MAIN STREET

●Daycare ●PreK● After School Program●
●School Breaks●Summer Camp●

## Daycare / PreK Summer Registration

**Ages 0-4**

Child's Full Name:_____ Child's Age_____

Child's Date of Birth: ___/___/_____ Grade 2026-27: _____ Gender:_____

Any known allergies?_____

Any special needs, IEP, or medical concerns?_____

Are they advised by a doctor to take any medicines regularly that we need to administer?_____

*Payments are due the Friday before the week begins through our Brightwheel App.
*Schedule must be consistent week to week.

| | **FULL TIME 4-5 DAYS PER WEEK** Cost Per Day | **PART TIME 2-3 DAYS PER WEEK** Cost Per Day |
|---|---|---|
| **Infant** 0-17mo | 65 | 80 |
| **Waddler** 18mo- 29mo | 60 | 75 |
| **PreK 30mo-4yrs** (2 ½- up) | 55 | 70 |
| **PreK CAMPS 9am-3pm** (3&4 year olds) | 55 | 70 |
| **PreK Camp Before Care** 7:30-9am | 10 | 10 |
| **PreK Camp After Care** 3-6pm | 25 | 25 |

*My child will attend the daycare/camp weekly on the following days (please circle which applies):

Mondays Tuesdays Wednesdays Thursdays Fridays

***Start Date:_____ Shirt Size:_____**

Main Street Day Care's hours of operation are 7am-6pm. **Summer Hours: 7:30am-6pm.**

***Upon enrollment the following is required:

- Complete application
- Ages 4 & Under Registration fee of $99/child
- Ages 4 & Under Current medical records (immunization & universal health records)

**Enrollment Agreement (continued)**
**Discounts & Fees**

- The oldest sibling will receive a 10% reduction in tuition rates if enrolled in full time childcare.
- Church members (someone who attends and serves at the church regularly) will receive a 10% reduction in tuition rates of the oldest enrolled child.

- Potty Training fee of $25 per week, goes directly to staff member.(4 and under)
- Children 5 and older must be fully potty trained.
- Tuition is due on a weekly basis the Friday before the week starts through our Brightwheel App. A reminder will be posted on the App. **A late fee of $25.00 will be charged if the tuition is not paid on the due date.**
- A fee of **$20.00** is charged for every 10 minute increment that your child(ren) remains in our care after 6pm.
- There will be a **$35.00** fee for any check that is returned to our facility.
- In quoting our rates, we have taken into account snow days, holidays, illnesses, and vacations into consideration and there will be no credits given. Sorry for any inconvenience. We do not allow school aged children to attend during delayed openings or early dismissals from school due to weather or emergencies. **Tuition is due whether your child attends or not.**

- School will be closed on the special holidays and staff training days listed on the posted Special Holidays 2025-26 Form and updated annually; **tuition is still due for these holidays and closures.**
- Main Street Child Care requires 30 days written notice of termination of services OR a full payment will be required. Rates and holidays are subject to change annually two weeks prior notice will be given.
- First Line of communication is through our Brightwheel App, parents and guardians agree to use app for billing and communication regarding their child.

- We welcome kids of all abilities however, we do not have licensed RBTs, BCBAs, CPI Certified, or ABA trained professionals.
- We reserve the right to make a determination if we cannot accommodate your child's behavioral or unique needs. We will reduce hours if it is in the best interest of your child or refer them to another program.

**I have read and understand this enrollment agreement:**

Parent/Guardian Signature_____ Date:_____

Please return this application in person or through email- msadaycare@gmail.com.

# ENROLLMENT APPLICATION

| Name of Child: | Date of Birth: | Enrollment Date: |
|---|---|---|
| | | |

**PARENT/GUARDIAN INFORMATION**

*Please check the box (☐) to indicate the primary residence of the child listed above.*

☐ PARENT/GUARDIAN #1 ☐ PARENT/GUARDIAN #2

| | | | |
|---|---|---|---|
| Name: | | Name: | |
| Relationship: | | Relationship: | |
| Telephone: | | Telephone: | |
| Home Telephone: | | Home Telephone: | |
| Home Address: | | Home Address: | |
| Employer Name: | | Employer Name: | |
| Employer Telephone: | | Employer Telephone: | |
| Employer Address: | | Employer Address: | |
| Email Address: | | Email Address: | |

