

East Hampton Nursery School
P.O. Box 135, 111 Main Street
East Hampton, CT 06424
(860) 267-2681

Directions for completing the registration packet:

In order to complete your child's registration process at East Hampton Nursery School without delay, it is important that you read the following directions and complete the packet in its entirety.

Application for Enrollment

The information on this page is critical for our records as well as a requirement for the state. Please note: you **MUST** have an emergency contact other than the parents that live locally and are able to be contacted in the event of an emergency or illness.

Class List Form

Picture Release Form

In addition to signing this form, please be sure to **circle** whether or not you give permission to have your child's photo taken and/or published.

Field Trip Permission Form

Pick Up Authorization Form

The first person on this list should be the person listed on the Application for Enrollment.

Authorization for the Administration of Medication by Child Day Care Personnel

Please be sure to return this form even if it does not apply to your child. If your child does not require medication, simply fill in your child's name and write N/A on the form. We need to have this on file for all students.

Authorization For Emergency Medical Care

Your child's name and your signature are required. Your physician's information is optional on this form.

Early Childhood Health Assessment Record

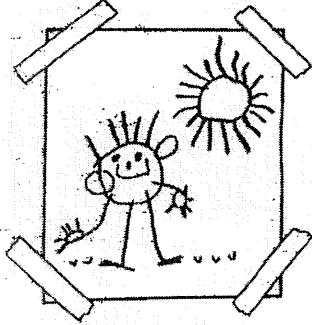
This two page form is also a state requirement. The first page is to be filled out by a parent and must be signed and dated at the bottom. The second page is to be filled out by your child's physician. Your child must have a current physical dated within the last year and all immunizations must also be current. These forms must returned with the rest of the packet on June 1st unless your child has a June, July or August birthday in which case the forms should be returned **as soon as the physical is completed**. Forms **MUST** be at school before the first day.

Parent Handbook Policies and Procedures

The Parent Handbook is available to be downloaded from our website:
www.easthamptonnurseryschool.com.

Sibling Information Form

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2011-2012
Application for Enrollment

Enrollment Date: _____

Name of Child: _____ Name Child Prefers: _____

Date of Birth: _____ Gender: Circle MALE or FEMALE

Child's Residence: _____

Name of Mother: _____ Email: _____

Mother's Address: _____

Mother's Home Phone #: _____ Cell / Business #: _____

Mother's Business Address: _____

Name of Father: _____ Email: _____

Father's Address: _____

Father's Home Phone #: _____ Cell / Business #: _____

Father's Business Address: _____

Emergency Contact: _____ Address: _____ Phone #: _____
(other than parent/guardian)

Cell #: _____

Family Physician: _____ Address: _____ Phone #: _____

Please check the session you desire:

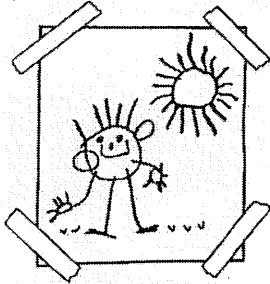
- _____ 3 Year Old Session on Tuesday & Thursday 9:00-11:30 a.m.
- _____ 3 Year Old Session on Tuesday & Thursday 12:15-2:45 p.m.
- _____ 4 Year Old Session on Monday, Wednesday & Friday 9:00-11:30 a.m.
- _____ 4 Year Old Session on Monday, Wednesday & Friday 12:15-2:45 p.m.

The cost of the 3 year old session is \$140.00 per month and the 4 year old session is \$170.00 per month.

• There is a \$50.00 non-refundable registration fee that is to accompany this application

Note: If one or both parents are not authorized to pick up their child from school, please notify us in writing prior to the first day of school. We also require a copy of the court order regarding custody.

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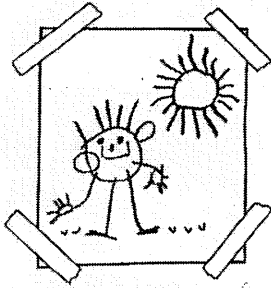
CLASS LIST FORM

_____ Please check here if you give permission to the Board of Directors at the East Hampton Nursery School to print your child's address and telephone number on a class roster to be distributed to classmates.

Parent Signature

Date

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PICTURE RELEASE FORM

Please circle the one that applies:

I do / I do not give permission to the Board of Directors at the East Hampton Nursery School to have photographs of my child, _____, taken.

