Children's Community School

Early Childhood Program

Documents Required For Enrollment

Student's Name: _____ School Year 2014-2015

Thank You, for your interest in our program! To complete your application you **MUST** bring the following documents, along with your application we will need:

___ Pre-k Application

___ Child's Birth Certificate/ Verification of Birth

___ Child's Current Medical Insurance

___ Current physical and immunization records (shots)

___ Current Dental Exam for ages 1 year and older

___ Proof of address

___ EBT "connect card", if applicable

___ Guardianship papers, if applicable

___ Nutrition Form

Acceptable Proof of Income Includes

___Current 1040 Tax Form

- Paid weekly: Last 4 Weekly Pay Stubs
- Paid Bi-weekly: Last 2 bi-weekly Pay Stubs
- Unemployment Letter or Statement
- Social Security Award Letter
- TFA/DSS Award Letter
- Child Support
- DCF Foster Support

___ Pre-K Program Handbook

___ Completed Visit to Classroom/ Introduction to Teachers

Teacher: _____

CCS PRE-K REGISTRATION/ EMERGENCY FORM

Child's name: _____ M or F Date of Birth: _____

Address: _____ City: _____ Zip: _____

FAMILY INFORMATION:

Mother or Primary Guardian Information:

Name: _____

Address: _____

Cell Phone: _____

E-mail: _____

Work Place: _____

City: _____

Work Phone: _____ Ext_____

Normal work days/hrs: _____

Father or Other Guardian Information:

Name: _____

Address: _____

Cell Phone: _____

E-mail: _____

Work place: _____

City: _____

Work Phone: _____ Ext_____

Normal work days/hrs: _____

Primary language spoken at home: _____ Second language: _____

EMERGENCY INFORMATION:

Allergies or Chronic Illness: _____

Current medication (type/dose): _____

Is this medication in the nurse's office at school? _____

Child's doctor: _____ Dr.'s Phone: _____

Insurance: Private Husky No insurance

Insurance Carrier and Member ID#: _____

Emergency Hospital Preference: _____

EMERGENCY CONTACTS:

In case of emergency we will first contact the mother or primary guardian listed above, then the father or other guardian listed above, then the people listed below. By listing their names, you give permission for these people to pick up your child if we are unable to contact you.

Name	Phone	Relation to Child

I give my permission for the school nurse or staff trained in first aid to administer first aid or to obtain care for my child from a licensed physician. I also give my permission for my child to be taken by police or ambulance to the hospital listed above or, if that is impossible, to another hospital or medical facility. I understand a staff person will accompany my child. If I cannot be contacted, I authorize the administration of Children's Community School to act on my behalf.

Parent Signature: _____ **Date:** _____

CCS PRE-K APPLICATION

Date of Application: _____

Date you would like your child to start school: _____

I am interested in:

_____ Full day/Full year care (7 or more hours per day, including summer and most school vacations)

_____ School day/School year care (8:45 AM - 2:45 PM, following school calendar)

Child's name: _____ M or F Date of Birth: _____
(Last) (First)

Address: _____ Phone: _____
(Street) (Zip code)

Whom should we contact regarding this application?

Name: _____ Relationship to child: _____
(Last) (First)

Address (if different from child's address above): _____

What is the primary language spoken at home? _____

Do you currently receive Care 4 Kids? _____

Names of family members currently attending Children's Community School:

_____

_____

Has your child attended daycare or preschool before? _____ If yes, where? _____

Why do you want your child to attend Children's Community School?

_____

_____

_____

_____

PARENT SURVEY - PreK

Parent's Name: _____

Child's Name: _____

What language do you use most frequently with your child? _____
Would you like to have someone available to translate? _____

Please list the major holidays that you celebrate:

_____

Do you need help finding any of the following services?

_____ Child Care Assistance
_____ Insurance
_____ Help with Reading
_____ ESL (English as Second Language)
_____ GED
_____ Job Training
_____ Transportation
_____ Housing
_____ Food Stamps
_____ Heating Assistance
_____ Clothing
_____ Mental Health Relief

Please check any areas you would like to learn more about:

_____ Nutrition
_____ Cooking Healthy Foods
_____ Budgeting
_____ Family Fun at Home
_____ Reading with my child
_____ Other: _____
_____ Child Discipline
_____ Stress Management
_____ Single Parenting
_____ Sibling Rivalry

I would like to be involved at school in the following ways:

_____ Read to children
_____ Join the class for a meal
_____ Teach a special skill
_____ Help with fundraising
_____ Other: _____
_____ Chaperone a field trip
_____ Help with outdoor play
_____ Share my culture
_____ Serve on Child Advisory Committee

What days/times are you available to help? _____

PARENT QUESTIONNAIRE – PreK

Name of Child: _____

1. What makes you proud of your child?

2. What do you see as your child's strengths?

3. Every parent can describe the strengths of their child, but most parents also have worries and concerns about their child. Describe any concerns you have.

