____

Mobile Phone Number: _____ Primary Language: _____

Email Address: _____

Name: _____ Relationship to Child: _____

Authorized to Pick Up Child? ☐ Yes ☐ No

Address (if different from above): _____

Home Phone Number: _____ Work Phone Number: _____

Mobile Phone Number: _____ Primary Language: _____

Email Address: _____

Name:_____ Date of Birth:_____

PEOPLE AUTHORIZED FOR PICK UP & EMERGENCY CONTACTS:

Please provide contact information for at least three (3) additional individuals that are permitted and available to pick up your child. ***ANYONE PICKING UP A CHILD MUST HAVE A PHOTO ID.***

Name & Relationship to Child	Address	Phone Number(s)
1.)		
2.)		
3.)		
4.)		
5.)		

Please indicate any legal orders regarding guardianship, foster care, or orders of protection related to your child. Please provide a copy of any guardianship orders or orders of protection related to your child.

ORDER OF PROTECTION:

Is your child currently covered by an Order of Protection? ☐ YES ☐ NO

FOSTER CARE INFORMATION:

Responsible Agency:_____

Agency Address:_____

Caseworker:_____ Phone Number:_____

*Signature of Parent/Guardian:*_____ *Date:*_____

Name:_____ Date of Birth:_____

CONSENT FORM:

I give permission for Just Kids Early Childhood Learning Center to photograph/videotape my child, _____ . These photographs/videos may be used for the school's display, website, internet usage, social media pages, promotional materials, in-service trainings, and/or educational presentations.

Signature: _____ Date:_____

I give permission for Just Kids Early Childhood Learning Center to seek emergency medical treatment for my child, _____ , which may encompass calling my M.D., providing first aid/emergency medical care, including the use of an epinephrine auto-injector for the treatment of anaphylaxis, and/or contacting 911 in the event of an emergency.

Signature:_____ Date:_____

I give permission for Just Kids Early Childhood Learning Center to release and obtain records and information as necessary to and from Just Kids Diagnostic and Treatment Center.

Signature:_____ Date:_____

I understand that my child's daily educational placement does not include a planned nap. In the event that my child is tired and falls asleep in class, they will be provided with a mat, made as comfortable as the classroom allows and continuously supervised by the classroom staff. The nurse may also be called in to assess the wellness of my child. I understand that, if the nurse determines that my child is not well enough to remain in school, I will be called to pick them up.

Signature: _____ Date:_____

I understand that individual student tracking devices are **only** permitted if they **do not** impose on the privacy rights of others. I understand that any and all tracking devices cannot have the ability to look and/or listen in. Just Kids Early Childhood Learning Center has been advised to abide by the Federal Guidelines regarding the privacy of others.

Signature: _____ Date: _____

I give Just Kids permission to post photos and/or videos of my child on Seesaw, the school's communication app. These images will be used to share updates on my child's progress, highlight classroom activities and participation, and contribute to their educational portfolio.

Signature:_____ Date:_____

I have been informed on how to access the Just Kids Family Handbook which includes information related to parental rights and my child's education. I acknowledge that I can request a copy of the handbook at any time throughout the school year.

Signature: _____ Date: _____

JUST KIDS
an early childhood learning center
Cam-Held Enterprises, Inc.

NYS PRESCHOOL CONSENT FOR THE USE OF TELEHEALTH /TELETHERAPY DURING REMOTE LEARNING

Student's Name:		
DOB:	School District:	
Service Types to be Delivered (Please specify):	SP/ OT/ PT/ VI/ PSY/ ED ☐ ☐ ☐ ☐ ☐ ☐	
Address:		
Apt #	City/Town:	State: New York
Zip Code:	County:	
Email:		

Dear Parent/Guardian,

Just Kids Early Childhood Learning Center is committed to providing your child's educational and therapeutic services. In the event that your child needs to transition to remote learning, teletherapy/telehealth services and remote instruction will be provided. Please sign the consent below so we may continue to provide continuity of services during times of remote learning.

I (Parent/Guardian of (**Child's Full Name**) _____ consent to have my child's center-based services delivered using teletherapy and other technologies for remote learning in my home. I understand that this model of delivering services will fulfill the mandate for my child's IEP.

I understand that teletherapy and educational services as a delivery method to my home is only available during the event of a transition to remote learning. I am aware that my child's center-based services will resume when remote learning has concluded.

I understand that services will be delivered in a variety of technology-based strategies to appropriately meet my child's needs. I understand that my child's team is accessible to answer any questions that I may have regarding my child's progress during remote learning.

