Dear Parents,

The following forms must be submitted to the preschool office before your child will be admitted to The Sunshine School/Camp Billi Marcus 2012-13 School and Camp Program:

- ☐ Master Profile (**completely filled out**)
- ☐ Health Form (signed and dated by your doctor's office)
- ☐ Sunscreen & Topical Ointment Form
- ☐ 3231 Immunization Form (obtained from your doctor's office)
- ☐ Food Allergy Action Plan (*if applicable)*
- ☐ Student History Form (**New Families only**)

Please be sure and download our policies and procedures from the website and keep a copy for important information.

All required forms are included in this packet, with the exception of the 3231 Immunization Form that must be obtained from your child's doctor's office.

No child will be permitted to attend without all of the above forms on file in our office.

Completed forms may be submitted:

- In person to the preschool office
- Scan & Email to Karen.saul@atlantajcc.org
- Fax to 678-812-3915
- Mail to: The Sunshine School
  Marcus Jewish Community Center of Atlanta
  1415 Old Canton Road
  Marietta, Georgia 30062
  Attention Karen Saul

If you have any questions, please contact:

- Karen Saul – Karen.saul@atlantajcc.org, 678-812-3715

2012 - 2013 MJCCA Preschool & Camp CHILD MASTER PROFILE

THE SUNSHINE SCHOOL AT TEMPLE KOL EMETH / CAMP BILLI MARCUS

Please complete one per child. Registration forms are also available online at www.atlantajcc.org

Today's Date:	☐ HD ☐ FD	Gender ☐ F ☐ M	**Membership:** **MJCCA: ☐ Yes ☐ No** **TKE: ☐ Yes ☐ No**
Child's Last Name	First	Middle	Nickname
Birthdate (mm/dd/yyyy)	Age (as of Sept. 1, 2012)	Child lives with ☐ Parents ☐ Mother ☐ Father ☐ Grandparents ☐ Guardian	
Marital status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	For Divorced Parents or Legal Guardians:	Who is responsible for payment? Name Who has custody of this child? Name	
Parent/Guardian 1 Name	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.	Parent/Guardian 2 Name	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.
Home Address		Home Address	
City	State / Zip	City	State / Zip
Subdivision	County	Subdivision	County
Home Phone #	Fax #	Home Phone #	Fax #
Work Phone #	Cell #	Work Phone #	Cell #
Email address (please print)		Email address (please print)	
Occupation / Business Name	Business Address	Occupation / Business Name	Business Address
Grandparents' Names May be released to Grandparents ☐ Y ☐ N	Address Phone	Grandparents' Names May be released to Grandparents ☐ Y ☐ N	Address Phone

EMERGENCY CONTACT. Individuals other than Parents whom we may contact and release child to if parent cannot be reached.

Name	Relationship	Home Phone _____ Work Phone _____ Cell Phone _____	Address
Name	Relationship	Home Phone _____ Work Phone _____ Cell Phone _____	Address

Allergies: Does your child have any allergies? ☐ Yes ☐ No If yes, allergy form must be completed and picture of child attached.

If yes, please list allergies:

Additional Support: Does your child or has your child ever received any medical or educational therapies (PT, OT, Speech, etc.) ☐ Yes ☐ No

If yes, please list therapies: Date of last therapy session:

I understand and give my permission to MJCCA that my child and/or his voice may appear in printed material, photographs or visual and/or audio recordings from the MJCCA.	☐ Yes ☐ No
I give permission for my address, phone numbers and email to be released to other preschool families.	☐ Yes ☐ No
I hereby authorize MJCCA to include my child in supervised water activities (if applicable).	☐ Yes ☐ No
I have read and fully understand the 2012-2013 MJCCA Preschool Policies that are available at www.atlantajcc.org.	☐ Yes ☐ No

Authorization For Treatment: Should the need for medical attention arise; (and in case of our unavailability), as parents or legal guardians, we want the MJCCA and/or staff to arrange and authorize medical treatment as necessary for our child,
Child's Medical Insurance Co._____ Group # _____ ID # _____

The MJCCA will use the nearest available hospital. Should specialist advice or treatment be required, our preferences are:

Doctor _____ Address_____ Ph_____

Dentist_____ Address_____ Ph_____

In the absence of a parent or guardian, ☐ I hereby give authorization ☐ I do not give authorization to the named emergency contact person to have access to my child's health information.

This information is complete to the best of my knowledge.

Parent/Legal Guardian Signature

_____

Date _____

The Sunshine School & Camp Billi Marcus	678-812-3720	East Cobb

2012 - 2013 MJCCA Preschool & Camp HEALTH FORM

THE SUNSHINE SCHOOL AT TEMPLE KOL EMETH / CAMP BILLI MARCUS

Please complete one per child. Registration forms are also available online at www.atlantajcc.org

Child's Full Name	Date of Birth
Address	Phone Number

MEDICAL / IMMUNIZATION INFORMATION

Please, note that Georgia Health Form #3231 is required for all children. Families new to Georgia may provide an official document equivalent to the GA 3231 immunization record. All records must be in English.

Height	Weight	Gender ☐ F ☐ M

Chronic Medical Conditions ☐ Y ☐ N If Yes, provide details.	Dietary needs or restrictions ☐ Y ☐ N If Yes, provide details.
Medicine or Food Allergies ☐ Y ☐ N If so, a completed Allergy Form is required along with this form.	Any regular or PRN medicines ☐ Y ☐ N If so, which ones?

