Sandman Consolidated School
838 Seashore Road
Cape May, NJ 08204
Telephone: (609) 884-9410
Fax: (609) 884-9412

Maud Abrams School
714 Townbank Road
Cape May, NJ 08204
Telephone: (609) 884-9420
Fax: (609) 884-9421

LOWER TOWNSHIP ELEMENTARY SCHOOL DISTRICT
905 SEASHORE ROAD
CAPE MAY, NEW JERSEY 08204

TELEPHONE: (609) 884-9400
FAX: (609) 884-1821
Day Care Office: (609) 884-9430 ext. 5 Fax: (609) 898-9008
Email: daycare@lowertwpschools.com

Memorial School
2600 Bayshore Road
Villas, NJ 08251
Telephone: (609) 884-9430
Fax: (609) 886-0315

Carl T. Mitnick School
905 Seashore Road
Cape May, NJ 08204
Telephone: (609) 884-9470
Fax: (609) 884-9481

May 25, 2018

Dear Parents/Guardians:

Welcome to Lower Township Day Care Program. Our goal is to provide you with a safe, affordable, and enjoyable before and after school care facility for all of our students. In order to participate in our program you must be registered into our school district, fully potty-trained, and be at least 4 years old before October 1st. We are a state licensed center so we must follow all guidelines. Preschool students that attend our center must have an universal health care record form completed by their doctor (form is attached) and a copy of your child's immunization records in order to be registered into the program. Kindergarten through 6th grade will need to have a doctor's note stating they are able to participate in the program. Space is limited and a two week deposit is required to secure a space for your child.

Our program is supported financially only by the parents and guardians that utilize it. All payments are billed monthly and are due the first Monday of the month. All accounts must be paid in full at that time. Failure to do so will result in termination of service until all payments are made. If payments are not paid in an orderly time period, you will be asked to find other child care.

Our program hours are 7:00 am to 5:45 pm everyday, except for the day before Thanksgiving, Winter Break, and Spring Break. Day Care closes at 4:00 p.m. The last day of school our program closes at 2:30 pm. If lateness occurs more than 3 times, your child will be terminated from the program.

Once registered into our program, you will receive a Day Care Parent Handbook. The forms inside must be completed and returned in order for your child to participate in the program. If there are any custody agreements, we will need a copy on file in our Day Care Office. Since we are the Day Care Program, we do not have access to files brought to the main offices of the schools. These agreements must be submitted to the Day Care Office at Memorial School.

The registration form is online under Day Care or you may come to Memorial School during school hours to complete a registration. Please be aware during the summer months our Day Care Office is closed. We do check our mail, email and voice mail periodically. We will return on August 20, 2018. Our contact information is as follows:

Phone number:	(609) 884-9430 ext. 5
Email:	daycare@lowertwpschools.com
Mailing address:	Lower Township Day Care Program David C Douglass Memorial School 2600 Bayshore Road Villas, NJ 08251

We look forward to seeing you in September!

Mrs. Shannon Basco, Day Care Supervisor Mrs. Debi Douglass, Day Care Secretary

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905 Seashore Road
Cape May, NJ 08204
Telephone: (609) 884-9470
Fax: (609) 884-9481

May 14, 2018

Dear Parents/Guardians:

As the close of the school year rapidly approaches, we have already begun planning next year's Day Care Program. At this time, approximately 400 students are participating in our before & after-school sessions. Throughout the year preschoolers will participate in special activities that include presentations, fun competitions and holiday celebrations. Students of all ages will enjoy a variety of art/craft projects and physical activities/games designed by our staff, often in consultation with subject area specialists from our schools.

In order to reserve a space in this low-cost, fun and safe program, please complete the registration information on the attached form and return it to the Day Care Office located at Douglass Memorial School by **June 15th, with your 2-week deposit, which will be applied to June 2019** and the child's immunization & healthcare records, in order to start the first week of school. Be sure to indicate your anticipated needs for before-school (AM) or after-school (PM) care. I will be calling you on or about **August 13th** with your program/bussing information. **Registrations received after our deadline will begin September 10th. This does not guarantee placement. First Come/First Serve basis.**

We are now State Licensed. Space is very limited!!!

Our staff looks forward to working with your child in the coming school year.

