REQUIRED REGISTRATION DOCUMENTS

Three proofs of residency

Any three items that have the parent's name, address & date.

one of these items must be within the past 30 days

The other two items must be within the past year.

If the family is homeless and or living with other family members

For families in shelters

We must have a letter from the shelter stating that the family is housed there.

For families that live with other family members

They must have a letter from the person that they're living with the Letter must contain ***the name of the person and address of the person with whom they reside it must have the parent's name and the child's name in the body of the letter they will also have to have two proofs of residency within the past year accompanying the letter it must also be notarized if they do not have anyone to notarize it we will notarize it for them.***

Proof if Income

If your Pay is WEEKLY

LAST FOUR paystubs

If your pay is BI-WEEKLY

LAST TWO paystubs

If you receive any type of assistance

Food Stamps

A copy of your family first card

SSI, Unemployment, TANF

A Statement Print out

Birth certificate

Immunization record.

Physical form.

Health Insurance Card

Parent/Guardian Photo ID

Blonnie's Early Learning Academy, Inc.

Enrollment Application Booklet

PROGRAM OPTION: TO BE COMPLETED BY THE AGENCY

HEAD START ☐ EARLY HEADSTART: CENTER-BASED ☐ PREGNANT SERVICES ☐

DATES:
INTAKE DATE: _____ENROLLMENT DATE: _____ENTRY DATE: ___ DROP DATE: _____

RE-ENROLL DATE: _____PREGNANT TO CENTER_____ ___EHS TO HS DATE:_____

Part 1: PARENT/LEGAL GUARDIAN INFORMATION

1st Parent/Legal Guardian: _____

Date of Birth: _____ Relationship to Child: _____

Address:_____

Email Address_____@_____

Telephone Numbers: Home: ( ) _____Cell: ( ) _____ Other: (_____

- **Are you currently employed: Yes [No [**
- **Are you currently in school: Yes [No [Highest Level of Education completed: _____**
- **Are you or anyone in the household in the military/active duty/veteran Yes [ ] No [ ]**

2nd Parent/Legal Guardian: _____

Date of Birth: _____ Relationship to Child: _____

Address: _____

Email Address_____ _____@_____

Telephone Numbers: Home: ( ) _____ Cell: ( ) _____ Other: ( ) _____

- **Are you currently employed: Yes [No [**
- **Are you currently in school: Yes [No [Highest Level of Education completed:_____**
- **Are you or anyone in the household in the military/active duty/ veteran Yes [ ] No [ ]**

Family Type: Single [ ] 2 Parent/Guardian [ ] Foster Family [ ]

Part 2: CHILD'S INFORMATION

Full Name of Child: _____

Date of Birth/Due Date (EHS): _____ Sex: Male [ ] Female [ ] Other[

Ethnic Origin:_____ Primary Language: _____

Part 3: FAMILY INFORMATION

Household Members Dependent Upon Your Income: (Name and Date of Birth for all in the household)

***For Pregnant Women applying for Early Head Start, include unborn child & estimated date of birth**

Name	Date of Birth	Relationship to Child

Part 5: GENERAL CONSENT

Parent Release Form for Media Recording

I, _____the undersigned, do hereby grant, or deny permission to **Blonnie's Early Learning Academy, Inc.** to use the image of my child(ren)_____, as marked by my selection(s) below. Such use includes the display, distribution, publication, transmission, or otherwise use of photographs, images, and/or video taken of my child(ren) for use in materials that include, but may not limited to printed and digital materials (e.g., brochures, newsletters, videos, etc.) which are utilized on **Blonnie's Early Learning Academy, Inc., website, social media and all marketing tools.** I further understand that the child's last name will not be used in conjunction with any video, printed, or digital images..

PLEASE SELECT ONE OF THE BELOW BOXES

❑ **I deny** permission to use my child's image at all.

❑ **I grant** permission to use my child's image.

❑ **Unrestricted usage:** I give unrestricted permission for my child's image to be used in print, video, and digital media for the above purposes by The Leaguers, Inc., without further notifying me.