**EMERGENCY CONTACTS**

Persons authorized to pick up your child and/or contact in case of emergency if neither parent is available to assume responsibility for the child.

| | | | |
|---|---|---|---|
| Name of contact #1: | | Name of contact #2: | |
| Relation: | | Relation: | |
| Telephone Number: | | Telephone Number: | |
| Home Telephone: | | Home Telephone: | |
| Employer Number: | | Employer Number: | |

**CUSTODY**

| Name of person PROHIBITED from picking up your child: | |
|---|---|

If a non-custodial parent has been denied access, or granted limited access, to the child by a court order, please submit documentation to thi effect for the center to maintain a copy on file, and to comply with the terms of the court order.

**PERMISSIONS**

| | |
|---|---|
| ☐ I give permission for my child to participate in ***WALKING TRIPS*** within the center's neighborhood, using routes that pose no known safety hazards to children, with the understanding that the walk involves no entrance into another facility unless otherwise indicated. | ☐ I ***DO NOT*** give permission for my child to participate in ***WALKING TRIPS*** within the center's neighborhood, using routes that pose no known safety hazards to children, with the understanding that the walk involves no entrance into another facility unless otherwise indicated. |
| ☐ I give permission for my child to be ***PHOTOGRAPHED*** during normal daycare hours, field trips, or activities and understand that photographs may be used in promoting child care services, either in print or on the Internet. | ☐ I ***DO NOT*** give permission for my child to be ***PHOTOGRAPHED*** during normal daycare hours, field trips, or activities and understand that photographs may be used in promoting child care services, either in print or on the Internet. |

**RECEIPT OF POLICIES**

I (we) attest that all of the information on this application is accurate, and that I (we) have received the following information:

- ☐ Center Policies and Procedures
- ☐ Information to Parents Document
- ☐ Policy on the Expulsion of Children from Enrollment
- ☐ Policy On The Use Of Technology And Social Media
- ☐ Policy On The Management Of Illnesses/Communicable Diseases
- ☐ Políicy On The Release Of Children
- ☐ Policy on the Methods of Parental Notification of Injuries (if applicable)
- ☐ Other:_____

☐ Other:_____

**MEDICAL INFORMATION**

| | |
|---|---|
| Child's Health Care Provider: | |
| Health Care Provider Phone: | |
| Health Care Provider Address: | |
| Name Of Insurance Company/HMO: | |
| Group #: | |
| Identification #: | |
| Subscriber's Name On Insurance Card: | |
| Known Allergies (including medication): | |
| Medication My Child is Taking: | |
| List Special Conditions, Disabilities, Medical/Physical Restrictions, Medical Information For Emergency Situations: | |

**HEALTH STATEMENT**

As the parent/guardian of the above named child, I certify that he/she is in good physical health and may participate in the normal activities of the program and has no conditions or specific needs that require specific accommodations, unless otherwise indicated in the medical information provided above or an attached Universal Health Record or a Care Plan for Children with Special Health Needs.

Parent/Guardian Initials:

**EMERGENCY TREATMENT**

As the parent(s)/legal guardian(s) of the above named child, I (we) attest that the information above is correct. I (we) authorize the child care center staff to obtain emergency treatment for my child and understand that I (we) shall be promptly notified.

Parent/Guardian Initials:

| Parent/Guardian Signature #1: | Date: | Parent/Guardian Signature #2: | Date: |
|---|---|---|---|
| | | | |


**First Day Checklist**

Your child(ren) requires the following items on their first day at Main Street Day Care:

## 4 and Under-

- Labeled Water Cup
- A change of seasonally appropriate clothing in a labeled gallon sized freezer bag
- Diapers/Pullups/Wipes (if applicable) labeled
- Labeled bottles (if applicable)
- Formula (if applicable)
- Lunch (Labeled)
- Naptime cot sheet and blanket (We will keep it here and wash it on Fridays.)
- Labeled bottle of SunBlock (when applicable)
- All required documentation

Parent Signature:_____ Date:_____

**Infant Care Policy**

Sudden Infant Death Syndrome (SIDS) is the unexpected death of a seemingly healthy infant for whom no cause of death can be determined based on an autopsy, an investigation of the place of death, and a review of the infant's clinical history.