Does Child have any history of:

Vision Impairment or eye infection ☐ Y ☐ N If yes, what? _____

Hearing Impairment or ear infection ☐ Y ☐ N If yes, what? _____

Tubes in ears? ☐ Y ☐ N

Speech problems ☐ Y ☐ N If yes, what? _____

Rashes ☐ Y ☐ N If yes, what? _____

Are any restrictions on normal physical activities indicated? ☐ Y ☐ N

If Yes, provide details:

Physician's Name (please print)

Physician's Signature	Date
Physician's Address	Phone

In the event of an emergency, I hereby give permission to the physician selected by the director or other MJCCA official to order x-rays, routine tests, and treatment for the health of my child. In the event that I cannot be reached in an emergency situation, I hereby give permission for a physician selected by the preschool director or other MJCCA official to hospitalize, secure proper treatment for, and order injections and/or anesthesia and/or surgery for my child.

I authorize any physician, nurse or other health care provider to communicate with the staff and director of MJCCA Preschools, or his/her designee, about my child's medical condition, treatment and/or prognosis. I further authorize the director to discuss any medical conditions with his/her designee, or the child's teacher when the director, in his / her sole discretion, believes such communication to be in the best interest of the child.

I, the parent/legal guardian, assume all risks and hazards incidental to the conduct of activities and transportation to/from the activities. I understand that aspects of the MJCCA preschools & Camps may be physically and emotionally demanding. Both my child(ren) and I agree to follow any and all rules, guidelines, and safety instructions that may be provided by MJCCA staff. I recognize the inherent risk of injury or disability in activities. I understand that each participant must assume the risk of injury or disability that could result from any of these activities. I hereby release, indemnify, defend, save, and hold the MJCCA its officers, directors, trustees, employees, members, agents, and activity providers harmless, with respect to any and all claims or liability for any injury to my child(ren) from participation in any and all Camp activities and all claims by or on behalf of myself, my child(ren), or third parties for loss or damage unless the alleged loss is solely the result of the MJCCA's gross negligence or misconduct.

I give permission for this information on _____ to be shared with my child's school.
(Child's name)

SIGN HERE Parent/Legal Guardian Signature Date

Parent Name (please print)

The Sunshine School at Temple Kol Emeth	678-812-3720	1415 Old Canton Road, Marietta, GA 30062

2012 - 2013 MJCCA Preschool & Camp STUDENT HISTORY FORM

THE SUNSHINE SCHOOL AT TEMPLE KOL EMETH / CAMP BILLI MARCUS

Please complete one per child. Registration forms are also available online at www.atlantajcc.org

Date	Child's First Name	Child's Last Name	Child's Nickname
Parent/Guardian 1 Name		Parent/Guardian 2 Name	

Please describe your child's birth. Was he/she premature or overdue? Were there any complications?

Has your child experienced a serious illness or hospitalization? ☐ Yes ☐ No
If Yes, please desribe.

Has your child been in preschool before? ☐ Yes ☐ No

Dates Where?

Are there any special procedures we need to follow to care for your child, or does your child have any special needs?

What is the primary language spoken at home?

Why have you enrolled your child in our program?

How do you think we can best contribute to your child's happiness and development?

What factors did you consider to ultimately select our program? Please rank in importance 1-8 with 1 being most important.

Location	Cost	Judaics	Facility
Staff	Reputation	Hours	MJCCA resources

How did you hear about our preschool? Please mark all that apply.

☐ Website ☐ Postcard ☐ Printed Ad ☐ Email

☐ Current Preschool Family Name:_____

☐ Other MJCCA Member Name:_____

What special skills/talents do you or another family member have that you would be willing to share with your child's class or our school community?

Thank you for taking time to complete this. We use this to help make your child's transition to school successful and to help improve our program.

The Sunshine School at Temple Kol Emeth	678-812-3720	1415 Old Canton Road, Marietta, GA 30062

Food Allergy Action Plan

Name: _____ **D.O.B.:** ___/___/___

Allergy to: _____

Weight: _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Place Student's Picture Here

Extremely reactive to the following foods: _____

THEREFORE:

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, crampy pain

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

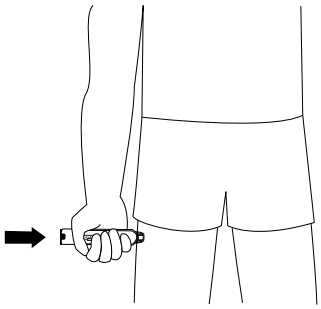
TURN FORM OVER

Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg

Twinject® 0.3 mg and Twinject® 0.15 mg Directions

Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

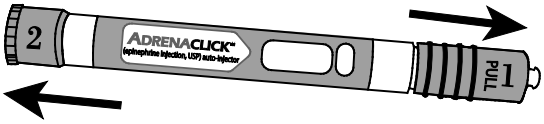
SECOND DOSE ADMINISTRATION:
If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___)_____-_____) Doctor:_____ Phone: (___)_____-_____
Parent/Guardian:_____ Phone: (___)_____-_____

Other Emergency Contacts
Name/Relationship: _____ Phone: (___)_____-_____
Name/Relationship: _____ Phone: (___)_____-_____

Authorization to Dispense
Sunscreen / Bug Spray / Topical Ointment

590-1-1-.20(1) – Georgia Bright From The Start

Parental Authorization

Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of parent.

I give the Sunshine School of the MJCCA at Temple Kol Emeth permission to apply one or more of the following topical ointments/preparations to my child, _____ in accordance with the directions on the label of the container.

_____ Baby Wipes
_____ Band-aids
_____ Neosporin or similar ointment
_____ Bactine or similar first aid spray
_____ Sunscreen
_____ Insect Repellent
_____ Non-Prescription ointment (such as A & D, Desitin, Vaseline)
_____ Baby Powder
Other (please specify)
_____
_____ _____

Parent/Guardian Signature
_____

Date _____ / _____ / _____

School will maintain form in child's general file