I, _____ parent/guardian of_____ agree/permit Blonnie's Early Learning Academy, Inc.:

- **allow agency staff to make home visits during the school year at my convenience** Yes [ ] No [ ]
- **my child may go on all field trips taken by the program, provided that I have received information about the specific trip, date, destination, time of departure and return prior to each trip. I understand that children will be accompanied by teachers, aides, and volunteers, and that I may choose to attend also** Yes [ ] No [ ]
- **I give permission to The Leaguers Head Start Program to copyright and/or publish the photographic portraits or pictures of my child on its Social Media or in its recruitment campaigns.** Yes [ ] No [ ]
- **I authorize the release of any medical information to process this application** Yes [ ] No [ ]
- **I authorize the Development screening** Yes [ ] No [ ]
- **My child can participate in daily walks within the neighborhood accompanied by staff** Yes [ ] No [ ]
- **Social Emotional Well-Being Observation** Yes [ ] No [ ]
- **Height screening** Yes [ ] No [ ]
- **Weight screening** Yes [ ] No [ ]
- **Vision screening** Yes [ ] No [ ]
- **Hearing screening** Yes [ ] No [ ]
- **The Center Staff to secure needed emergency medical care in case of emergency when I cannot be contacted** Yes[ ] No [ ]

I have read the foregoing, and the above answers and the answers given to the interviewer for the data entry system are true and complete to the best of my knowledge and belief. I understand that if any of this information changes, or is found to be incorrect, I am obligated to notify the program immediately. I understand that the information provided above will remain strictly confidential.

Signature of Parent/Guardian	Date	Signature of Interviewer	Date

Part 6: INFORMATION TO PARENTS

- Blonnie's Early Learning Academy, Inc. Head Start/Early Head Start Program works in collaboration with all participating parents to assist them in identifying and **accessing resources** that are responsive to their interests and goals. These resources include emergency and crisis assistance, education and other appropriate interventions. This information is available in the Family Advocate's office, and in the Parent Room. We have also uploaded these resources to our website for easy access at **http://www.blonniesearlylearningacademy.com** Please contact your Family Advocate if you need assistance with accessing these resources.
- **Daily attendance** in our program is necessary for students to gain the FULL benefit of a high quality education. Consistent attendance in the early grades is shown to increase scores in reading and math and helps children develop strong socioemotional skills needed to become successful learners. Please note this is not daycare. Students should not be absent during school days unless they are sick. Vacation and trips should be planned on days when school is not in session. If your child experiences unexcused chronic absenteeism, they may lose their placement. By initialing below, you are acknowledging the importance of your child's education and are committing to bringing your child to school every day.

Initial if read and understand _____

Use Only for Early Head Start Child Care Partnership

By signing below I understand and agree that:

- I have read the foregoing, and the above answers and the answers given to the interviewer for the data entry system are true and complete to the best of my knowledge and belief.
- I understand that if any of this information changes, or is found to be incorrect, I am obligated to notify the program immediately.
- The information provided above will remain strictly confidential
- I have been informed and am aware that, once enrolled, my child/children are eligible to remain in the program until the child ages out.
- I understand if my child care subsidy is interrupted or lost, I will work with the program to regain my subsidy.

Initial if read and understand _____

Part 7: NEEDS ASSESSMENT- *The Needs Assessment will be update annually*

1. **To which group does your child belong?**

   ___ Early Head Start
   ___Head Start
   ___Pregnant Services

2. **How did you learn about our program?**
   - o Friend /Neighbor/Relative
   - o Flyer or Poster
   - o Internet (list site below, if known)
   - o Social Media/Website
   - o Billboard Ad
   - o **Other**: _____

3. **Is your child enrolled Child Care and Resource Referral services (Programs for Parents/ 4C's)?**
   - o Yes
   - o No: (Please Specify)

     _____

4. **Which of the following activities would you like to participate in? (Check all that apply):**
   - o Classroom Volunteer
   - o Field Trips
   - o Planning Events/Workshops/Activities
   - o Parent Center Committee/Policy Council
   - o **Other (Please specify):** _____

     _____

5. **What may *prevent* you from attending parent activities?**
   - o Lack of Transportation
   - o Unavailable Childcare
   - o Language Barrier
   - o Work Conflicts
   - o Not Interested
   - o Health & safety concerns
   - o **Other** (Please specify): _____

6. **How would you prefer to be informed regarding workshops, community resources, school activities, etc.?**

- Flyer/ Newsletter
- Agency Website
- Center Parent Bulletin Board
- Phone Call
- Email: _____
- Social Media (Facebook, Twitter)
- **Other:** _____

7. **Please check if you would be interested in attending workshops OR receiving information in the following areas:**

