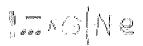
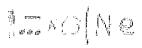
Imagine Early Learning Centers Enrollment Information

Occupation Phone Phone Occupation
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Occupation
Phone
Phone
Center Family Directory. respondence via e-mail.
i.e. asthma, sight, hearing, speech
g patterns, likes and dislikes)



Imagine Early Learning Centers Emergency Contact Information

Child's Name	DOB:	
Home Address:		
Parent /Guardian Name:		
Phones (H):	(W):	(C):
Email:		
Parent /Guardian Name:		
Phones (H):	(W):	(C):
Email:		
Pediatrician's name:	Pho	one:
Allergies (if applicable):		
AUTHORIZED ESCORTS:	Relationship to child	Best Contact #:
	Parent	i
	Parent	
1.		
2.		
3.		
Parent Signature(s)		Date
IT IS THE PARENT'S RESPON	ISIBILITY TO PROVIDE T	HE CENTER WITH



CURRENT CONTACT INFORMATION AT ALL TIMES.

Imagine Early Learning Centers Authorization Form

Child's Name: Center:						
Parent (1): Parent (2):						
Address:						
is deemed necessary for the protect	ning Center staff to seek whatever emergency medical assistance ction of my child while he/she is in their care. I understand that sporting my child to an emergency room, possibly via ambulance the parent(s) in the case of emergency.					
Pediatrician's Name	Phone #					
Parent Signature	Date					
Allergy Authorization (Please ch	eck boxes in agreement) ergies is required on my child's medical form. e it must be posted in the classroom(s). my child, I give consent for any Imagine staff member to					
Parent Signature	Date					
Please include any special instruc	ctions regarding allergies on the back of this paper.					
Trip Authorization I give permission for my child to ta excursions, walks in the neighborh	ke part in all extra-curricular activities, and to go on field trips, nood, and to the Center playground. If I object to my child taking rill notify the center Director. I understand that my decision not to I trip or activity may result in my need to arrange for alternative					
Parent Signature	Date					
Media Authorization Imagine uses photographs and vid in a safe, secure and thoughtful m	deos of center children for educational and promotional purposes anner.					
artwork, to be used by the Center	and/or videos that include my child, and copies of my child's for any purpose that the Center may deem appropriate, including and promotion of the Center and its programs and activities, in tions as well as in all other media, whether now known or later site and Facebook page).					
Parent Signature	Date					
1	Family Enrollment Packet					

Imagine Early Learning Centers Permission to Apply Cream, Ointment or Sun block

Dear Imagine Parents,

Licensing regulations require permission for the staff at Imagine to apply cream, ointment or sun block to your child while here at school. This includes diaper cream, sun block and any other types of ointments. Please be specific when filling out the permission slip. **This form must be updated every 6 months**.

Thank you.

PERMISSION TO APPLY CREAM, OINTMENT or SUN BLOCK

I allow the staff members of IMAGINE Early Learning Center to apply cream, ointment or sun block to my child. I understand that I must provide these lotions and that the staff at IMAGINE is not responsible for any rash or adverse effect that might occur as a result of the application of the lotion. In addition, I understand that I am specifically responsible for applying sun block in the morning at home and the staff at IMAGINE is only responsible for reapplying in the afternoon.

understand that I am specifically responsible for applying sun block in the morning at home and the staff at IMAGINE is only responsible for reapplying in the afternoon.
Name of Child
Type of Sun block / Special Instructions:
Type of Cream / Special Instructions:
Type of Ointment / Special Instructions:

Parent Signature

Date

1... NO NE

Family Enrollment Packet

Imagine Early Learning Centers Child's Health Insurance Notification/Authorization

Insurance carrierPolicy numberName of insured

1. - x 0 / N @

	r fill the information in on this form and submit it or ask us to make a copy of your d for your child's file.
医去松节三型医光亮异型	
AUTHORIZAT	TION
I hereby autho health informa	orize all Imagine staff and the following individuals to have access to my child's ation in their Imagine file (i.e. Authorized Escorts, Medical Form, and Pediatrician).
Name	
Name	
Name	
Name	
Dr:	
显岩型型导项有多型型型	1 3 2 2 2 2 3 3 3 3 4 4 4 6 4 6 6 6 6 6 6 6 6 6 6 6
	I have provided the requested health insurance information for my child(ren).
	I can verify health insurance coverage for my child(ren) and can readily provide it if necessary, but I <i>prefer not</i> to have that information in my child's file.
Parent signatu	ire Date

