Dear Families,

Thank you for your interest in The Jointure's Creative Cuddles in home daycare program. Creative Cuddles offers experienced, caring, friendly and dedicated staff and provides a daily experience that meets each child's individual needs. A lifelong love of learning begins for children at birth. Infants and toddlers are curious and learn through hands on experiences and learn to use their senses to explore.. Creative Cuddles provides an environment that stimulates children's brains while allowing them to participate in hands-on experiences with their trusted caregiver. Your child will be with the same caregiver on a daily basis, which will help ensure stability and create a healthy routine for you and your child. The provider builds a supportive and loving relationship with you and your child to nurture social-emotional development while developing skills as they learn to move and play.

Infant Development

- Rolling, crawling and pulling themselves up to explore
- Watching, listening and responding to people and their environment
- Using their senses to explore
- Reaching developmental milestones
- Feeling safe with their trusted caregiver

Toddler Development

- Reacting, recognizing and responding to familiar children and adults
- Expressing themselves with sounds; babbling and expressing themselves forming words
- Purposefully playing with objects using developmentally appropriate fine motor skills. Ex. Holding a crayon, throwing/ catching a ball, feeding themselves using utensils.
- Ability to calm and comfort themselves with love and encouragement from familiar adult
- Following simple directions. Ex. Helping put toys away
- Establishing a healthy attachment to their caregiver
- Trying new and different activities like hopping, clapping to the rhythm of a song, challenging puzzles, exploring art with paint, playdough etc.

Creative Cuddles providers devote time cuddling and talking to your baby. Caregivers demonstrate a healthy early learning for exploring and communicating. The play area is complete with age appropriate toys and books that allow infants and toddlers to explore and reach developmentally appropriate milestones. Children enjoy both indoor and outdoor activities while following a daily schedules, including a consistent drop off routine, nap times, feeding times and play times.

The relationship with creative Cuddles providers and their families builds a relationship of trust, confidence and independence from infants to toddlers and creates a smooth transition for children when they are ready to enter the next level of lifelong learning.

Please complete the attached forms and return with a $50.00 non-refundable Registration Fee and one Month's Tuition payable to The Jointure. If you have any questions, please contact our office at 908-722-1563.

Thank you,

Darnell A. Scott
Director of Children's Programs

Creative Cuddles 2025-2026

Start Date:_____

Office Use:

da s
da s
5 da s

Cash chec CC r CH

Allergy_____

Child's Name:_____

Age:_____ Birth date: ___/_____/_____ ☐ Female ☐ Male

Mother/ Guardian: Last Name: _____ **First Name:**_____

Email:_____

Address:_____

Town/Zip:_____

Business Name:_____

Title/ Position:_____

Cell Phone:_____

☐ Check box if you wish to recieve emergancy text messages.
Please provide your carrier_____.

Home Phone:_____

Work Phone: _____

☐ Primary Pick- Up ☐ Payer Only

☐ Primary Guardian

Father/ Guardian: Last Name: _____ **First Name:**_____

Email:_____

Address:_____

Town/Zip:_____

Business Name:_____

Title/ Position:_____

Cell Phone:_____

☐ Check box if you wish to recieve emergancy text messages.
Please provide your carrier_____.

Home Phone:_____

Work Phone: _____

☐ Primary Pick- Up ☐ Payer Only

☐ Primary Guardian

Any special instructions, such as custody or restraining orders must be attached to this application and discussed personally with the camp director. All information will be kept confidential.

