CHILD ENROLLMENT & EMERGENCY MEDICAL CARE FORM

Date of Application: _____ Date of Enrollment: _____ Last Day of Enrollment: _____
Child's Name: _____ Child's Date of Birth: _____
Child's Address: _____ City: _____ Zip Code _____
Mother's Name: _____Address: _____
City: _____ Zip Code: _____e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Mother's Employer: _____ Work #: (_____) _____
Mother's Employer Address: _____ City: _____ Zip Code _____
Father's Name: _____Address: _____
City: _____ Zip Code: _____e-mail Address: _____
Home Telephone #: (_____) _____ Cell #: (_____) _____
Father's Employer: _____ Work #: (_____) _____
Father's Employer Address: _____ City: _____ Zip Code _____

****

Weekly Care Schedule: (please include the child's hours in care for each day)
Sunday: _____
Monday: _____
Tuesday: _____
Wednesday: _____
Thursday: _____
Friday: _____
Saturday: _____

Persons permitted to remove the child from the child care program on behalf of parent. (Use back for additional names.)
Name: _____
Phone #: _____Relationship _____

****

In an emergency, adults to be contacted if parent cannot be reached and to whom the child can be released.
(Use back for additional names.)
Name: _____
Phone #: _____Relationship _____

****

Medical Information

Known Allergies: _____ Last Tetanus: _____
Insurance Carrier: _____ Insurance ID: _____

Child's Physician: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____
Child's Dentist: Name: _____ Phone #: (_____) _____
Address _____ City:_____ Zip Code: _____

****

Emergency Authorization

I give my consent for the First Aid and CPR certified staff of **(program's name)** _____, to administer first aid and CPR to my child and to contact the above named physician or dentist if my child has a medical emergency. I also give my consent for my child to be transported to the nearest hospital in the event of a medical emergency. I will be responsible for all medical fees.
Preferred Medical Facility: _____

****

Behavior Management and Parent Handbook

I acknowledge that I have read the parent handbook and agree to abide by the policies contained in it and that the techniques used to manage child behaviors in the facility have been discussed with me prior to enrollment.

Signature of Parent or Guardian: _____ **Date**: _____

Signature of Parent or Guardian: _____ **Date**: _____

169 Ledge Hill Rd. - NGNSDirector@gmail.com - 203-457-0808

NGNS Permanent Child Pick-Up Form

Child's Name:_____ Teacher:_____

Class and Days:_____

Please list those who will be picking up your child on a regular basis. If you need to arrange for pick up by someone other than those listed on this form, please call the director. Please note that we are required to check a photo ID before releasing a child to a non-parent.

Name:_____ Phones:_____/_____Relationship:_____

Name:_____ Phones:_____/_____Relationship:_____

Name:_____ Phones:_____/_____Relationship:_____

Name:_____ Phones:_____/_____Relationship:_____

Name:_____ Phones:_____/_____Relationship:_____

Parent/Guardian Authorization: _____ Date:_____

Teacher Signature 1:_____Date:_____

Teacher Signature 2:_____Date:_____

Permissions

CHILD'S NAME:

CLASS LIST PERMISSION
Signing below this paragraph means that I agree to give my permission for my child's name, address, email address and telephone number to be included on the North Guilford Nursery School Class Friends list. The list is distributed to each student's family for the purpose of socializing, at your own discretion, outside of the school program. My child's parent(s) or guardian(s) names will be included on the list for contact purposes.
Parent/Guardian Signature and date:

PERMISSION TO TAKE AND USE PHOTOGRAPHS
Signing below this paragraph means that I agree to give my permission for photos of my child to be taken by the North Guilford Nursery School staff for their use with the school program; photos of the children participating in daily program activities, to be used for display in the school, online (via the school's Facebook page) or submitted for publication in the local newspapers. Names are not used with photos.
Parent/Guardian Signature and date:

FIELD TRIPS PERMISSION
Participation in field trips is optional. Families will be given details regarding date, time, and location of field trips that their child's class intends to participate in. North Guilford Nursery School does NOT provide transportation for any student. Families are responsible for transporting their child to and from the field trip site. Parent(s)/Guardian(s) must remain at the field trip site.
Parent/Guardian Signature and date:

Sample

Tuition Agreement

North Guilford Nursery School, Inc. ("School") and the undersigned parents ("Parents"), by entering into this tuition agreement to enroll their child listed below ("Student") for the **2022-2023** school year, executed by the parents on the signed date below, agree as follows:

1. **Consent:** This agreement is entered into with mutual consent of Parents and the School. ____ (parent initials)
2. **Enrollment deposit:** The School requires a **$100.00** security deposit ("Deposit") to reserve a spot for the student in the **2022-2023** school year. The $100.00 Deposit is deducted from your child's final tuition installment in June. The school also collects a $75.00 non-refundable registration fee at enrollment. _____ (parent initials)
3. **Tuition and charges:** Parents agree to pay the full amount for tuition and fees. Tuition is billed through Brightwheel. It is payable through Brightwheel (bank transfer or credit card) or paid directly to the school by check. Regardless of payment method it is due on or before **the 15th of each month.** The first monthly installment must be paid no later than **September 15th,** and the final monthly installment must be paid no later than **June 15th.** _____(parent initials)
4. **Additional fees:** Parents agree that additional fees for school services may be charged during the **2022-2023** school year (e.g., Enrichment, Drop-in Days, Summer Camp, Fundraisers, etc.). Additional fees are due when charged, will be billed through Brightwheel, and payable through Brightwheel or paid directly to the school by check. _____ (parent initials)
5. **Payment obligation:** Parents have an individual and joint obligation to pay all tuition and fees under this agreement. Parents' failure to pay any amount when due pursuant to the terms of this Agreement, may, at the School's sole discretion, result in the suspension or dismissal of the Student from the School. Parents shall pay any costs and attorney's fees the School incurs in collection of Parents' outstanding balance. _____ (parent initials)
6. **Early withdrawal/removal:** Parents must provide at least Thirty (30) days signed WRITTEN NOTICE to the NGNS Executive Director to withdraw the Student from the School during the **2022-2023** school year. Tuition will be collected during the 30-day notice period, and after the 30-day notice period, Parents will no longer be responsible for tuition payments pursuant to this Agreement. _____ (parent initials)
7. **Payment agreement:** Parents understand and agree that the majority of the School's expenses and obligations are incurred on an annual basis, that financial commitments for School services are made based upon anticipated enrollment, and that the educational operating expenses of School do not diminish with the departure of some students over the course of the school year. Parents understand and agree that, regardless of Student's absence, withdrawal, or dismissal from the School, Parents remain obligated to pay the amount of tuition set forth in sections 3 and 5 of the Agreement. _____(parent initials)

Parents:

Student:

Program: 2's Program, 2 days/week (Monday, Friday)

Total Tuition:

# of installments: 10

Amount per installment:

Parent Signature: _____

Date: _____

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑Male ❑Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑American Indian/Alaska Native ❑Native Hawaiian/Pacific Islander ❑Asian ❑White ❑Black or African American ❑Other ❑Hispanic/Latino of any race	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months?	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2); Public Act No. 18-168.

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name_____ Birth Date_____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT**____in/cm_____% ***Weight**____lbs._____oz /_____% **BMI**_____/_____% ***HC**____in/cm_____% (Birth–24 months) ***Blood Pressure**____/ ____ (Annually at 3–5 years)

Screenings

***Vision Screening**
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
❑ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑Unable to assess
❑Referral made to: _____

***Hearing Screening**
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
❑ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑Pass
	❑ Fail	❑Fail

❑Unable to assess
❑Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level
≥ 5µg/dL ❑nNo ❑nYes

***TB:** High-risk group? ❑No ❑Yes
Test done: ❑No ❑Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ❑No ❑Yes
❑Referral made to: _____
Has this child received dental care in the last 6 months? ❑No ❑Yes

*Result/Level: *Date

Other:

***Developmental Assessment:** (Birth–5 years) ❑No ❑Yes **Type:**

Results:

*IMMUNIZATIONS ❑Up to Date or ❑Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

***Chronic Disease Assessment:**

Asthma ❑No ❑Yes: ❑Intermittent ❑Mild Persistent ❑Moderate Persistent ❑Severe Persistent ❑Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑Rescue medication required in child care setting: ❑No ❑Yes

Allergies ❑No ❑Yes: _____
Epi Pen required: ❑No ❑Yes
History/risk of Anaphylaxis: ❑No ❑Yes: ❑Food ❑Insects ❑Latex ❑Medication ❑Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑No ❑Yes: ❑Type I ❑Type II **Other Chronic Disease:** _____
Seizures ❑No ❑Yes: Type: _____ _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑Vision ❑Auditory ❑Speech/Language ❑Physical ❑Emotional/Social ❑Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑No ❑Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑No ❑Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑No ❑Yes This child may fully participate in the program.
❑No ❑Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

❑No ❑Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Child's Name:_____ **Birth Date:**_____ REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached.
https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____(date); _____(confirmed by)

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN /PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child Questionnaire

Please take a few minutes to answer the questions below and then return the completed form to your child's new teacher. This questionnaire will help the teacher get to know your child. Thank you!

