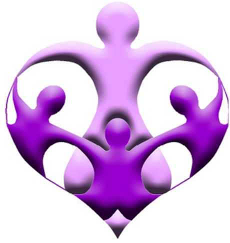

Tender Years

Learning Center

507 Walnut Hill Road
North Yarmouth, ME 04097
(207) 829-6062

www.tender-years.com

Authorization for Pick-Up Form

Child's Name:____

Please list below all individuals other than parents who are authorized to pick up your child/children. Unless the person is the child's parent, a photo I.D. will be required.

Person 1	Person 2
Name:	Name:
Relationship:	Relationship:
Address:	Address:
Address:	Address:
Phone:	Phone:
Person 3	**Person 4**
Name:	Name:
Relationship:	Relationship:
Address:	Address:
Address:	Address:
Phone:	Phone:

I do hereby authorize Tender Years Learning Center to release my child to the above listed people in the event I am unable to pick him/her up myself. I release Tender Years Learning Center from any and all responsibility for problems that may develop when such persons take my child from the premises.

____

Signature of Parent/Legal Guardian Date

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D.O.B.____/____/____

Child's Height:________ Child's Weight________

EMERGENCY INFORMATION RECORD

CHILD'S LAST NAME	CHILD'S FIRST NAME		
PARENT/GUARDIAN NAME	HOME PHONE		
HOME ADDRESS	CITY	STATE	ZIP
ALTERNATE HOME ADDRESS	CITY	STATE	ZIP
PARENT 1 NAME	BUSINESS PHONE	CELL PHONE	
PARENT 2 NAME	BUSINESS PHONE	CELL PHONE	

IN CASE OF AN EMERGENCY AND PARENT IS NOT AVAILABLE, CONTACT:

NAME 1	ADDRESS	PHONE
NAME 2	ADDRESS	PHONE
CHILD'S PHYSICIAN	ADDRESS	PHONE
CHILD'S DENTIST	ADDRESS	PHONE

HOSPITAL WHERE CHILD SHOULD BE TAKEN IF PARENT OR PHYSICIAN IS UNAVAILABLE

ALLERGIES AND OTHER MEDICAL CONDITIONS: (Please explain checked items below or, if necessary, use the other side of this form.)

- o ALLERGIES
- o EPILEPSY
- o URINARY
- o ASTHMA
- o HEART PROBLEMS
- o NEURO-MUSCULAR
- o DIABETES
- o RECURRING ILLNESS
- o OTHER *(please list)*________________________________
- o HEARING IMPAIRED
- o VISUALLY IMPAIRED

In case of an accident or serious illness or injury, I request the school contact me. If the school is unable to reach me, I hereby authorize the staff at Tender Years Learning Center to call the physician indicated and to follow his/her instructions. If it is impossible to contact this physician, the school may take whatever actions seem necessary.

Parent/ Legal Guardian Signature:________________________________ Date:__________

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Learning Center

D.O.B.____/____/____ Child's Height:________ Child's Weight________

CHILD'S LAST NAME	CHILD'S FIRST NAME	**HEALTH INSURANCE**
INSURANCE COMPANY	ADDRESS	PHONE
CITY	STATE	ZIP
POLICY NUMBER	GROUP NUMBER	MEMBER ID
POLICY HOLDER	RELATIONSHIP TO STUDENT	
PRIMARY CARE PHYSICIAN		

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HIPPA Consent Form

Under HIPAA, the federal Health Insurance Portability and Accountability Act of 1996, health care providers are required to safeguard the confidentiality of health records. Therefore, your child's health records should somewhere include a signed authorization from parents or legal guardians for the healthcare provider to share information (about health exams, immunizations, illness visits) with Tender Years.

I, ______________________________, parent or guardian of ______________________________, authorize the office of

Parent name printed *Child name printed*

______________________________ to share information with Tender Years Learning Center regarding my child's health

Physician's name

exams, immunizations and illness visits.

The following individuals are authorized to have access to health information about my child.

1. Karen Bruder ______________________________

2. ______________________________

3. ______________________________

____
Parent or Legal Guardian's Signature

____
Date

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Use of Photographs/Videos – Consent Form

Under the *Freedom of Information and Protection of Privacy Act*, it is necessary for Tender Years Learning Center to obtain consent in order to use photographs or videos of your child.

Photographs of program participants may be taken for the purposes of observation and assessment as well as for creating school keepsakes or mementos. Images and or videos may be used as supporting evidence for developmental referrals. Images may also be used for marketing purposes. If consent is not granted, photos or videos of your child will not be used.

__ I consent to the use of photos/videos to be taken of my child for observation/assessment and or referral purposes.

__ I consent to the use of photos/videos to be taken of my child for school keepsakes and mementos as well as the class directory.

__ I consent to the use of photos/videos taken of my child by Tender Years Learning Center for marketing purposes.

__ I do NOT consent to any use of photos or videos taken of my child.

____
Child's Name

____
Parent or Legal Guardian's Name (Please print)

____ ____________________
Parent or Legal Guardian's Signature Date

UNIVERSAL CHILD HEALTH RECORD

Endorsed by:

American Academy of Pediatrics New Jersey Chapter	*New Jersey Department of Health and Senior Services*	*New Jersey Academy of Family Physicians*

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Date of Birth / /
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 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 behavioral/mental health issues/concerns:	☐None ☐Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/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		

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	