Emergency Contact:_____
(Last Name) (First Name)

Relationship:_____

Cell Phone:_____

Doctor's Name:_____
(Last Name) (First Name)

Doctor's Address:_____

Phone Number:_____

Name and Phone Number (s) of person (s) other than parents authorized to pick up your child:
(within 30 mintues of the school)

1._____ Phone Number:_____ Relationship:_____
(Last Name) (First Name)

2._____ Phone number:_____ Relationship:_____
(Last Name) (First Name)

3._____ Phone Number:_____ Relationship:_____
(Last Name) (First Name)

4._____ Phone Number:_____ Relationship:_____
(Last Name) (First Name)

How did you hear about us:_____ Referred by:_____

Creative Cuddles

Child's Name:_____ Age:_____

Monthly Tuition

Days Attending (Circle): M T W TH F

Days	Per Day	Week	Sibling Discount
3	$70	$210	$195 Weekly
4	$68	$272	$252 Weekly
5	$65	$325	$300 Weekly

****PLEASE INCLUDE A $50.00 REGISTRATION FEE (PER CHILD)****

Tuition is billed in the middle of the month. **A $50.00 Non- Refundable Registration Fee is due at the time of enrollment to hold your child's place.** Invoices will be emailed regardless of method of payment. Invoices are sent at the beginning of the month. Payment is due by the 5th of the month. If there are any changes to your email throughout the year, please contact our Creative Campus office at 908-722-1563. Two (2) weeks' notice is required if you wish to withdraw your child from the program.
A $25.00 late fee will be imposed for every 15 Minutes interval or part thereof.
(EX: 5:31-5:45= $25.00, 6:46-7:00= $50.00 each etc.)

Tuition is payable by check, money order, cash, credit/debit card or Direct Deposit. All checks and money orders are payable to "The Jointure." Please put your child' s name and provider on the payment. An Automatic Credit/Debit Card and Direct Deposit form is available in the **FORM** tab under **PAYMENT FORM** at www.jointure.org. All Credit/ Debit Card transactions will incur a 3% fee per transaction. Invoices will still be sent monthly via email.

Payments may be made in person at The Creative Campus or mailed to:
The Jointure
500 US HWY 22
Bridgewater, NJ 08807
I have read and fully understand the policies of Creative Cuddles Program and agree to abide by these policies. If you have any questions regarding tuition or billing, please call 908-722-1563

Parent/Guardian Print:_____ Date:_____

Parent/Guardian Signature:_____

AUTHORIZATION

To the best of my knowledge, the history provided below is correct and complete. I know of no reason to restrict applicant's activity and give permission for participation in all activities except as noted herein. In the event that I cannot be reached in an **EMERGENCY**, I hereby give permission to the physician selected by The Jointure to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child.

_____ _____

Signature of Parent/Guardian **Date**

_____ _____ _____

Insurance Company **ID#** **Group #**

DISEASE OR PAST/PRESENT HISTORY

YES	NO		DETAILS	YEAR
_____	_____	Serious Illness	_____	_____
_____	_____	Serious Injury	_____	_____
_____	_____	Surgery	_____	_____
_____	_____	Ears	_____	_____
_____	_____	Eyes	_____	_____
_____	_____	Nose/Sinus	_____	_____
_____	_____	Teeth	_____	_____
_____	_____	Throat/Tonsils	_____	_____
_____	_____	Chest/Lungs	_____	_____
_____	_____	Heart	_____	_____
_____	_____	Stomach/Bowels	_____	_____
_____	_____	Appendicitis	_____	_____
_____	_____	Kidney/Bladder	_____	_____
_____	_____	Menstrual Problems	_____	_____
_____	_____	Hernia Rupture	_____	_____
_____	_____	Back/Limbs/Joints	_____	_____
_____	_____	Behavioral Conditions	_____	_____
_____	_____	Allergies (Specify)	_____	_____
_____	_____	Other (Specify)	_____	_____

****Please list any SPECIAL NEEDS/ALLERGIES/MEDICATIONS****

_____

My Child is in good health and can participate in The Creative Cuddles Program.

_____ _____

Signature of Parent/Guardian **Date**

SPECIAL INSTRUCTIONS: _____

_____

If your child requires lifesaving medication (Epi-pen, Benadryl, etc.) please complete attached Medical Permission Form. A **doctor's signature and **Action Plan** are also required to begin the program.**

10:122-7.5 Administration and control of prescription and non–prescription medicines and health care procedures may be used to record administration of medication to children.