CHILD'S NAME:_____

Please list the names and ages of your child's brothers and sisters or other children in the home.

With whom does your child live?

Do you have any pets? If so, what types and what are their names?

What responsibilities does your child have at home?

Please list any fears your child may have.

What comforts your child when s/he is upset?

What are your child's interests and hobbies?

If we asked you to tell us about your child, what would be the first things you would say?

Does your family have any special celebrations you'd like to share with the class?

Has your child had previous experience in a school or childcare setting? How was it?

Please share something special about your child.

If there is any other important information you'd like to share with your child's teacher or the director in a more confidential manner, please do not hesitate to schedule an appointment.

We're looking forward to an exciting year ahead!

GUILFORD PUBLIC SCHOOLS: 2023-2024 SCHOOL CALENDAR

August/September 2023 [18/18]

Su	M	T	W	Th	F	Sa
27	28	29	30	31	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

October 2023 [21/39]

Su	M	T	W	Th	F	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

November 2023 [18/57]

Su	M	T	W	Th	F	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

December 2023 [16/73]

Su	M	T	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

January 2024 [21/94]

Su	M	T	W	Th	F	Sa
31	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

P/T Conf. Early Dismissal Times:
GHS: 12:20 p.m.
Middle Schools: 12:25 p.m.
Elementary: 12:05 p.m.

First Day of School for Students

- September 5

Holidays and Vacations (No School)

- September 4: Labor Day
- September 25: Yom Kippur
- October 9: Columbus Day/ Indigenous Peoples' Day
- November 22, 23, 24: Thanksgiving
- December 22: Early Dismissal
- December 25-Jan. 1: Winter Recess
- January 15: Martin Luther King Day
- February 19, 20: Winter Recess
- March 29: Good Friday
- April 8-12: Spring Break
- May 27: Memorial Day

Staff Professional Development (No School for Students)

- August 30, August 31, September 1, November 7, March 8

Staff PLC (Early Dismissal for Students Only)

- September 27, October 25, January 24, March 27, April 24, May 22

Early Dismissal*

- June 12 (Early Dismissal for Students)

Last Day of School*

- June 13 (Early Dismissal for Students)
- June 13 Graduation

Emergency Closing Make-up Days

- June 14, 17, 18, **, 20, 21, 24, 25, 26, 27, 28 (In case of extenuating circumstances, other calendar adjustments may be made (i.e. April vacation)

Parent/Teacher Conferences*

- **Elementary:** Nov. 20 & 21; April 4 & 5
- **Middle:** Nov. 16 & 17; April 1 & 2
- **GHS:** Nov. 8 & 9; March 13 & 14

Key

****June 19: Juneteenth**

	Staff Professional Development
	First and Last Days of School
	Early Dismissal (Students Only)
	Holidays and Vacations
	Staff PLC: Early Dismissal for Students Only
	P/T Conferences – Elementary
	P/T Conferences – Middle
	P/T Conferences – GHS

February 2024 [19/113]

Su	M	T	W	Th	F	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

March 2024 [19/132]

Su	M	T	W	Th	F	Sa
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

April 2024 [17/149]

Su	M	T	W	Th	F	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

May 2024 [22/171]

Su	M	T	W	Th	F	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

June 2024 [9/180]

Su	M	T	W	Th	F	Sa
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29

PLC; December 22, June 12 and 13 Early Dismissal Times:
GHS: 12:20 p.m.
Middle Schools: 1:03 p.m.
Elementary Schools: 1:52 p.m.

*Please note: Early dismissal times for students on Parent/Teacher Conference dates differ from the early dismissal times on PLC dates, December 22, and on the last two days of school (see times listed above).
BOE APPROVED: 12/12/2022