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: _____

AFFILIATION STATUS (please circle all that apply): Temple Israel Temple Beth El LJCC Unaffiliated

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, 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 is 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: _____

_____

_____

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 INFORMATION
Occasionally, representatives or employees of the Charlotte Jewish Preschool (CJP) may want to take photographs, videos, or interview individuals during school programs, projects, or special events. These materials will help us showcase our CJP community and may be used on our website, social media platforms, and in printed materials. Please note that we do not list children's names without prior consent from parents or guardians.
If you prefer that your child not be photographed, videotaped, or interviewed for marketing purposes, including social media, please let us know by emailing Stephanie at stephanie.zubrinsky@charlottejewishpreschool.org

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: _____

Child Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

The parent/guardian must submit a certificate of immunization on child's first day of attendance.

Child's full name:	**Date of birth:**

Enter the date of each dose received (Month/Day/Year) or attach a copy of the North Carolina immunization record.

Vaccine Type	Abbreviation	Trade Name	Combination Vaccines	1 date	2 date	3 date	4 date	5 date
Diphtheria, Tetanus, Pertussis	DTaP, DT, DTP	Infanrix, Daptacel	Pediarix, Pentacel, Kinrix					
Polio	IPV	IPOL	Pediarix, Pentacel, Kinrix					
Haemophilus influenza type B	Hib (PRP-T) Hib (PRP-OMP)	ActHIB, PedvaxHIB **, Hiberix	Pentacel					
Hepatitis B	HepB, HBV	Engerix-B, Recombivax HB	Pediarix					
Measles, Mumps, Rubella	MMR	MMR II	ProQuad					
Varicella/Chicken Pox	Var	Varivax	ProQuad					
Pneumococcal Conjugate*	PCV, PCV13, PPSV23***	Prevnar 13, 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 doses of that vaccine.

Signature of child's doctor or authorized representative	Date	Record updated by:	Date

Minimum State Vaccine Requirements for Child Care Entry

By This Age:	Children Need These Shots:						
3 months					1 Hep B		
5 months		2 Polio			2 Hep B		
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	2 Hep B	4 PCV	
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

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.

Updated May 2023

NORTH CAROLINA
Child Care Health and Safety Resource Center
800-367-2229
healthychildcare.unc.edu

Child Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

Vaccines Recommended (not required) by the Advisory Committee on Immunization Practices (ACIP)

Vaccine Type	Abbreviation	Trade Name	Recommended Schedule	1 date	2 date	3 date	4 date	5 date
Rotavirus	RV1, RV5	Rotateq, Rotarix	Age 2 months, 4 months, 6 months.					
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.					
Coronavirus disease 2019	COVID-19	Comirnaty, Spikevax, Nuvaxovid, Jcovden	Annually after age 6 months.					

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