MIDDLE-BROOK
REGIONAL HEALTH COMMISSION
111 Greenbrook Road
Green Brook, NJ 08812
(732) 968-5151
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PARTICIPATING MUNICIPALITIES
BOROUGH OF BOUND BROOK
TOWNSHIP OF GREEN BROOK
BOROUGH OF SOUTH BOUND BROOK
BOROUGH OF WATCHUNG
TOWNSHIP OF WARREN

CHILD CARE CENTER INSPECTION REPORT

General Information

Name of Center Before + After Care Busy Time Child Care/CTF.

Address 113 Bayberry Ln. Watchung.
(street) (city) (state) (zip code)

Telephone Number 755-8184 (908).

Name of Center Sponsor (owner) Watchung BOE.

Address _____
(street) (city) (state) (zip code)

Telephone Number _____

Center Information

Is the center? New ___ Renewing ___ Relocating ___ Under new sponsorship ___
Indicate the date on which the center first began/will operating _____

Days and Hours of Operation 7AM OPENS - until School Begins.

Mon	___am	Tues	___am	Wed	___am	Thurs	___am	Fri	___am
	___pm		___pm		___pm		___pm		___pm
Sat	___am	Sun	___am						
	___pm		___pm						

3:25pm - 6:30pm. From Monday to Friday.

Sessions: Morning ___ Afternoon ___ All day ___ Night ___

Does (will) the center remain open? Year round ___ School Year ✓

Number of Children 130 Number of Nursery Rooms _____

Age Group: Under 1 yr ___ Age 1-2 ___ Age 3 ___ Age 4 ___ Age 5 ___ Age 6 ___

Public Health
Middle-Brook Regional Health Commission

Staff Information

Name of Center Director Nichole Ditota, CPR.
Name of Head Teacher/Supervising Caregiver same.
Medical director (emergency contact) Call 911 & PARENTS.

Additional Staff (include Name, Position, and indicate if certified in Child 1st Aid/CPR).

1. LISA MAHON, SUBSTITUTE.
2. Katie Latier.
3. Kimberley Clark.
4. DANIEL Rago
5. LEANNE SOLOMON, CPR.
6. DIVYA Pande, CPR
7. Sara Greenzweig CPR
8. DIVYA Pande.
9. Christine ZEINAN.
10. DEREK GEAN.
11. LISA MAHON.
12.
13.
14.

Food Service Operations

Does (will) the Center participate in a Food Program? Yes ___ No ✓

List any Chapter 12 Violations

* PREPACKAGE SNACKS ARE PROVIDED.

SATISFACTORY

Physical Center Checklist

Fire drills	___	Air conditioning	✓	Lighting	✓
First aid kit	✓	Adequate ventilation	✓	Heating type	HVAC/Boilers
Screened windows	___	Floor/window fans	N/A	Ceiling/walls	___
Septic/sewers (circle)		Well/city water (circle)			
Toilets	✓	Wash basins	✓	Towels/soap	✓
Waste baskets	✓	Fountains	Fountain (w/ Bottle)	Chairs	✓
Tables	✓	Linens	N/A	Beds/Mats	N/A
Blankets/pillows	N/A	Cots	N/A Cribs N/A		

Extermination services _____
(name) (phone number)

Indoor maintenance and sanitation _____

_____

Outdoor maintenance and sanitation _____

_____

Transportation Services

Is transportation provided? Yes ___ No ___

If yes, complete the following:

Name of Company (if other than center) providing transportation:

_____

Address _____
(street) (city) (state) (zip code)

Telephone Number _____

Make, Model, Year of Vehicle(s) Vehicle(s) License Number(s)

1. _____
2. _____
3. _____
4. _____
5. _____

Vending Machines

Is (are) there vending machine(s) at the Center? Yes ____ No ____

List type, Location, and Name of manager food service operation

1. _____
2. _____
3. _____

Additional Comments and Summary

(Inspector)

10/7/21
(Date)