Family Enrollment Packet

CHILD & ADOLESCENT HEADING DEPARTMENT OF HEADIN & MENTAL HYGIENE	AIMAXƏLHITAN Düvendiyyed —	VATIOZ IFO Vation		Please Clearly FREE	STUDENT ID	NUMBER OSIS				
to be completed by parent o										
Child's Last Name	First Name		Middle Name			Sex Female Date of Birth (Month/Day/Year) Male / / /				
Child's Address			mic/Latino? F Yes □ No		ALL that apply) [ve Hawailan/Pacif	ic Islander	Other_			hite
J	ate Zip Gode I	School/Center/Camp I	MITTANES.			District Phone Numbers Number Home				· w.
Health insurance ☐ Yes (including Medicaid)? ☐ No ☐ Foster Parent	ime		First				Work			
to be completed by Health C	ARE PROVIDER	If "yes" to	any Item,	pleas	e exploin (aitach	ı adder	idum,	if needs	ol)
Birth history (age 0-6 yrs) ☐ Uncomplicated ☐ Premature: weeks gestatio	Does the child/adoleson	cent have a past or pre ty and attach MAF/Asthma / current medication(s):	Action Plant: 🔲	Intermitten	t 🔲 Mild Persist	ent □ M	oderate Pers	sistent □ □ Oral ster	Severe Persist	ent
Complicated by	Attention Deficit Hyp		Orthopedic i							n needed)
Allergies	☐ Chronic or recurrent☐ Congenital or acquir	olitis media ed heart disorder	☐ Seizure diso ☐ Speech, hea	rder iring, or vist	ual impairment	The second secon				
☐ Drugs (list)	Developmental/learn □ Diabetes (attach MAF)		☐ Tuberculosis ☐ Other (special		lion of disease)	B-2701 T-200-2 1000	NO STATE OF STREET		ere presentation and account	
Foods (list)						Dietary □ N	Restriction lone \Box	is Yes <i>(list be</i>	elow)	
Other (list)		Explain all checked	items above or	on adden	dvn1 				CANADA AND COMPANY PROPERTY.	er a recessor a residence del constituto del consti
PHYSICAL EXAMINATION	General App		NI Abi		NI Abni		N/ A	hni		
-	%ile)	NI Abni ENT ☐ ☐ Lymph i	i			Skin			social Developn	nent
	%ile) De	,			- 1	Neurolog Back/spir		□ Langu:□ Behavi	-	
J	%ile)	•	ascalal [LAUGIII	nea I C	Daoreapii	10 141			
Head Circumference (age ≤2 yrs) cm (
Blood Pressure (age ≥3 yrs)	SCREENING TESTS	Date Done	Resi	ılle		6003	Date	Done	Results	 ;
DEFENDING (050 C) 10)	Blood Lead Level (BLL)	1			Tuberculosis	Only require	ed for students	enterina inter	mediate/middle/iun.	ior or high school
If delay suspected, specify below Cognitive (e.g., play skills)	(required at age 1 yr and 2 yrs and for those at risk)			μg/dL μg/dL	PPD/Mantoux pi		ot previously a		mediate/middle/jun. YC public or private 	
☐ Communication/Language	Lead Risk Assessment (annually, age 6 mo-6 yrs)			k <i>(do BLL)</i> t risk	PPD/Mantoux re	i	/		□Neg	□ Pos
Social/Emotional	Hearing Pure tone audiometry	Pure tone audiometry					/	_/	│ □ Neg │ □ Nl □	☐ Pos] Not
	OAE			rmai	(if PPD or Interfero	n positive)		_1,		idicated
Adaptive/Self-Help		Head Start Only	/ 	n/di	Vision				Acuity Right	1
Motor	Hemoglobin or Hematocrit (age 9-12 mo)	//		g/dL %	frequired for new school entrant and children age 4–7 yrs)		/ with g	_/ glasses	Left_	/ No Yes
IMMUNIZATIONS - DATES CIR Number			Influenza		,	,	1	1	/	_/
of Child			MMR			/		_/	/	_/
Rotavirus/		_//	Varicella		/	./		_/	*	
DTP/DTaP/DT//			Td		/		/	/	/	
	/	_//	Tdap/_	/	-	Нер А	/	_/	/	-/
Hib///	//	1	Meningococcal	l		/	/	/		
PCV//		1	HPV		!	./	/	'	/	_/
Polio//			Other, specify: _	العرباز [/ Child (V20.2)	/i	ses/Proble	nie illeh	'	-' D-9 Code
RECOMMENDATIONS	diet	1	ASSESSMENT	[_] wen	Gillia (VZV.Z)	្រា មានកិប្បត	12#211.10mg	ша шы	10	D-9 code
Restrictions (specify)		-								
Follow-up Needed No Yes, for Appt. date://										
Referral(s): ☐ None ☐ Early Intervention ☐ Speci	ar concarion Detriat	☐ Vision								
Other Date DOI:MIT PROVIDER Date DOI:MIT PROVIDER DOI:MIT P										
Health Care Provider Signature Health Care Provider Name and Degree (print)	Provider License	Provider License No. and State				TYPE OF EXAM: NAE Current NAE Prior Year(s				
Facility Name		National Provide	r Identilier (NPI)		Comments				
Address	Cily		State Zip				Date I.D. NUMBER			
Talantana	I Fax					eviewed: -		/L		4
Telephone ())			1	reviewer:		mana i departe de la		