4. How do you successfully discipline your child?

5. What should we know about your culture to help your child adjust to our program?

6. Are there any circumstances in your family that you wish to share that may have impacted your child (e.g. divorce or separation, death, unemployment, move of your home, birth of a sibling, family illness, arrest or incarceration of family member)? Has support been available to you? Please explain.

Administration of INSECT REPELLANT and/or SUNSCREEN

I give permission for a member of the school staff to apply sunscreen to my child _____(child's name). Sunscreens must be free of amino benzoic acid (PABA) or its derivatives with both UVA and UVB protection and a SPF of 15 or better.

_____(parent signature)

I give permission for a member of the school staff to apply insect repellent to my child _____(child's name) if it is likely that they might be exposed to disease carrying insects. Insect repellent should contain DEET.

_____(parent signature)

DEPARTMENT OF PUBLIC HEALTH

THE CITY OF WATERBURY

CONNECTICUT

Dear Parent:

Connecticut Law recognizes the importance of good dental health for our school children. Periodic dental appraisal is required for all students before school entry and again in grades 6 and 10.

Please take this form to your dentist for completion and return it to your child's school nurse by September 15.

Thank you.

School Nurse

TO THE DENTIST: School _____

Name of Student_____Grade _____

1) ( ) Has had all necessary dental work completed.

2) ( ) Is under dental treatment.

3) ( ) Expected completion date _____.

4) ( ) Is not in need of dental work at this time.

_____ _____

Date Signature of Dentist

DH-1

Dear Pre-Kindergarten Parent/Guardian:

Your child is required to comply with the State of Connecticut mandates for school entry into Pre-Kindergarten. These requirements state that all students entering pre-school must have the following:

1. A completed physical examination on a state approved assessment form upon entry into the Pre-Kindergarten program. The physical exam must be completed within the current year and submitted to the school nurse by the first day of school.

2. 4 doses of DTaP (Diphtheria, Tetanus acellular Pertussis,) and 3 doses of IPV (Polio Vaccine)

3. 1 doses of MMR (Measles, Mumps, Rubella) on or after the first birthday.

4. 3 doses of the Hepatitis B vaccine. The last dose given on or after 24 weeks of age.

5. 1 dose of Varicella vaccine on or after the first birthday or must submit a physician's note confirming that the student has had the disease.

6. 1 dose of Haemophilus Influenzae Type b (Hib) vaccine on or after the first birthday.

7. 1 dose of Pneumococcal vaccine on or after the first birthday.

8. 1 dose of Influenza vaccine administered each year between August 1 – December 31st (2 doses separated by at least 28 days required for those receiving the vaccine for the first time). Children enrolling after March 31 during any given year are not required to meet this requirement until the following January.

9. 2 doses of Hepatitis A given six months apart, first dose on or after the first birthday.

0. The following is also a local **public school** requirement:
A normal lead test must be documented annually for pre-kindergarten students. If not provided on school entry, your child must have this test done within 8 weeks of starting school in order to remain enrolled.

Please make sure your child complies with these requirements or they will not be allowed to enter school in September.

Sincerely,

Michael J. Rokosky, M.D.
School Medical Advisor

ttached are the following forms:

The state approved physical examination form
Health questionnaire to obtain general health, family and immunization histories
Dental form to be completed by your child's dentist

order that the health program in the school may be planned with the best understanding of your child's health eds, please complete and return the attached forms to school as soon as possible.

****

is child will be examined by our family doctor. The attached report will be completed and returned to the school.

ave a scheduled an appointment on _____ with _____.
Date Physician

ou have any questions or difficulties in obtaining these requirements, please feel free to contact your school nurse assistance.