Yours truly,

Debi Douglass

Debi Douglass
Day Care Secretary

DC-Regis-Ltr-(PS)

Name_____

Phone _____ Grade/School_____

Teacher _____ Bus_____

Program _____ Fees_____

***Payment is due on 1st Monday of month**

Month	Due	Paid	Office	Memo
9/4				
10/1				
11/5				
12/3				
1/7				
2/4				
3/4				
4/1				
5/6				
6/3				
Deposit				

Make checks payable to: LTES Day Care

PAYMENT ENVELOPE PROCEDURES

The **MONTH** column is self-explanatory. The dates shown are the first **Monday of each month** when payment is due.

Reminder: Any Day Care Fees **not** received by the 15th of each month **will** result in immediate termination from the Program.

The **DUE** column will be completed by the office. This will indicate the **anticipated** fees for each month. These are based on your requested Day Care needs.

Please Note: When you do not use the program according to your pre-paid needs (ie vacation, long-term illness, adjustments will be made only when a Monday through Friday absence occurs.)

The **PAID & OFFICE** column will be completed by the Day Care Office. It will note the amount paid, your check number or money order received. The initials in the **MEMO** column indicate payment has been received.

Parents are not to make any changes or write on the payment envelope.

When remitting your monthly fees in cash, **please** place it in the payment envelope, **DO NOT SEAL**, then place it in a larger, white envelope **marked "Day Care"** and be sure to **include your child's name** and **grade** , seal this envelope and give it to the Day Care Assistants.

It is **important** that you check your child's book bag regularly for the payment envelope and any notices of importance, if the Day Care Assistants, personally have not handed to you.

Any **ADJUSTMENTS,** due to inclement weather will be credited during the year.

Notify the Day Care Office of any vacations you will be taking during the school year with a phone call or note.

I hope this clearly explains the payment process.

LOWER TOWNSHIP ELEMENTARY SCHOOL - DAY CARE PROGRAM
2018 - 2019

Day Care Phone 884-9430 X 5 - Fax: 898-9008
Email: daycare@lowertwpschools.com

Start Date: _____

Child'sName_____**Birthdate**_____**Grade**_____**School**____

Child's Name _____**Birthdate** _____**Grade** _____**School**____

Child's Name _____**Birthdate** _____**Grade** _____**School**____

Mother's Name _____Address_____City_____

Email Address _____Home #_____Cell #_____

Place of Employment _____ Work #_____

Father's Name _____Address _____City_____

Email Address _____Home #_____Cell #_____

Place of Employment _____Work #_____

Child living with: Mother/Father _____ Mother_____ Father_____ Guardian_____

Guardian Address _____City _____Cell #_____

****List ONLY people who have permission to pick up your child: (Excluding Parents)**

Please give names, relationship & phone number of those people who have permission to pick up your child or may be notified in case of emergency or illness, or if we are unable to reach you, the parent/guardian. These people should live in Lower Township. Please provide a telephone number where these people may be reached during program hours.

Name _____**Relationship**_____**Phone**_____

Name _____**Relationship**_____**Phone**_____

Name _____**Relationship**_____**Phone**_____

Physician's Name _____**Phone**_____

***Allergies:** _____**Mild:** _____**Moderate:** ____**Severe:**____

***Health Conditions:** _____**Mild:** _____**Moderate:**____**Severe:**____

Office Use Only--Bus Stop/Time/Driver_____

Start_____ Program _____Days _____Fee_____ Deposit - CK/CA _____

Teacher _____Grade/School_____ Bus_____ Envelope___ POA_____

PARENT/GUARDIAN AGREEMENT

In case of accident or illness, I authorize the Day Care Program personnel to act in the best interest of my child. I know that payment is required and agree to abide by the guidelines set forth in the Day Care Program Parent/Guardian Handbook.

1) Hours of operation: 7:00am until the start of school / Dismissal until 5:45pm* (Note: Exception – Half-days before holiday breaks students **must** be picked up by 4:00pm. *A late fee of $15.00 is charged for pick up after our closing time of 5:45pm or 4:00pm.
2) Fees must be paid on the first Monday of each month. If not paid within two (2) weeks, termination will result.
3) It is the parent/guardian's responsibility to report any changes in pertinent information provided on the registration form, such as phone numbers, medical updates, emergency contacts and student release information. This information in the Day Care office and the child's school office must be identical.
4) **NO** Day Care will be provided on dates when school is not in session.
5) Day Care adheres to the district transportation guidelines. **Daily changes are not permitted.**
6) Day Care operates on a **"three strikes and you're out"** platform in terms of student behavior. Please see the Day Care Parent/Guardian Handbook for further details, as well as the Student Code of Conduct in the District Parent/Guardian Handbook.
7) **Must** submit **Immunization** and **Health Care Records** for Pre-School Student Enrollment.

