2019 Glee Registration Form

Please fill out and return along with Universal Health Record Form prior to the start of camp for each registrant. All forms must be returned and approved before the first day of camp.

SECTION I.

Parent/Guardian First Name _____ Parent/Guardian Last Name _____

Address _____ City, State _____ Zip _____

Email _____ D/O/B _____

Home # ( )_____ Work # ( )_____ Cell # ( )_____

SECTION II.

Child's Name _____ D/O/B _____ Grade (Sept '19) _____

Emergency Contact Information:

Name _____ Relationship _____ Phone # _____

List those people, including yourself, who may pick up your child. No child will be released to anyone other than those listed. You must make any changes to this list in writing to the site supervisor.

Name _____ Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

Name _____ Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

Name _____ Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

Name _____ Home # ( ) _____ Work # ( ) _____ Cell # ( ) _____

☐ Check this box to inform us if your child has special needs or a developmental or physical disability so that we may accommodate your child. Please elaborate below:

_____

_____

_____

SECTION III.

EMERGENCY RELEASE: In the event my child should become injured or ill at a Cherry Hill Township sponsored camp, I hereby authorize the staff of the camps to arrange for whatever emergency medical care is deemed necessary and reasonable at the time, including transportation to a local hospital.

NOTICE OF CODE OF CONDUCT/EXPULSION POLICY: Cherry Hill Township seeks to provide a safe environment for all participants and staff in our recreation programs. In order to preserve this safe environment, Cherry Hill Township reserves the right to dismiss any child who commits any act that may compromise the safety of our programs. Threats, assaults, vandalism, possession of drugs or alcohol are just some examples of inappropriate behaviors and activities that could result in the dismissal of an individual from a Cherry Hill Recreational program.

By signing below, I acknowledge and understand the above Notice of Code of Conduct/Expulsion and Emergency Release Policy. I, the registrant/guardian (circle one), by applying to participate in a Cherry Hill Township Recreation Program, do hereby waive, release, absolve, indemnify and agree to hold harmless Cherry Hill Township, the organizers, sponsors and supervisory of the program.

Signature _____ Printed Name _____ Date _____

UNIVERSAL CHILD HEALTH RECORD

* Read page 2 of this form

**GLEE **

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 PARENTS

Child's Name *(Last)* (First)	Gender ☐ Male ☐ Female	Date of Birth / /
Does your 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 behaviors/mental health issues/concerns	☐ None ☐ Special care plan attached**	Comments:
Emergency plans ● List plan needed & signs/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		

Box **MUST** be checked. ☐

I have examined the above child and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care activities, including physical education and competitive contact sports, unless noted above.

Name of Health Care Provider (Print)	**Health Care Provider Stamp**
Signature **Date**	

***** Provide copies of any special care plans***

Instructions for completing the Universe 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 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 weight 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 & Senior Services, Immunization Program at 609-588-7512.
   - 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 http://www.nj.gov/health/forms/ch-15.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 go 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.

   ** ** ** ** ** ** ** ** ** ** **

   Any medications given at camp must have a prescription from the doctor.

   ** ** ** ** ** ** ** ** ** ** **

   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 permission 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 devises, 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 breast feeding 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.

   ** ** ** ** ** ** ** ** ** ** **

   PARENTS: Read your child's completed form before leaving your doctor's office. Did she/he check "special care plan attached"? If so, we will need a opy of that care plan submitted with your form.

   ** ** ** ** ** ** ** ** ** ** **

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 health 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.