Date Completed: _____ Date of Enrollment: _____

## CHILD'S INFORMATION SHEET

*To be completed, signed, and placed on file on the first day and updated as changes occur, and at least annually*

**CHILD INFORMATION:** Date of Birth: _____

Full Name:_____
Last First Middle Nickname

Child's Address:_____

**FAMILY INFORMATION:** Child lives with: _____

**Guardian #1 Name**: _____ E-mail: _____

Cell Number: _____ Home Number: _____

Employer: _____ Work Number: _____

**Guardian #2 Name**: _____ E-mail: _____

Cell Number: _____ Home Number: _____

Employer: _____ Work Number: _____

**CONTACTS:**

Child will be released to the parents/guardians listed above. The child can also be released to the following individuals, as authorized by the person who signs this information sheet. In the event of an emergency, if the parents/guardians cannot be reached, the CJP has permission to contact the following individuals:

| Name | Relationship | Phone Number 1 | Phone Number 2 |
|---|---|---|---|
| Name | Relationship | Phone Number 1 | Phone Number 2 |
| Name | Relationship | Phone Number 1 | Phone Number 2 |

**HEALTH CARE NEEDS:**

*For any child with health care needs, such as allergies, asthma, or other chronic conditions that require specialized health services, a medical action plan shall be attached to this information sheet. The medical action plan must be completed by the child's health care professional. Medical Action plan must be updated annually and as changes occur. Is there a medical action plan attached? Yes_____ No_____*

List any allergies, symptoms, and type of response required for allergic reactions:_____

_____

List any health care needs, concerns, symptoms of, and type of response for the health care needs/concerns: _____

_____

List any particular fears or unique behavior characteristics the child has: _____

_____

List any types of medication taken for health care needs: _____

Please share any other information that has a direct bearing on assuring safe medical treatment for your child: _____

_____

**EMERGENCY MEDICAL CARE INFORMATION:**

Name of health care professional: _____ Phone Number: _____
Hospital preference: _____ Phone Number: _____

I, as the parent/guardian, authorize the CJP to obtain medical attention for my child in an emergency.

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

I, as the operator, do agree to provide transportation to an appropriate medical resource in the event of an emergency. In an emergency situation, other children in the facility will be supervised by a responsible adult. I will not administer any drugs or any medication without specific instructions form the physician, or the child's parent, guardian, or full time custodian.

**Signature of Administrator:** _____ **Date**: _____

**IEP (Individual Education Plan)/ IFSP (Individual Family Service Plan) INFORMATION:**

Does your child have an IEP (Individual Education Plan) or IFSP (Individual Family Service Plan)? _____

Has your child, in the past, or is he/she seeing a:
Speech Therapist: _____ Occupational Therapist:_____

Physical Therapist: _____ Counselor/ Therapist: _____

Are you willing to share the evaluation with your child's teacher? _____

**OTHER INFORMATION:**

Please detail any social or emotional experience of which you think your child's teacher needs to be aware. For example: birth difficulties, adoption, divorce, serious accidents or illnesses, losses, moves, ear infections. Etc. _____
_____

_____

How does your child react to new people and new situations? _____

_____

Does your child exhibit any behaviors that are challenging or troublesome for you? _____

Other comments or concerns that you would like to share with your child's teacher: _____
_____

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**ON-SITE FIELD TRIP PERMISSION:**
We give our child permission to participate in field trips such as walks around the Shalom Park property and visits to the Temples. We understand that CJP teachers will supervise these field trips.

Signature of Parent/ Guardian: _____ Date: _____

**PHOTO/ VIDEO/ SOCIAL MEDIA/ WEBSITE PERMSSION (CHECK THOSE THAT APPLY)**

___ I give permission for my child to be photographed or videotaped by CJP staff members, who will be taking pictures & videos to be used in brightwheel communications from a secure, CJP-provided tablet.

___ I give permission for my child to be photographed, videotaped, and/or interviewed by employees of the CJP for marketing purposes, including social media (such as Facebook).

Signature of Parent/Guardian: _____ Date: _____

**FAIRSHARE AGREEMENT**
I understand my commitment to the CJP "Fair Share Program," and agree to volunteer for the designated hours. I further understand that it is my responsibility to log in my hours in order to receive credit for them. Please note that failure to participate in the Fair Share program has financial implications. For more information about the Fair Share program, please refer to the CJP Family Handbook.