Parent/Guardian Signature _____ **Date**_____

ATTENDANCE CONTRACT

For the safety of the students, Day Care transportation arrangements must be consistent. Students **may not** participate in Day Care less than five days a week and be transported home by the district on the other days. The schedule must be a permanent one **daily changes will not be honored**.

For students whose Day Care schedules vary from week to week, the student will be required to attend Day Care everyday and the parent/guardian will transport the student home from Day Care. **Bus transportation will not be provided.**

Circle the program desired below: Monday Thru Friday Only

PRE-SCHOOL

	Session	Hours	Cost/Week	Deposit due/Registration
Must be 5 days	AM-Program	7:00 – 9:30 am	$23.00 per week	$46.00
Must be 5 days	AM/E	7:00 – 1:00 pm	$74.00 per week	$148.00
Must be 5 days	E/AM	9:30 – 1:00 pm	$63.00 per week	$126.00
Must be 5 days	E/PM	12:00 – 3:30pm	$63.00 per week	$126.00
Must be 5 days	PM/E	12:00 – 5:45pm	$74.00 per week	$148.00
Must be 5 days	PM-Program	3:30 – 5:45 pm	$23.00 per week	$46.00

NOTE: ALL DAY CARE FEES ARE SUBJECT TO CHANGE!

Vacation & long-term illnesses are not charged when absences occur during a **Monday through Friday week only. Parents must provide note or call the Day Care Office with dates.**

If a student requires 1:1 aide, parents/guardians will be responsible for the current hourly rate. You may contact the **Day Care Office at 884-9430 X 5** with any questions.

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

CAPE REGIONAL MEDICAL CENTER
Cape May Court House, New Jersey
LOWER TOWNSHIP ELEMENTARY SCHOOLS
Cape May, New Jersey

DAY CARE

POWER OF ATTORNEY FOR MEDICAL TREATMENT

Name of Student _____ Grade _____ Teacher's Name _____

Dear Principal/Supervisor:

Student's Date of Birth ___/___/___

In the event that I cannot be contacted, I _____
Parent/Guardian's Name *(PLEASE PRINT)*

living at _____
Address (Please Print) *City/State/Zip* *(PLEASE PRINT)*

Phone Numbers: (Home) _____ (Work) _____ (Cell) _____

give permission for school authorities to act in my place as parent/guardian. In the event of a serious injury or illness requiring treatment, I understand that physicians at Cape Regional Medical Center or another medical facility will make such diagnosis and render such recommendations for treatment, as they deem reasonable and necessary under the circumstances.

ADDITIONAL EMERGENCY CONTACTS:

Name: _____ *(Please Print)* Relationship: _____ *(Please Print)* Phone #: _____

Name: _____ *(Please Print)* Relationship: _____ *(Please Print)* Phone #: _____

Known Allergies: _____

Medical Conditions/Serious Illnesses: _____

Medications and dosages being received: _____

_____

Family Physician: _____ *(Please Print)* Phone Number: _____

I understand that for the safety of my child, or to provide for their educational program, the school nurse may need to share information about my child with appropriate school staff. This will be done in a confidential manner. If I do not wish this information shared, I must request this in writing and file it with the school nurse.

I received a copy of this document for my records. If there are changes or additions to the above information, I understand it is my responsibility as the parent/guardian to inform the school in writing.

Please check one box, sign and date below:

☐ I do give my POWER OF ATTORNEY to Lower Township School District.

_____ _____
Signature of Parent/Guardian *Date*

☐ I do NOT give my POWER OF ATTORNEY to the Lower Township School District.

_____ _____
Signature of Parent/Guardian *Date*

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

      Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

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	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Instructions for Completing the Care Plan for Children with Special Health Needs (CH-15)

This Care Plan template is designed to supplement the Universal Child Health Record (UCHR, CH-14). It should be used for children with special health needs (CSHN). The UCHR is designed to be concise and does not provide sufficient space for detailed instructions that a CSHN might need. Use this Care Plan when your instructions for the child's care cannot be fit on to the UCHR. This Care Plan should be utilized as a template that can be adapted as needed. Not all parts need to be completed for some children, but other children may require extra pages to be attached to fully explain the instructions for the child's care.