New York State Recommended Childhood and Adolescent Immunization Schedule

A check I means that this is the earliest and best time for your child to be immunized. If your child misses the "best time" for vaccination, he or she should still be immunized as quickly as possible. Ask your doctor about getting your child caught up.

	Age									
Vaccine against:	Birth	2 months	4 months	6 months	12 months 18	3-24 months	4-6 years	11-12 years		
Hepatitis A					e ₂ p ^e					
Hepatitis B	1	√ 1-4 mo.	:	√6-18 mo.	Recommended for any child not previously vaccinated against Hepatitis B virus.					
Diphtheria, Tetanus, Periussis (DTaP)		1		1	y ^r 12-18 mo.		1			
Haemophilus influenzae type b (Hib)		J.	1	1/1	√ 12-15 ino.					
Polio (IPV)		2/	1	√ 6-18 mo.			1			
Pneumococcal Disease (PCV) ²		-/	1	1	√ 12-15 tna. A	Ask your doctor if your child 2 years old or older should get vaccinated with PPSV.2				
Measles, Niumps, Rubella (MMR)					√ 12-15 mo.		<i>y</i> /			
Varicella (Chickenpox)			:		√ 12-15 mo.		,p ^p	A second catch-up dose is recommended for any child who has had only one dose.		
Rotavirus		3/	1	V 1						
Tetanus, Diphtheria, Pertussis (Tdap)				•				√11-18 yrs.		
Meningococcal Disease (MCV4) ³	volument burnistic materials in		:				ir diild 2 years old or tinated with MCV4.1	1		
Human Papillomavirus (HPV)		The state of the s			Table to promise the second se			√ a		
Influenza		The state of the s	:	Recommended y	nded yearly for all children aged 6 months and older. Ask your doctor if your child should receive one or two doses.					

[|] For some types of tilb and Rotavirus, the 6-month dose is not needed.
| PPCV = Preumococcal Conjugate Vaccine PPSV = Preumococcal Polysaccharide Vaccine
| MCVI = Meningococcal Conjugate Vaccine
| 4The HPV vaccine is given through a series of three shots over a 6-month period, it is now recommended for boys and girls.

This schedule is aligned with national guidelines set by the Adviracy Committee on Immunization Practices and recommendations by the CDC.

Imagine Early Learning Centers Family Handbook Acknowledgement

I acknowledge that I have received the Imagine Family Handbook and Enrollment Package. I acknowledge that it is my responsibility to read and understand these documents. If I have any questions regarding any of the policies, I will discuss them with the Director. I understand that my continued eligibility for enrollment at the Center is contingent upon my following these policies.

I am aware of the Center's Emergency Evacuation procedure.

Date Parent (1) Signature Date

Parent (2) Signature (if applicable)