_____ _____
ld's Name **Grade** **Parent's Signature**

chool Forms/Pre K-Imm/PE 9/97; 3/00; 12/08; 3/11

Previous School Attended:					Child's Grade:		
Child's Name:				DOB: / /		☐ M	☐ F
Child's Home Address:				Home Phone			
Child Lives With :	☐ Both Parents	☐ Mother	☐ Father	☐ Guardian			

PARENT/GUARDIAN'S EMERGENCY CONTACT INFORMATION

1	Mother's Name	Mother's Cell Telephone Number	Mother's Place of Work Phone Number
2	Father's Name	Father's Cell Telephone Number	Father's Place of Work Phone Number
3	Guardian's Name	Guardian's Cell Telephone Number	Guardian's Place of Work Phone Number

IN CASE OF AN EMERGENCY OR ILLNESS PLEASE *PRINT* THE NAME/S OF ALL THOSE THAT YOU WOULD TRUST TO PICK-UP YOUR CHILD AT SCHOOL IN YOUR ABSENCE

	Name of Trusted Adult	Their Phone Number	Their Relationship to Your Child
1			
2			

PLEASE *PRINT* THE NAMES OF THIS CHILD'S BROTHERS/SISTERS THAT CURRENTLY ATTEND WATERBURY SCHOOLS

	Print Name of Sibling	DOB	School They Attend	Living at the Same Address?
1		/ /		☐ Yes ☐ No
2		/ /		☐ Yes ☐ No
3		/ /		☐ Yes ☐ No

STUDENT HEALTH ASSESSMENT RECORD PLEASE CIRCLE "Y" IF "YES" OR "N" IF "NO"

Any Health Concerns	Y	N	Hospitalizations/Emergency Room Visits	Y	N	Concussion	Y	N
Allergies to Food or Bee Stings	Y	N	Any Broken Bones or Dislocations	Y	N	Fainting or Blacking Out	Y	N
Allergies to Medications	Y	N	Any Muscle or Joint Injuries	Y	N	Chest Pain	Y	N
Any Other Allergies	Y	N	Any Neck or Back Injuries	Y	N	Heart Problems	Y	N
Any Daily Medications	Y	N	Problems Running	Y	N	High Blood Pressure	Y	N
Any Problems with Vision	Y	N	"Mono" Mononucleosis in this past year	Y	N	Bleeding More Than Expected	Y	N
Uses Glasses or Contacts	Y	N	Has ONE Kidney or Testicle	Y	N	Problems Breathing or Coughing	Y	N
Hearing Problems	Y	N	Excessive Weight Gain/Loss	Y	N	Smoking	Y	N
Speech Problems	Y	N	Dental: Braces, Caps, Bridges	Y	N	Asthma treatment (Past 3-years)	Y	N
FAMILY HISTORY:								
Has Any Relative Ever Have a Sudden Unexplained Death (Less Than 50-years old)				Y	N	Seizure Treatment (Past 2-years)	Y	N
Do Any Immediate Family Members Have High Cholesterol				Y	N	Diabetes	Y	N
				Y	N	ADHD/ADD	Y	N

PLEASE EXPLAIN ALL "YES" ANSWERS BELOW - FOR ILLNESSES, INJURIES, ETC., PLEASE LIST THE CHILD'S AGE & YEAR AT THAT TIME

IS THERE ANYTHING THAT YOU WANT TO DISCUSS WITH THE SCHOOL NURSE? EXPLAIN BELOW:

PLEASE LIST ALL MEDICATIONS THAT YOUR CHILD WILL NEED TO TAKE IN SCHOOL:

RELEASE OF INFORMATION STATEMENT: *I give permission for release and exchange of information on this form between the school nurse and the health care provider for confidential use in meeting my child's health and educational needs in school.*

PARENT/GUARDIAN SIGNATURE DATE

H: School Forms/Health Questionnaire 2013

READINESS INFORMATION:

STUDENT INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	DATE OF BIRTH mm/dd/yy

STREET ADDRESS	TOWN	ZIP CODE

GENDER MALE/FEMALE	RACE W-white B-black H-hispanic A-Asian O-other	PUBLIC/HUSKY HEALTH INSURANCE YES/NO	PRIVATE HEALTH INSURANCE YES/NO

GUARDIAN/PARENT SIGNATURE	DATE

OFFICE USE ONLY

SR ENTRY DATE	SR WITHDRAWAL DATE

FAMILY INCOME	FAMILY SIZE (including student)	CARE 4 KIDS Y/N