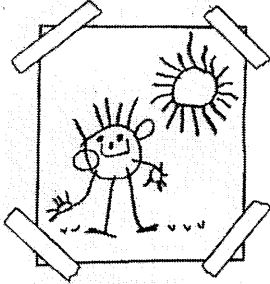
I also do / I also do not give permission to publish a photograph of my child with his / her name in the local newspapers (i.e. Middletown Press, Hartford Courant, Rivereast, Reminder News).

Parent Signature

Date

Rev. 1/08

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FIELD TRIP PERMISSION FORM

I give permission for my child, _____ to
participate in all field trips this year.

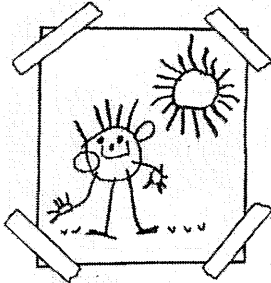
I understand that specific details about each field trip will be sent home prior
to each event.

Parent Signature

Date

Rev. 1/08

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PICK UP AUTHORIZATION FORM

I, _____, give permission to the following people to pick up my child, _____, from East Hampton Nursery School at any time. I understand that the individuals listed below must be prepared to show identification. I understand that the first person listed below must be my child's emergency contact as noted on the Application for Enrollment and he/she **must be a local resident.**

Name

Relationship

Phone #

(Emergency Contact)

1) _____ Home: _____
Cell: _____

2) _____

3) _____

Parent Signature

Date

**If possible, please notify the staff in advance if someone other than the parent will be picking up the child.

The State of CT requires this form to be on file regardless if your child is on medication. Please complete in its entirety if this applies, if you child does not take medication, please complete child's name and write N/A across form. Thank you!

Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse):

Name of Child _____ Date of Birth ___/___/___ Today's Date ___/___/___

Medication Name _____ Controlled Drug? YES NO

Dosage _____ Method _____ Time of Administration _____

Specific Instructions for Medication Administration _____

Medication Administration Start Date ___/___/___ Stop Date ___/___/___

Relevant Side Effects of Medication _____

Plan of Management for Side Effects _____

Known Food or Drug: Allergies? YES NO Reactions to? YES NO Interactions with? YES NO

If "yes" to any of the above, please explain _____

Prescriber's Name _____ Phone Number (____) _____

Prescriber's Address _____ Town _____

Signature _____

Parent/Guardian Authorization:

I request that medication be administered to my child as described and directed above and attest that **I have administered at least one dose of the medication to my child without adverse effects.**

Name of Day Care Program _____ Today's Date ___/___/___

Child's Name _____ Address _____ Town _____

Name of Parent/Guardian Authorizing Administration of Medication _____

Relationship to Child: Mother Father Guardian/Other explain: _____

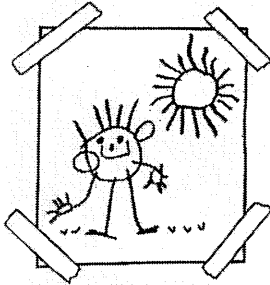
Address _____ Town _____ Phone Number (____) _____

Signature of Parent/Guardian Authorizing Administration of Medication _____

Name of Childcare Personnel Receiving Written Authorization and Medication _____

Title/Position _____ **Signature (in ink)** _____

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AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I hereby authorize emergency medical care for my child,

while in attendance at East Hampton Nursery School, if in the judgement of the staff, treatment is required for an injury. I also hereby authorize any treatment deemed necessary by the attending physician.

I understand that whenever possible, I will be notified prior to medical treatment of my child. Should prior notice prove impossible, I will be notified at the earliest possible time.

I understand that I am financially responsible for any expenses for medical care of transportation incurred on my child's behalf. The policy of East Hampton Nursery School in an extreme emergency is to call "911".

I prefer you attempt to contact:

Dr. _____ Phone # _____

My child is **allergic** to the following medications and anesthetics:

Parent Signature

Date



State of Connecticut

Early Childhood Health Assessment Record



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 I) which will also be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunization and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse, a physician assistant or the school medical advisor prior to entering an early childhood program in Connecticut.

Please print

Form with fields for Name of Child, Social Security Number, Birth Date, Sex, Address, Race/Ethnicity, Parent/Guardian, Home Phone Number, Work/Cell Phone Number, Early Childhood Program, Program Phone Number, Primary Health Care Provider, Preferred Hospital, Health Insurance Company/Number* or Medicaid/Number*.

* If applicable

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

Part I — To be completed by parent

Important: Complete Part I before your child is examined. Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left. (Explain all "yes" answers in the space provided below.)