INDIVIDUAL PERMISSON FOR MEDICATION OF HEALTH CARE PROCEDURE

ONLY IF CHILD REQUIRES LIFE-SAVING MEDICATION DURING PROGRAM HOURS

Name of Child:_____

Child's condition for administering medication:_____

Name of medication/procedure_____

_____ Prescription _____ Non-Prescription _____ Doctor's approval required

Amount to be administered_____

Time(s) to be administered_____

Dates to be administered From_____ To_____

Refrigeration necessary _____Yes _____No

Special Instructions_____

_____

_____

_____

Possible adverse reactions:_____

_____

I authorize the administration of medication to my child.

_____ _____

Parent's Signature Date

All prescription medication must have physician authorization!

I authorize the following prescription medication to be administered as instructed above for this patient.

Physician Signature:_____ **Date:**_____

Physician Name:_____ **Phone:**_____

In consideration of the above named child being allowed to participate in the Jointure's program, I , the parent or legal guardian of the above mentioned child, hereby waive and forever release the Jointure, it's trustees, employees, agents, staff, volunteers, successors, partners, and assigns, from any and all liability, claims, demands, or causes of action, arising out of or in any way related to the handling of medically related situations for my child while participating in any Jointure program, specifically inclusive of claims based upon the negligent administration of the above medication.

I fully assume all risk and waive all liability in connection with my child's medical needs while participating in any Jointure Program, without limitation, to the fullest extent permitted by law. I will indemnify, save and hold harmless each of the above releases from any litigation expense, attorney fees, loss or liability, damage against the Jointure and/or the school district.

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

Print Name:_____

Illness Policy

If a child exhibits any of the following symptoms, the child may not enter the program. If such symptoms occur while at the program, the child will be removed from the group and parents will be notified to pick up their child as soon as possible but no later than 1 hour after contact. In order to ensure the health of the other children, parents must provide a minimum of two (2) local emergency contacts. Parents will be called for pick up if any of the following symptoms are displayed including but not limited to:

- Severe pain discomfort
- Diarrhea
- Vomiting
- Oral temperate 100.4
- Lethargy
- Severe coughing
- Yellow eyes or Jaundiced skin
- Red eyes with discharge
- Infected untreaded skin patches
- Difficult or rapid breathing
- Skin rash in conjunction with fever or behavior changes
- Skin lesion(s) that are weeping or bleeding
- Mouth sores with drooling
- Stiff neck

If your child is sent home due to the list above, he/she may not return the next school day and the child must be symptom free and fever free without fever reducing medication for at least 24 hours before returning. If your child is out of school for 2 or more days, a doctor's note is necessary to return.

I acknowledge and understand The Jointure's Creative Cuddles illness policy and procedures.

_____ _____

Print Name Date

_____

Signature

Universal Health Care Record and Immunization

All children in the Creative Cuddles Program are required to provide a completed Universal Health Care Record (New Jersey Department of Health Form CH-14) and an immunization record provided by the child's physician prior to the child starting the program. All records must be updated and provided annually. All children enrolled must receive annual flu shot by December 31st of that year. Any child who has not provided such documentation will be removed from the program until documentation is provided. Child that are exempt from physician examination, immunization or medical treatment must provide a detailed written statement, explaining how the examination, immunization, or medical treatment conflicts with the child' s exercise of bona-fide religious tents or practices.

WAIVER OF LIABILITY AND INDEMNITY AGREEMENT

IN CONSIDERATION of being permitted to utilize the facilities, services and programs of The Jointure for any purpose, including, but not limited to observation or use of facilities or equipment, or participation in any program affiliated with the Jointure, the undersigned, for himself or herself and any personal representatives, heirs, and next of kin, hereby acknowledges, agrees and represents that he or she has, or immediately upon entering or participating inspect and carefully consider such premises and facilities or the affiliated program. It is further warranted that such entry into the Jointure for observation or use of any facilities or equipment or participation in any program constitutes an acknowledgement that such premises and all facilities and equipment thereon and such affiliated program have been inspected and carefully considered and that the undersigned finds and accepts same as being safe and reasonably suited for the purpose of such observation, use or participation.