Signature of Parent/ Guardian: _____ Date: _____

Charlotte Jewish Preschool
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# Child's Immunization Report

**Child's Name: _____ Date of Birth: _____/_____/_____**

Instructions: Enter each date of each dose received (Month/Day/Year) or attach a copy of the child's North Carolina Immunization Registry (NCIR) immunization record. The parent/guardian must submit a certificate of immunization on child's first day of attendance and as new vaccinations are administered. *G.S. 130A-155(b) requires all day care facilities to have this information on file.*

**If child's doctor prefers to provide the child's "North Carolina Immunization Registry" (NCIR) record, please go to the bottom of page 2**

## ENTER DATE OF EACH DOSE (MONTH/DAY/YEAR)

| Vaccine Type | Vaccine Abbreviation | Trade Name | Combination Names | 1 Date | 2 Date | 3 Date | 4 Date | 5 Date |
|---|---|---|---|---|---|---|---|---|
| Diptheria, Tetanus, Perussis | DTap, DT, DTP | Infranix, Daptacel | Pediarix, Pentacel, Kinrix | | | | | |
| Polio | IPV | IPOL | Pediarix, Pentacel, Kinrix | | | | | |
| Haemophilus Influenza Type B | Hib (PRP-T) Hib (PRP-OMP) | ActHIB, Pedvax HIB** | Pentacel | | | | | |
| Hepatitis B | HepB, HBV | Engerix-B, Recombivax HB | Pediarix | | | | | |
| Measles, Mumps, Rubella | MMR | MMR II | Proquad | | | | | |
| Varicella/Chicken Pox | Var | Varivax | Proquad | | | | | |
| Pnuemococcal Conjugate* | PCV, PCV-13, PPV-23 | Prevnar, Pneumovax*** | | | | | | |

*Required by state law for children born on or after 7/1/2015.
**3 shots of PedvaxHIB are equivalent to 4 Hib doses. 4 doses are required if a child receives more than one brand of Hib shots.
***PPSV23 or Pneumovax is a different vaccine than Prevnar 13 and may be seen in high risk children over age 2. These children would also have received Prevnar 13.
**Note:** Children beyond their 5th birthday are not required to receive Hib or PCV vaccines.

**Gray shaded boxes above indicate that the child should not have received any more does of that vaccine.**

| Record updated by: | Date: | Record updated by: | Date: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## MINIMUM STATE VACCINE REQUIREMENTS FOR CHILD CARE ENTRY

| By this age: | Children Need These Shots: | | | | | | |
|---|---|---|---|---|---|---|---|
| 3 months | 1 DTap | 1 Polio | | 1 Hib | 1 Hep B | 1 PCV | |
| 5 months | 2 DTap | 2 Polio | | 2 Hib | 2 Hep B | 2 PCV | |
| 7 months | 3 DTap | 2 Polio | | 2-3 Hib** | 2 Hep B | 3 PCV | |
| 12-16 months | 3 DTap | 2 Polio | 1 MMR | 3-4 Hib** | 3 Hep B | 4 PCV | 1 Var |
| 19 months | 4 DTap | 3 Polio | 1 MMR | 3-4 Hib** | 3 Hep B | 4 PCV | 1 Var |
| 4 years or older in child care only | 4 DTap | 3 Polio | 1 MMR | 3-4 Hib** | 3 Hep B | 4 PCV | 1 Var |
| 4 years and older and in Kindergarten | 5 DTap | 4 Polio | 2 MMR | 3-4 Hib** | 3 Hep B | 4 PCV | 2 Var |
| Note: For children behind on immunizations, a catch-up schedule must meet minimal interval requirements for vaccines within a series. Consult with child's health care provider for questions. | | | | | | | |

## VACCINES RECOMMENDED BY THE ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP), BUT NOT REQUIRED

| Vaccine Type | Abbreviation | Trade Name | Recommended Schedule | 1 Date | 2 Date | 3 Date | 4 Date | 5 Date |
|---|---|---|---|---|---|---|---|---|
| Rotavirus | RV1, RV5 | Rotateq, Rotarix | Ages 2 mo., 4 mo., 6 mos. | | | | | |
| Hepatitis A | Hep A | Havrix, Vaqta | First dose, age 12-23 months. Second dose, within 6-18 months | | | | | |
| Influenza | Flu, IIV, LAIV | Fluzone, Fluarix, Flulaval, Flucelvax, FluMist, Afluria | Annually after age 6 months | | | | | |

____ **Please check here if the child's doctor is substituting the child's NCIR mentioned on page 1.**

**Signature of child's doctor: _____ Date: ____/_____/_____**

**Printed name of child's doctor: _____ Doctors' phone number: _____**

This form is based on the Child Immunization History (August 2019) form which is located at:
https://www.ncchildcare.nc.gov/Portals/0/documents/pdf/I/Immunization_Record.pdf?ver=93na4R-CIiPaGuXRudapMA%3d%3d