Topics	*Information*	*Workshop*
Adult Education/GED/ESL		
Child Abuse and neglect		
Child Support		
Clothing		
Crisis Assistance		
ELA		
Emergency services		
Financial Literacy/Asset Building		
Food/Nutrition		
Greif and Loss		
Housing/shelter		
Intimâtes Partner violence. Domestic Violence		
Job Training		
Legal Aid		
Mental Health		
Preventive medical/oral health		
Relationship/marriage		
School Readiness- Screening & assessment, curriculum		
Substance abuse/ Tobacco Education		
Transition between programs		
Transportation		
Other(s):		

8. **Please List Best Available times/days for workshops:**

   1st. Option: _____

   2nd Option: _____

   3rd Option: _____

9. **Check which of the following community, public/ private services your family has used within the last year:**
   - Adult Education
   - Community Healthcare Center/Family Dental Clinic
   - Domestic Violence services
   - Energy Assistance
   - Family Success Centers
   - Food & Clothing Bank
   - Medicaid/ Medicare/Charity Care
   - Mental Health services
   - NJ Family Care
   - Public Assistance (TANF or SSI)
   - Public Housing/Section 8
   - SNAP- Supplemental Nutrition Assistance Program
   - TRA- Temporary Rental Assistance
   - Transportation Subsidy
   - Unemployment
   - Unhoused services/prevention
   - Victim Advocate Services
   - WIC – Women Infants and Children
   - Other: _____

10. **If you were not able to have access to any of the above services, why not? (check all that apply)**
    - Lack of Transportation
    - Insufficient or No Health Insurance
    - Language Barriers
    - Limited Funds / Resources
    - Unavailable Documentation
    - Lack of knowledge about services
    - Unavailable Childcare
    - Other (Please specify)
    - Not Needed

Parent Signature: _____ **Date:** _____

CHILD INFORMATION/PICK UP AUTHORIZATION FORM

Child Information/Pick Up will be updated annually

ATTENTION PARENTS: Only those persons authorized by you submitting their name on this form will be permitted to pick up your child. If you for any reason have to send someone who is not on this list, you must call to inform the staff/teacher. You should tell them who the person is and who they will be picking up. Head Start children will not be released to anyone who is not on the list, or under the age of twelve (12), or anyone who appears to be intoxicated. Inform them that their identification may be requested for verification.

** NOTE: No one under the age of 18 will be allowed to pick-up a child from an Early Head Start classroom unless they are the parent of the child.*

Child: ______________________ **School Hours:** ____________

Birth Date: ____________ **Home Phone Number:** ( ) ____________

Home Address ______________________

1st Parent/Legal Guardian: ______________________

Work Number: ( ) ____________ **Ext/Dept.** ____________

Mobile: ( ) ______________________

Email Address ____________ @ ____________

2nd Parent/Legal Guardian: ______________________

Father's Work Number: ( ) ____________ **Ext/Dept.** ____________

Father's Mobile : ( ) ______________________

Email Address ____________ @ ____________

Emergency contact #1: ____________ **Relationship** ____________

Home Phone: ( ) ____________ **Other phone:** ( ) ____________

Emergency contact #2: ____________ **Relationship** ____________

Home Phone: ( ) ____________ **Other phone:** ( ) ____________

PICK UP AUTHORIZATION

Name: ______________________
Address: ______________________
____
Telephone: ( ) ____________
Alternate #: ( ) ____________
Relationship to child: ____________

Name: ______________________
Address: ______________________
____
Telephone: ( ) ____________
Alternate #: ( ) ____________
Relationship to child: ____________

Name: ______________________
Address: ______________________
____
Telephone: ( ) ____________
Alternate #: ( ) ____________
Relationship to child: ____________

Name: ______________________
Address: ______________________
____
Telephone: ( ) ____________
Alternate #: ( ) ____________
Relationship to child: ____________

Name: ______________________
Address: ______________________
____
Telephone: ( ) ____________
Alternate #: ( ) ____________
Relationship to child: ____________

Name: ______________________
Address: ______________________
____
Telephone: ( ) ____________
Alternate #: ( ) ____________
Relationship to child: ____________

Parent Signature: ______________________ **Date:** ____________

Attendance Commitment

Dear Parent/Guardian,

Your child's daily attendance in our preschool program is essential for their growth, learning, and success. A high-quality Head Start education provides children with the skills they need to thrive academically and socially, but to gain the **full benefit**, regular attendance is key.