IN FURTHER CONSIDERATION OF BEING PERMITTED TO ENTER THE JOINTURE FOR ANY PURPOSE INCLUDING, BUT NOT LIMITED TO OBSERVATION OR USE OF FACILITIES OR EQUIPMENT, OR PARTICIPATION IN ANY PROGRAM AFFILIATED WITH THE JOINTURE,

THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING:

1. THE UNDERSIGNED HEREBY RELEASES, WAIVES, DISCHARGES AND CONVENANTS NOT TO SUE the Jointure, its directors, officers, employees, and agents (hereinafter referred to as "releases") from all liability to the undersigned, his personal representatives, assigns, heirs, and next of kin for any loss or damages, and any claim or demands therefore on account of injury to the person or property or resulting in death of the undersigned, whether caused by the negligence of the releases or otherwise while the undersigned is in, upon, or about the premises or any facilities or equipment therein or participating in any program affiliated with the Jointure.
2. THE UNDERSIGNED HEREBY AGREES TO INDEMNIFY AND SAVE AND HOLD HARMLESS the releases and each of them from any loss, liability, damage or cost they may incur due to the presence of the undersigned in, upon or about the Jointure premises or in any way observing or using any facilities or equipment of the Jointure or participating in any program affiliated with the Jointure whether caused by the negligence of the releases or otherwise.
3. THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR AND RISK OF BODILY INJURY, DEATH OR PROPERTY DAMAGE due to negligence of release or otherwise while in about or upon the premises of the Jointure and/or while using the premises or any facilities or equipment thereon or participating in any program affiliated with the Jointure.

THE UNDERSIGNED further expressly agrees that the foregoing RELEASE, WAIVER AND INDEMNITY AGREEMENT is intended to be as broad and inclusive as is permitted by the law of the State of New Jersey and that if any portion thereof is held invalid, it is agreed that the balance shall, notwithstanding continue in full legal force and effect.

THE UNDERSIGNED HAS READ AND VOLUNTARILY SIGNS THE RELEASE AND WAIVER OF LIABILITY AND INDEMNITY AGREEMENT, and further agrees that no oral representations, statements or inducement apart from the foregoing written agreement have been made.

_____ Creative Cuddles

Name of Child **Name of Program**

_____ _____

Parent/Guardian Signature **Date**

TERMS AND CONDITIONS TO PARTICPIATE IN CREATIVE CUDDLES

PROVIDER RESPONSBILITY

- Physician authorized note stating provider is in good health with negative Mantoux test
- Criminal disclosure and background check
- Open Door Policy
- Daily information updates
- Liability insurance
- Safety locks in kitchen and bathrooms
- Safety plugs in electrical outlets
- Pet health code compliance
- Smoke detector and carbon monoxide detector on every level of home
- First aid supplies
- Provider holds babies while bottle feeding
- Age appropriate toys
- Infant and toddler equipment

PROVIDER NUTRITION REPONSIBILITY

- Table food for breakfast, lunch and snacks
- Toys and Art supplies
- Separate washcloth and towel for each child

PARENT RESPONSIBILITY

- Formula, bottles, baby food
- Diapers (disposable) and wipes
- Change of clothes, sweater or jacket
- Linens for Pack N Play
- Blanket, cup, bibs

JOINTURE RESPONSBILITY

- Visits to provider by trained staff
- Information on age appropriate curriculum and educational activities
- Lending library of resources
- Resource for liability insurance
- CPR, First Aid and Epi-Pen training and information on community and statewide early childhood workshops and conferences
- Weekly attendance forms for children
- Tax statements for families
- Office and support staff
- Written references

I have read and understand the terms and conditions of the responsibilities of the child care provider , parents and of The Jointure above.

