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: _____

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, promotional materials, in-service trainings, and/or educational presentations.

Signature:_____ Date:_____

I give permission for Just Kids Early Childhood to seek emergency medical treatment for my child, _____, which includes calling my M.D. for emergency medicine 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 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 pictures and/or videos of my child on the school's social media pages. I understand that these pictures will be posted to celebrate student achievements and connect families to Just Kids Early Childhood Learning Center.

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 _____

Suffolk County Department of Health
Office of Children with Special Needs
Preschool Special Education Program

Medicaid Consent Form

Dear Parent/Guardian of: _____ Child's SS# / CIN# _____
This is to ask your permission (consent) to bill your or your child's Medicaid Insurance Program for special education and related services that are on your child's Individualized Education Program ("IEP"). This consent allows the School District/Suffolk County to bill for covered health-related services and to release information to the School District's Medicaid billing agent for that purpose.

I have received with this Medicaid Consent Form separate written notification from the School District or IEP service provider that explains in detail my federal rights regarding the use of public benefits or insurance to pay for certain special education and related services.

I understand and agree that the School District/Suffolk County may access Medicaid to pay for special education and related services provided to my child.

I understand that providing consent will not impact my or my child's Medicaid coverage. Upon request, I may review copies of records disclosed pursuant to this authorization. Services listed in my child's IEP must be provided at no cost to me whether or not I give consent to bill Medicaid. I have the right to withdraw consent at any time and the School District must give me annual written notification of my rights regarding this consent.

I also give my consent for the School District or Suffolk County or IEP service provider to release the following records and information about my child to the State's Medicaid Agency for the purpose of billing for special education and related services that are in my child's IEP:

-- Records and service information that likely will be shared --	
Prescriptions	Service Provider Attendance
Referrals	"Under the Direction of" Certification
Treatment Logs	"Under the Supervision of" Certification
Individualized Education Program - IEP	"Under the Direction of" Logs
Calendar and Attendance Records	"Under the Supervision of" Logs
Bus Logs	Other unnamed documents needed to support Medicaid claims

I give my consent voluntarily and understand that I may withdraw my consent at any time. I also understand that my child's right to receive special education and related services is in no way dependent on my granting consent and that, regardless of my decision to provide this consent, all the required services in my child's IEP will be provided to my child at no cost to me.

Print Parent/Guardian Name: _____

Parent/Guardian 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 _____