Research has shown that children who attend school consistently in their early years develop **stronger reading and math skills**, as well as important **social-emotional abilities** that help them navigate relationships, solve problems, and become confident learners. At Blonnie's Early Learning Academy, Inc., we believe that **consistent attendance is directly linked to long-term academic success**, and we are committed to working with families to ensure that every child has the opportunity to build a strong educational foundation.

To support your child's success, we ask that you make **daily attendance a top priority**. Your child should attend school **every day unless they are sick**. Family vacations and trips should be scheduled **when school is not in session** to prevent interruptions in learning.

By signing the commitment statement below, you acknowledge the importance of your child's education and commit to ensuring their daily participation in our program.

Attendance Commitment Statement

I, _____, as the parent/guardian of _____, understand the importance of my child's daily attendance in a high-quality preschool program. I commit to bringing my child to school **every day**, unless they are sick, and to prioritizing their education by ensuring they are present and engaged in learning. I understand that my child's consistent attendance will help build a strong foundation for academic achievement, social-emotional growth, and lifelong success.

Parent/Guardian Print: _____

Parent/Guardian Signature: _____

Date: _____

Blonnie's Early Learning Academy, Inc.

Yolonda Severe, Executive Director
Office of Early Childhood

Where Passion Meets Progress

HEALTH HISTORY QUESTIONNAIRE

Student's Name _____
Date of Birth _____
Mother _____
Grade _____

Daytime Tel. No. _____
Parent/Guardian
Father _____
Child's Doctor _____
Dr. Phone Number _____

Household

Please list all those children living in the home.

Name	Relationship to Child	Date of Birth	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live.

_____
_____
_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

_____
_____
_____

Birth History

Birth weight: _____
Was the baby born at term? _____ Early? _____ Late? _____
If early, how many weeks' gestation? _____
Did mother have any illness or problem with her pregnancy?
□ Yes □ No Explain

_____
_____

During pregnancy, did mother
Smoke? □ Yes □ No Drink alcohol? □ Yes □ No
Use medications? □ Yes □ No
What? _____ When?

Was the delivery □ Vaginal □ Cesarean
If cesarean, why? _____

Did your baby have problems right after birth?
□ Yes □ No Explain

_____
_____

Was initial feeding □ Breast? □ Bottle?
Did your baby go home with mother from the hospital? □ Yes □ No Explain

_____

Has your child ever had?

Heart disease	□ Yes	□ No	□ Onset
Fainting	□ Yes	□ No	□ Onset
Kidney Disease	□ Yes	□ No	□ Onset
Sickle Cell	□ Yes	□ No	□ Onset
Lead Poisoning	□ Yes	□ No	□ Onset
Asthma	□ Yes	□ No	□ Onset

Seizure, Convulsion	□ Yes	□ No	□ Onset
Diabetes	□ Yes	□ No	□ Onset
Ear Infections	□ Yes	□ No	□ Onset
Lung Disease	□ Yes	□ No	□ Onset
Chickenpox	□ Yes	□ No	□ Onset

My child has had the childhood disease of chicken pox. □ Yes □ No Year ____ SignX_____
Has your child ever had asthma? □ Yes □ No

Has your child ever been in the hospital for any other reason? ☐ Yes ☐ No

Reason for hospitalization _____ How many days _____ Year _____

Reason for hospitalization _____ How many days _____ Year _____

Has your child ever had any broken bones? ☐ Yes ☐ No

If yes, please explain _____

Does your child have allergies to any foods or medications? ☐ Yes ☐ No

If yes, please explain _____

At what age did your child first walk? _____; talk in sentences? _____; was fully toilet-trained? _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No