_____	Creative Cuddles
Name of Child	**Program**
_____	_____
Parent/Guardian Signature	**Date**

THE JOINTURE PHOTO/VIDEO/INTERVIEW/WEBSITE CONSENT

I certify that I am the parent or legal guardian of _____ **whose date**
(Name of Child)

of birth is _____.
(mm/dd/yy)

Throughout the day, pictures and videos of your child may be taken. These photographs and videos, will only be used to promote our Creative Cuddles Program and/or The Jointure.

If you wish for your child to participate in the activities described above, please review this section.

I **GIVE** permission for my child to be photographed or otherwise recorded during events and activities. *(Please check if you give permission).*

☐Photo ☐Video ☐Website Consent ☐Facebook ☐Instagram

_____ _____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

If you **DO NOT** wish for your child to participate in the activities described above, please review this section.

I **DO NOT** give permission for my child to be photographed or otherwise recorded during events and activities. As a result, my child may not be able to participate in these events and activities.
*(Please check if you **DO NOT** give permission).*

☐Photo ☐Video ☐Website Consent ☐Facebook ☐Instagram

_____ _____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

THE JOINTURE RELEASE POLICY

Each child may be released only to the child's custodial parent(s) or person(s) authorized by the custodial parent(s) to take the child from the school and assume responsibility for the child in an emergency if the custodial parent(s) cannot be reached.

If a non-custodial parent has been denied access, or granted limited access, to a child by a court, the Jointure shall secure documentation to that effect, maintain a copy on file, and comply with the terms of the court order.

If the custodial parent(s) or Person(s) authorized by the custodial parent(s) fail to pick-up a child by The Jointure's after school program's daily closing time, the Provider shall ensure that:

1. The child is supervised at all times;
2. Staff member(s) attempt to contact the custodial parent(s) or person(s) authorized by the custodial parent(s); and
3. After closing time, and provided that other arrangements for releasing the child to his/her custodial parent(s) or person (s) authorized by the custodial parent(s) have failed, and the staff member(s) cannot continue to supervise the child, the staff member shall call the Division's 24-hour Child Abuse Hotline (1-800-792-8610) to seek assistance in caring for the child until the parent(s) or person(s) authorized by the child's parent(s) is able to pickup the child.

If the custodial parent(s) or person(s) authorized by the custodial parent(s) appears to be physically and/or emotionally impaired to the extent that, in the judgment of the director and/or staff member, the child would be placed at risk of harm if released to such an individual, the Provider shall adhere to the following procedure:

1. The child may not be released to such an impaired individual.
2. Provider attempts to contact the child's other custodial parent or an alternative person(s) authorized by the parent(s) for pick-up.
3. If the Provideris unable to make alternative arrangements, a staff member shall call the Division's 24-hour Child Abuse Hotline (1-800-792-8610) to seek assistance in caring for the child.

Custodial Information

If a non-custodial parent is not included among those persons authorized by the custodial parent to pick up the child, please provide a copy of court documents.

_____ _____

Parent/Guardian's Name (Please Print) **Child's Name**

_____ _____

Parent/Guardian's Signature **Date**

Provider Contract

This contract between _____,
(Provider Name)

residing at _____
(Provider Address)

and_____
(Parent/ Guardian Name)

at_____ for the care of
(Parent/ Guardian Address)

_____ on the following days each week.
(Child's Name)

This guarantees_____ a start date of_____

with_____at the address above.

_____ _____
Provider Signature Parent Signature

Monday, Tuesday, Wednesday, Thursday and/or **Friday.**

For a child's healthy development, it is important children arrive the same time each day and must be

picked up by 5:00 PM._____ will
(Parent/ Guardian Name)

arrive each day at _____ am unless the family notifies otherwise.
(Time)

Cuddles providers are full time employees and are entitled to vacation and sick time. Credits and refunds will not be approved for providers time off.