In the belief that proactive steps can be taken to lower the risk of SIDS in the child care setting and that parents and child care professionals can work together to keep infants safer while they sleep, Main Street Day Care will follow all of the following sleep practice guidelines:

**Safe Sleep Practice and Environment:**

1. Infants must always be placed on their backs to sleep.
2. Cribs are the only location in which infants may sleep.
3. Infants who fall asleep in another location must be moved to a crib immediately.
4. If an infant can roll over on their own, the crib must be labeled, “I can roll over” in the designated area.
5. No additional items may be placed in the crib at any time (toys, blankets, ect.)
6. Only a safety approved crib with a firm mattress and snug fitting sheet may be used in the daycare.
7. Sleeping infants must be in the direct line-of-sight of at least one staff member at all times.
8. The temperature of the infant room must be kept between 69 and 72 degrees F at all times.

Anything you would like us to know about your child’s sleep schedule or routine?

_____

_____

I, _____, understand that I must abide by the stated policies.

Parent/Guardian Name:_____

Signature:_____ Date:_____

**Health Screening Policy**

Prior to morning drop off, you must assess your child for any Covid like symptoms. Some of these symptoms include but are not limited to:

1. Shortness of breath
2. Fever
3. Body/Muscle aches
4. New loss of taste or smell
5. Diarrhea/Vomiting
6. Sore Throat
7. Headache

If your child is exhibiting any of these symptoms, please notify the school and remain home. Having a fever requires a negative covid test result to return to school.

The health and safety of students, staff and families is our priority. We appreciate your cooperation on this matter.

I acknowledge that I have received the Health Screening Drop Off Policy.

Print Name:_____

Signature:_____ Date:_____

**Introducing brightwheel**

brightwheel
The all-in-one app for preschool and daycare

Dear Parents,
To organize Main Street Daycare, we are using Brightwheel, a tool for classroom management, communication, photos, videos, online bill pay, and much more. Brightwheel is the industry leader in early education, proven to save time for staff, allowing for measurably more time with students, while also delivering a much better experience for parents.
**Easy steps to follow:**

1. **Create a free brightwheel account.** When you receive an invitation via email or text, please create a free parent account using either the web or mobile app. Make sure to use the same email address or cell phone number that the invitation was sent to. Here is a quick video overview.
2. **Confirm your child's profile.** You will see your child's profile after you create an account - you can confirm information such as birthday, allergies, and additional contacts. If you do not see your child's profile, please contact us with the email address or phone number you used to sign up. You will not see updates within brightwheel until we start to use it regularly.
3. **Set your account preferences.** You can adjust your notification preferences within your profile settings on the app.
4. **Add your payment information.** Brightwheel offers secure, automated online payments that saves time for us and gives you advanced tools and reporting. Please add your payment information. Here is an online Payments Setup Guide with more info.

See a video tutorial:
https://www.youtube.com/playlist?list=PLWkfMDOm0pnF0bWPntP7m7dSSi6lD6JUR!

We're excited to be adding this state-of-the-art system and hope you enjoy it!
God Bless,
Rachel Nash, Director

**2025-26**

# CALENDAR CLOSURES FOR SPECIAL HOLIDAYS

**Day Care, PreK, & After School Program**

**September 2025**
Labor Day Monday 9/1
Daycare Reset Clean Out Day Tuesday 9/2
Staff Training Day Wednesday 9/3

**October 2025**

**November 2025**
Wednesday 11/26 Early Dismissal Close at 3pm
Thanksgiving Break Thursday 11/27 & Friday 11/28

**December 2025**
Christmas Break 12/24-12/26
New Years Eve 12/31 Early Dismissal Close at 3pm

**January 2026**
New Years Day Thursday 1/1
Staff Training Day Friday 1/16
Martin Luther King Monday 1/19

**February 2026**
President's Day Monday 2/16

**March 2026**

**April 2026**
Good Friday 4/3
Easter Monday 4/6

**May 2026**
Staff Training Day Friday 5/22
Memorial Day Monday 5/25

**June 2026**
Juneteenth Friday 6/19

**July 2026**
Independence Day Friday 7/3

**August 2026**
***Closings for inclement weather will be messaged through Brightwheel at Director's discretion.

*APPENDIX H*

# 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<br>☐ Date Next Immunization Due: _____ |
|---|---|

### MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>• List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>• List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>• List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>• List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>• List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>• List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>• List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>• List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ 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 | |

# 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.