Has your child had any surgeries? ☐ Yes ☐ No Dates

Medical History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	When _____
Frequent Ear Infections	☐ Yes	☐ No	Explain _____
Problems with ears or hearing	☐ Yes	☐ No	Explain _____
Problems with eyes or vision	☐ Yes	☐ No	Explain _____
Any heart problems or heart murmur	☐ Yes	☐ No	Explain _____
Anemia or bleeding problem	☐ Yes	☐ No	Explain _____
Blood transfusion	☐ Yes	☐ No	Explain _____
Frequent abdominal pain	☐ Yes	☐ No	Explain _____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain _____
Bladder or kidney infection	☐ Yes	☐ No	Explain _____
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain _____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	Explain _____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain _____
Any chronic or recurrent skin problem? *(acne, eczema, etc.)*	☐ Yes	☐ No	Explain _____
Frequent headaches	☐ Yes	☐ No	Explain _____
Convulsions or other neurologic problems	☐ Yes	☐ No	Explain _____
Thyroid or other endocrine problems	☐ Yes	☐ No	Explain _____
Any other significant problems?	☐ Yes	☐ No	Explain _____
Use of alcohol or drugs?	☐ Yes	☐ No	Explain _____
Any toileting problems?	☐ Yes	☐ No	Explain _____
Does your child take medication for any reason?	☐ Yes	☐ No	Explain _____

What medication(s) does your child take?

Medication	Dosage	Frequency and time of Day taken

Development

Are you concerned about your child's physical development?	☐ Yes	☐ No	Explain _____
Are you concerned about your child's mental or emotional development?	☐ Yes	☐ No	Explain _____
Are you concerned about your child's attention span?	☐ Yes	☐ No	Explain _____

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Reviewing Nurse's Signature **Date**

Roger León
Superintendent

Newark Board of Education

Yolonda Severe
Executive Director OEC

Where Passion Meets Progress

School use only	School	PS ID	Grade	Homeroom

Student Information				
Last	First	Middle	DOB	
Address	Apt #	City	Zip	Gender F M
Race/Ethnic Group (Check all that apply) ___ Hispanic/Latino ___ American Indian ___ Asian ___ Black/African American ___ Pacific Islander ___ White		Previous School: Location:		
City of Birth	State of Birth		Country of Birth	
Did the student receive Early Intervention? **__Yes __No**	**Does the student have and IEP?** **__Yes __No**		**Does the student have siblings? __Yes __No**	
1st Sibling School:	**1st Siblings Name:**			
2nd Sibling's Name:	**2nd Siblings School:**			

Primary Parent/Guardian Information			
Parent/Guardian 1		**Parent/Guardian 2**	
Name		Name	
Address		Address	
Cell Phone		Cell Phone	
Home Phone		Home Phone	
Place of Work		Place of Work	
Work Phone (In case of emergency)		Work Phone (In case of emergency)	
Email Address:		**Email Address:**	
Relationship	Child lives with this parent: Yes No	Relationship	Child lives with this parent: Yes No

	Other Contact Person(s) – If my child is ill or injured and must be sent home from school while I am away from home, the following person(s) will take care of my child until I am available.		
	Name	Relationship	Can pick student up? Yes No
	Address	Primary #	Secondary #
	Name	Relationship	Can pick student up? Yes No

Roger León
Superintendent

Newark Board of Education

Yolonda Severe
Executive Director OEC

Where Passion Meets Progress

	Address	Primary #	Additional #
	Name	Relationship	Can pick student up? Yes No
	Address	Primary #	Secondary #
	Additional Siblings in this School		
	Name Grade	Name Grade	
	Name Grade	Name Grade	
	Parent/Guardian Signature: The above information is accurate as of today's date. I will update the school if it changes.		
	Name	**Signature**	**Date**
	Family Worker Signature:		
	Nurse's Signature (Type Name)		

SY 2025- 2026

Dear Parent/Guardian

Your child's consistent, daily attendance in our FULL DAY preschool program, virtually and in person, is necessary for them to gain the FULL benefit of a high-quality preschool education. Consistent attendance in the early grades, beginning in preschool, is shown to increase scores in reading and math and helps children develop strong socio-emotional skills needed to become successful learners.

The Newark Public Schools Preschool Program is an instructional program and requires your commitment to bring your child to school DAILY. Please note this is not daycare. Preschool students should not be absent during school days unless they are sick. Vacation and trips should be planned on days when school is not in session. If your child experiences unexcused chronic absenteeism, they may lose their placement.

By signing the contract below, you are acknowledging the importance of your child's preschool education and are committed to your child's daily attendance, virtually as well as in person, to preschool every day.

I, _____, am making a commitment to my child to bring him/her to school every day unless he/she is sick. I understand that my child's consistent daily attendance in a high quality preschool program will build a strong foundation for both academic and social/emotional success.