Creative Cuddles will be closed on the following holidays: New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving and 2 days for Christmas.
Please confirm with provider.

Parents will be given a minimum of 1 month advance notice of scheduled vacation time so parents make other arrangements.

Back up care is offered if another provider has availability. More information will be provided upon request.

Tuition must be paid in full and on time regardless of child's attendance each day.
THERE ARE NO REFUNDS FOR MISSED DAYS.

Date:_____

TO: The Creative Campus
500 US HWY 22
Bridgewater, NJ 08807

This letter will authorize The Jointure to charge my credit card or account as follows: Please choose the method which you intend to have withdrawals each month.

☐ **Credit Card**

☐ **Direct Debit** (PLEASE PRINT)

Name of Card (Visa/MasterCard/ Discover / American Express):_____

Cardholder's Name: **Last Name**:_____ **First Name:**_____

Address of Cardholder: _____

Card Number:_____ Phone Number:_____

Exp. Date:_____ Security Code:_____

Please note a 3 % Credit Card Fee every transaction

☐ **Direct Debit** (please fill out form or attach a voided check) (PLEASE PRINT)

Account Holder's Name: **Last Name:**_____ **First Name:** _____

Bank Name:_____ Account Phone Number:_____

ABA Routing Number:_____

Checking Account Number:_____

☐ **Check** *** Please make checks payable to "The Jointure"***

I, _____ understand that my account will be charged in the amount of $_____ on the 15th for the following month's tuition(i.e. October's tuition is due September 15th). Starting from _____ (Month) to _____ (Month). I also understand that if my child's schedule changes the amount charged to my account will reflect the changed tuition.

_____ _____

Name of Child: **Name of School/Site:**

Signature:_____ **Date:**_____

Payment Policies & Procedures

A $50.00 Non-Refundable Registration Fee is due at the time of Enrollment.
Subsequent payments are due on or before the 15th of each month regardless of method of payment.
(i.e. October's Tuition is due by November 15th.)
Invoices will be e-mailed in the beginning of the month regardless of the method of payment.

If there are any changes to your email, Please contact The Creative Campus Office, 908-722-1563.

Withdrawals , Refunds and Cancellation Terms & Conditions

(Please initial that you understand and agree)

1. _____All withdrawals must be completed and submitted with the Jointure's Withdrawal Form.
2. _____Tuition is based on a daily rate in accordance with registration documents. Refunds will not be approved for missed days.
3. _____A refund or credit will be determined on the day in which the withdrawal form is submitted. Any outstanding charges including the withdrawal fee must be paid in order for your child to be withdrawn from the program. **Withdrawal fee is $30.00.**
4. _____The $50.00 per child registration fee is non-refundable.
5. _____ Providers are full time employees and are entitled to vacation and sick leave. Refunds and or credits will not be issued for providers vacation and sick leave.
6. _____ Families may contact providers directly for any schedule changes.
7. _____It is the responsibility of the cardholder to notify The Jointure Administrative Office if there are changes to the account, and/ or card information.
8. _____Credit or Debit Cards or Direct Deposits resulting in "Non-sufficient Funds" will be charged $35 each time. Credit or Debit Cards consistently resulting in NSF will require all future payments to be made by cash or money order for the remainder of the year.
9. _____All charges on a Credit Card or Debit Card will incur a **non-refundable** 3% fee, per charge.
10. _____ In order to cancel your monthly Automatic Credit or Debit Cards or Direct Deposit Payments, written notification must be provided stating the date in which you choose to stop automatic payments. Once your account has been cancelled, you will receive a confirmation email.
11. _____Due to inclement weather, I understand I need to check with my child's provider for any closures or delayed openings.

By printing and signing below, I, _____, understand the policies and procedures regarding payments, withdrawals and refunds. I also understand the terms and conditions for utilizing Credit or Debit Card or Direct Deposit Automatic Payment and the cancellation and refund policies associated with it.

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 ☐ 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	