Parent Full Name/Guardian (Print)_____

Parent Signature_____ Date _____

Preschool Parental Consent to Use E-mail to Exchange Personally Identifiable Information

Child's Name: _____D.O.B. _____
Parent's Name _____
E-mail Address: _____

At your request, you have chosen to communicate personally identifiable information concerning your child's preschool services by e-mail without the use of encryption. Sending personally identifiable information by e-mail has a number of risks that you should be aware of prior to giving your permission. These risks include, but are not limited to, the following:

- E-mail can be forwarded and stored in electronic and paper format easily without prior knowledge of the parent.
- E-mail senders can misaddress an e-mail and personally identifiable information can be sent to incorrect recipients by mistake.
- E-mail sent over the Internet without encryption is not secure and can be intercepted by unknown third parties.
- E-mail content can be changed without the knowledge of the sender or receiver.
- Backup copies of e-mail may still exist even after the sender and receiver have deleted the messages.
- Employers and online service providers have a right to check e-mail sent through their systems.
- E-mail can contain harmful viruses and other programs.

Parental Acknowledgement and Agreement

I acknowledge that I have read and understand the items above which describe the inherent risks of using e-mail to communicate personally identifiable information. Nevertheless, I, _____, authorize JUST KIDS EARLY CHILDHOOD LEARNING CENTER whose e-mail address is "@justkidseclc.org" to communicate with me at my e-mail address, _____, concerning my child, _____, participation in the program including but not limited to communication regarding service delivery, his/her progress and any other related matters. I understand that use of e-mail without encryption presents the risks noted above and may result in an unintended disclosure of such information.

Parent's Signature _____Date _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED BY PRIVATE HEALTHCARE PROVIDER OR SCHOOL MEDICAL DIRECTOR
IF AN AREA IS NOT ASSESSED, INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special Education (CPSE).

STUDENT INFORMATION

Name:	Affirmed Name (if applicable):	DOB:
Sex Assigned at Birth: ☐ Female ☐ Male	Gender Identity: ☐ Female ☐ Male ☐ Nonbinary ☐ X	
School:	Grade:	Exam Date:

HEALTH HISTORY

If yes to any diagnoses below, check all that apply and provide additional information.

☐ **Allergies**	Type:	
	☐ Medication/Treatment Order Attached	☐ Anaphylaxis Care Plan Attached
☐ **Asthma**	Type: ☐ Intermittent ☐ Persistent ☐ Other:	
	☐ Medication/Treatment Order Attached	☐ Asthma Care Plan Attached
☐ **Seizures**	Type:	☐ Date of Last Seizure:
	☐ Medication/Treatment Order Attached	☐ Seizure Care Plan Attached
☐ **Diabetes**	Type: ☐ 1 Type: ☐ 2	
	☐ Medication/Treatment Ordered Attached	☐ Diabetes Medical Management Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: Consider screening for T2DM if BMI % > 85% and has 2 or more risk factors: Family History T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.

BMI_____ kg/m2
Percentile (Weight Status Category) ☐ <5th ☐ 5th - 49th ☐ 50th - 84th ☐ 85th- 94th ☐ 95th-98th ☐ 99th and >

Hyperlipidemia: ☐ Yes ☐ No ☐ Not Done	Hypertension: ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date	Lead Level Required for PreK & K	Date
TB-PRN	☐	☐		☐ Test Done ☐ Lead Elevated **≥ 5** µg/dL	
Sickle Cell Screen-PRN	☐	☐			

☐ **System Review Within Normal Limits**
☐ **Abnormal Findings–List Other Pertinent Medical Concerns Below (e.g., concussion, mental health, one functioning organ)**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine/Neck	☐ Skin	☐ Social Emotional
☐ Mental Health	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:	Diagnoses/Problems (list): ICD-10 Code*
☐ Additional Information Attached	*Required only for students with an IEP receiving Medicaid

Name:	Affirmed Name (if applicable):	DOB:

SCREENINGS

Vision & Hearing Screenings Required for New Entrants, PreK or K, 1, 3, 5, 7, & 11

Vision	**With Correction** ☐ Yes ☐ No	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity		20/	20/	☐ Yes	☐
Near Vision Acuity		20/	20/	☐ Yes	☐
Color Perception Screening ☐ Pass ☐ Fail					☐

Notes:

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes	☐

Notes:

Scoliosis Screening Required for Boys grade 9 and Girls grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐	☐

Notes:

FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS*/PLAYGROUND/WORK

☐ **Family cardiac history reviewed** – required for sports (Dominic Murray Sudden Cardiac Arrest Prevention Act)

☐ **Student may participate in all activities without restrictions.**

If Restrictions Apply, complete the information below.

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, or Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, or Volleyball
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, or Track & Field.
- ☐ **Other Restrictions:**

☐ **Other Accommodations*:** (e.g., brace, orthotics, insulin pump, prosthetic, sports goggles, etc.) Use the additional space below to explain.

*Check with the athletic governing body if prior approval/form completion is required for use of the device at athletic competitions.

MEDICATIONS

☐ Order Form for medication(s) needed at school attached

COMMUNICABLE DISEASE	**IMMUNIZATIONS**
☐ Confirmed free of communicable disease during exam	☐ Record Attached ☐ Reported in NYSIIS

HEALTHCARE PROVIDER

Healthcare Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone:	Fax:

Please Return This Form to Your Child's School Health Office When Completed.