_____ _____

Parent's/Guardian's Name-Please Print School

_____ _____

Parent's/Guardian's Signature Date

Roger León
Superintendent

Newark Board of Education

Marisol Diaz- Director
Office of Bilingual Education

Where Passion Meets Progress

HOME LANGUAGE SURVEY (HLS) 7/2021

Purpose: The home language survey is used solely to offer appropriate educational services (U.S. ED EL Toolkit, Chapter 1). This survey is the first of three steps to identify whether or not a student is eligible to be identified as an English language learner (ELL). "Home" is defined as a student's current place of residence.

Student Name: _____ **Student Date of Birth:** _____

Current Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone Number(s): _____

School Name: _____ **Student ID#** _____ **Gr.** _____

Survey Questions:

1.) List all languages used in the student's home.

_____

2.) Was the first language used by the student a language other than English?

_____ **No** _____ **Yes**

3.) Does the student speak or understand a language other than English?

_____ **No** _____ **Yes**

4.) When interacting with others at home (example: parents, guardians, siblings), does the student understand or use a language other than English **most of the time**?

_____ **No** _____ **Yes**

5.) When interacting with others outside the home (example: friends, caregivers), does the student understand or use a language other than English **most of the time**?

_____ **No** _____ **Yes**

Parent Signature _____ **Date:** _____

Results [For Internal Use Only]:

Did they answer "Yes" to either Question #4 or Question #5?

- No (Go to *Result C)*
- Yes (Go to *Result B*)

Result B:
The student is a ***possible*** ELL. Reviewer should proceed to Step 2 of Identification Process: Conduct Records Review Process.

Result C
The student is ***not*** an ELL. Reviewer should not proceed to Step 2: Identification Process is complete.

Certified Pedagogue (BNAT/NAT) Signature: _____ **Date:** _____

Language Code: _____

- **A:** Language(s) other than English (no English)
- **B:** Language(s) - Bilingual
- **E:** English (all)

Roger León
Superintendent

Newark Board of Education

Yolonda Severe, Deputy Superintendent
Office of Early Childhood

Where Passion Meets Progress

Family Engagement Agreement

Our Newark Preschool Program aims to bring a relentless focus on positive child and family outcomes to close the achievement gap and build a better future for children, families, and communities. To reach this goal, ***we need to work with you*** to make sure that your child is ready to be successful in Kindergarten and beyond. Please join us by signing and following through on this Family Engagement Agreement.

I, _____ parent/guardian of _____
(Your Name) (Child's Name)

who attends _____ will do the following:
(Center Name)

A: Be Involved

☐ Bring my child to school **on time and every day** because attendance is key to success.

☐ **Read with my child every night** to encourage a love of learning and build their vocabulary.

☐ **Participate** in monthly parent meetings, orientation, and other workshops, events and activities at the program.https://youtu.be/MqlgGje3en4

☐ **Volunteer** at least 12 hours per program year of my time to help my child learn and support the preschool program.

B: Work with the Newark Board Of Education

Our program will do the following for you and your child:

☐ Provide an excellent education program -- every day -- for all of our students.

☐ Work with you to set goals that will support your child's education at home.

☐ Help identify your strengths and skills and work with you to reach your own goals.

☐ Offer many ways for you to participate and volunteer at our program. (*See*

other side)

We have many opportunities for you to be actively engaged at our program. Here are some ways that you may choose to be involved:

C: Volunteer

Parent Volunteering. Our program is always looking for volunteers to support our program. Volunteering in your child's classroom, or getting involved in other ways, can be helpful in developing a resume full of experience, leadership and job skills. We expect each family to support our program by contributing volunteer hours during the program year.

Listed below are a variety of ways you can volunteer. **Please check all activities that you are interested in.** A staff member will follow up to get you involved!

_____ REGULAR CLASSROOM VOLUNTEERING: Work with children on art activities, read to individual children or small groups, help during meals or transitions; etc.

_____ SPECIAL CLASSROOM ACTIVITIES: Share your interests with the children by teaching a song, cooking a traditional family recipe, leading an art activity, etc.