- Yes No
1. Do you have any concerns about your child's general health, development or behavior?
2. Has your child been diagnosed with any chronic disease...
3. Does your child have any allergies...
4. Does your child take any medications...
5. Does your child have any problems with vision, hearing or speech...
6. Has your child had any hospitalization, operation, major illness or injury...
7. In the last 12 months, has your child experienced any difficulty with wheezing or excessive night coughing?
8. In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain...
9. Has your child had a dental examination in the last 12 months?
10. Would you like to discuss anything about your child's health with the child care provider or health consultant/coordinator?

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Blank lines for explaining "yes" answers.

I give permission for release of 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 and Date fields.

Part II — Health Evaluation

To the Health Care Provider: Please complete all sections and sign. Explain any screenings required by age but not conducted.

Child's Name _____
Birth Date (mm/dd/yy) _____
Date of History/Physical Exam (mm/dd/yy) _____

LENGTH/HEIGHT		WEIGHT		WT FOR HT/BMI	HEAD CIRCUMFERENCE ¹		BLOOD PRESSURE ²
IN/CM	%ILE	LB/KG	%ILE	%ILE	IN/CM	%ILE	/

Screening/Test Results				Immunization Record									
Screening Test	Result	Date	Abnormal/Comments	Vaccine (Month/Day/Year)									
				Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6				
Vision² Test type:				DTP									
Hearing³ Test type:				DTP/Hib									
Lead⁴ Risk: Yes/No				DTaP									
TB⁴ Risk: Yes/No				DT/Td									
Urinalysis (UA)⁴				OPV									
Anemia⁵ (HGB/HCT) Risk: Yes/No				IPV									
Developmental Assessment⁶ Test type:				MMR									
Has this child received dental care in the last 12 months?? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				Measles									
* Chronic Disease Assessment: Yes No Date of onset <input type="checkbox"/> <input type="checkbox"/> Asthma: <input type="checkbox"/> mild <input type="checkbox"/> moderate <input type="checkbox"/> severe <input type="checkbox"/> exercise induced <input type="checkbox"/> unclassified <input type="checkbox"/> <input type="checkbox"/> Diabetes: <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> <input type="checkbox"/> Anaphylaxis: <input type="checkbox"/> med. <input type="checkbox"/> food <input type="checkbox"/> insect <input type="checkbox"/> latex <input type="checkbox"/> <input type="checkbox"/> Seizures: Type _____ <input type="checkbox"/> <input type="checkbox"/> Other: Please specify _____				Rubella									
Minimum requirements: ¹ Up to 2 years; ² annual at 3 years; ³ annual at 4 years; ⁴ as needed; ⁵ 9-12 months; ⁶ each visit through 5 years; ⁷ annual at 2-3 years. Federal requirements (eg, Head Start, WIC) may vary. *Prior to Public School Entry: Same as above and Hgb/hct.				HIB									
				Hep B									
				Varicella									
				PCV									Pneumococcal conjugate vaccine
				Other Vaccines (Specify)									
				Disease Hx of above _____ (Specify) (Date mm/yy) (Confirmed by)									
				Exemption									
				Religious _____ Medical: Permanent _____ Temporary _____ Date _____									
				Recertify Date _____ Recertify Date _____ Recertify Date _____									

This child has the following problems which may adversely affect his or her educational experience:

Vision Auditory Speech/Language Physical Dysfunction Emotional/Social Behavior
 The child has a health condition which may require intervention at the program, e.g., seizures, allergies, asthma, anaphylaxis, special diet, long-term medication. *Specify:* _____

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

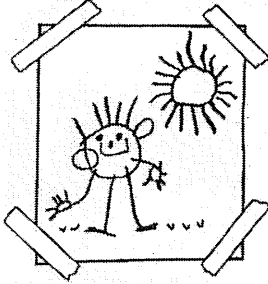
I would like to discuss information in this report with the early childhood provider and/or health consultant/coordinator.

Signature of health care provider	MD/DO NP PA	Name (Please type or print.)	Phone number
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Address: _____

Yes No Is this the child's Medical Home? Next Appointment (mm/yy): _____ Next Immunization Appointment (mm/yy): _____

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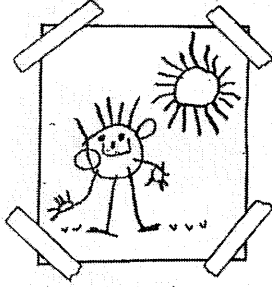
PARENT HANDBOOK POLICIES AND PROCEDURES

I, _____, parent/guardian of _____ have read, understand and agree to follow the policies and procedures within the East Hampton Nursery School Parent Handbook 2011-2012.

Parent Signature

Date

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SIBLING INFORMATION

Please list children in the family by order of birth:

Name of child	Birth date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Parent Signature

Date