In order to facilitate communication between the health care provider and the parent, it may be best to complete this form with the parent/guardian present. Parents often have practical knowledge that is important to incorporate into the plan, such as techniques to get the child to cooperate with treatments and specifics about the child care site/school like the hours attended and the resources/limitations of the out-of-home care provider. There is room at the end for optional parent notes and signature that will give permission for communication between the health care provider and the child care provider or school nurse.

Specific Instructions:

1. Complete the Universal Child Health Record (UCHR, CH-14).
2. Attach a copy of immunization record.
3. As appropriate check off the box labeled "Special Care Plan Attached."
4. Complete the Care Plan for Children with Special Health Needs
   - Complete the demographic information.
   - The Primary Health Care Provider is the medical home where the child's complete health records are maintained.
   - Specialty providers and their contact information should be included if the specialists play a major role in the child's health care such as adjusting medication doses.
   - Diagnosis – Include major diagnoses (preferably using lay terminology as necessary).
   - Allergies – Include medication allergies and other significant environmental allergies.
   - Routine Care – Complete the medication information. Include important side effects that child care providers should be watching for both with medications administered at home as well as those given at child care.
   - Describe any Needed Accommodations to particular activities.
     - Describe special diets or feeding techniques which may be needed such as feeding pureed foods, maintaining upright positioning during feeds, following a restrictive diet, etc.
     - Classroom activities – List any modifications needed to allow the child to participate such as extra rest breaks, use of adaptive equipment, etc.
     - Outdoor Activities/Field Trips- List any special precautions needed for class trips such as emergency kits, mobile phones, special vehicles, etc.
   - Special Equipment/ Medical Supplies
     - List special equipment that may be needed such as nebulizers, peak flow meters, glucometers, braces, hearing aids, wheelchairs, apnea monitors, etc.
   - Emergency Care
     - Help the child care providers to understand which signs/symptoms merit calling the parents and which are more serious and indicate that EMS should be activated.
     - Describe interim measures that should be taken while waiting for parent or EMS arrival such as administering an asthma nebulizer treatment or an Epi-Pen.
   - Special Staff Training
     - Are there special trainings that staff should attend in order to care for the child such as medication administration training, first aid/CPR, etc.? Include who might be available to provide such training.

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS

-To be completed by a Health Care Provider-

Child's Full Name	Today's Date Date of Birth
Parent's/Guardian's Name	Telephone No. ( )
Primary Health Care Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Specialty Provider	Telephone No. ( )
Diagnosis(es)	
Allergies	

ROUTINE CARE

Medication To Be Given at Child Care	Schedule/Dose (When and How Much?)	Route (How?)	Reason Prescribed	Possible Side Effects

List medications given at home:

NEEDED ACCOMMODATION(S)

Describe any needed accommodation(s) the child needs in daily activities and why:

Diet or Feeding: _____

Classroom Activities: _____

Naptime/Sleeping: _____

Toileting: _____

Outdoor or Field Trips: _____

Transportation: _____

Other: _____

Additional comments: _____

_____

_____

CARE PLAN FOR CHILDREN WITH SPECIAL HEALTH NEEDS
Continued

SPECIAL EQUIPMENT / MEDICAL SUPPLIES

1. _____
2. _____
3. _____

EMERGENCY CARE

CALL PARENTS/GUARDIANS if the following symptoms are present:

_____

_____

CALL 911 (EMERGENCY MEDICAL SERVICES) if the following symptoms are present, as well as contacting the parents/guardians:

_____

_____

TAKE THESE MEASURES while waiting for parents or medical help to arrive:

_____

_____

_____

SUGGESTED SPECIAL TRAINING FOR STAFF

_____

_____

_____

Health Care Provider Signature	Date

PARENT NOTES (OPTIONAL)

_____

_____

_____

I hereby give consent for my child's health care provider or specialist to communicate with my child's child care provider or school nurse to discuss any of the information contained in this care plan.

Parent/Guardian Signature	Date

Important: *In order to ensure the health and safety of your child, it is vital that any person involved in the care of your child be aware of your child's special health needs, medication your child is taking, or needs in case of a health care emergency, and the specific actions to take regarding your child's special health needs.*