_____ VOLUNTEER ON FIELD TRIPS.

_____ REPRESENT THE PROGRAM at community events/meetings or to recruit new families.

_____ Contribute Skills to support center operations – e.g. landscaping, sewing, carpentry, plumbing, cooking.

Skills:

_____

Parent/Guardian Signature:_____ Date:_____

Staff Signature: _____ Date:_____

Personal Visit Agreement Terms

The Newark Public Schools-Office of Early Childhood Family and Community Engagement program promotes partnerships between home, school, and the community based on the philosophy that parents are the first and most influential teachers. This program provides three basic services to your child and family:

1. Personal and/or home visits
2. Monthly activities for parents and children, workshops and trainings
3. Links to community resources

Your family worker/advocate is an integral part of this program serving as a liaison between home, school, and the community. Family Workers/Advocates are required to meet with each family three (3) times during the school year, either at home or at school. This gives you the opportunity to learn more about your child's development and advise you on helpful community resources and programs to provide additional benefits to your family. You will find your worker/family advocate to be knowledgeable and helpful to your child and family.

I would prefer my visits to take place at the following location:

Home: _____School: _____Either: ____

Parent Signature: _____Date: _____

Family Worker Signature: _____Date: _____

Completed visits:

Visit #1 Date: _____Time: ____ Parent Signature:_____

Visit #2 Date: _____Time: ____Parent Signature_____

Visit#3 Date: _____Time: ____Parent Siganture_____

Provide one copy to the parent/guardian and place the other copy in the child's folder.

Roger León
Superintendent

Newark Board of Education

Where Passion Meets Progress

School Nurse Services Acknowledgement, Office of Early Childhood, Newark Public Schools

Date: _____

Dear Parent/Guardian of: _____

Please note that all Newark Public Schools have school nursing services daily.
Community-based Preschool Programs do not offer full time school nursing support.

The parent/guardian of children requiring school nursing support will be informed of the Newark Public Schools that have age-appropriate pre-kindergarten seats available so that the child can be placed in the safest, most secure environment, while also providing school choice.

If at any time during the school year medical orders, as described above, are received for your child, transfer to a Newark Public School will be initiated for your child's safety and health needs.

I, _____ understand that it is my responsibility to notify the school nurse or family worker in writing of any changes in the health status of my child immediately as it occurs during the school year:

Parent Signature _____

If you have any questions regarding this issue, please contact a NPS Office of Early Childhood registration and/or nursing services representative by calling 973-733-6234.

Reviewed with: _____ Parent/Guardian

_____ Family Worker

_____ Name of Center

_____ Center Phone Number

_____ Director/Center Manager

_____ School Nurse

Rev2020

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

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	

THE NATIONAL CENTER ON Health

THE LEAGUERS Inc.
Head Start/Early Head Start Sites
405-425 University Avenue
Newark, NJ 07102

Head Start Oral Health Form—Children

Patient Information

Child's name _____ Date of birth _____ Parent's/guardian's name _____ Phone number _____

Address _____ City _____ State _____ Zip code _____

This practice is the child's dental home: ☐ Yes ☐ No

Current Oral Health Status

Does the child have any teeth with untreated decay? ☐ Yes (decay) ☐ No (decay free)

Does the child have any teeth that have previously been treated for decay, including fillings, crowns, or extractions? ☐ Yes ☐ No

Are there treatment needs? ☐ Yes, urgent ☐ Yes, not urgent ☐ No treatment needs

Oral Health Care Services Delivered During Visit

Diagnostic/Preventive Services

Examination: ☐ Yes ☐ No
X-rays: ☐ Yes ☐ No
Risk assessment: ☐ Yes ☐ No
Cleaning: ☐ Yes ☐ No
Fluoride varnish: ☐ Yes ☐ No
Dental sealants: ☐ Yes ☐ No

Counseling/Anticipatory Guidance

☐ Yes ☐ No

Referral to Specialty Care

☐ Yes ☐ No

_____
(Please specify specialist)

Restorative/Emergency Care

Fillings: ☐ Yes ☐ No
Crowns: ☐ Yes ☐ No
Extractions: ☐ Yes ☐ No
Emergency care: ☐ Yes ☐ No

Other: _____
(Please specify)

Future Oral Health Care Services

All treatment completed: ☐ Yes ☐ No Next recall date: _____ / _____ (month/year)

More appointments needed for treatment? ☐ Yes ☐ No

If yes: Approximate number of appointments needed: ____ Next appointment: Date: _____ Time: _____

Additional Information for Parents, Head Start Staff, and Medical Providers

Oral Health Provider's Contact Information and Signature

Provider name *(please print)* _____ Phone number _____ Fax number _____

Practice name _____ Address _____

Provider signature _____ Date of service _____

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