PREK REGISTRATION

1. **Need Birth Certificate**

2. **Immunization Records from doctor**

3. **$200 Administration Fee (non-refundable)**

4. **Cut-off date - Oct. 31**

5. **Parent must return following:**
    a. **Registration form**
    b. **Parent Survey/Student Assessment form**
    c. **Physical form**

R: _____
ADMIN: _____

OUR LADY OF LOURDES SCHOOL
44 Cleveland Avenue
Milltown, NJ 08850
(732) 828-1951

PRE-K PROGRAM 4 YR. OLD
2010-2011

PUPIL _____ **SEX: [ ] female [ ] male**
Last Name First Middle In.

ADDRESS _____ **PHONE** _____
Number & Street City, State & Zip Code

PLACE OF BIRTH _____ **DOB** _____
City & State

REGISTERED PARISH _____
Parish and City

****

FATHER'S NAME _____ **OCCUPATION** _____
Last First

Place of Employment: _____ _____
Name Phone #

_____
Cell#

_____
Address

MOTHER'S NAME _____ **OCCUPATION** _____
Maiden Name First

Place of Employment _____ _____
Name Phone #

_____
Cell #

_____
Address

EMERGENCY: <u>OTHER THAN HOME</u> - preferably a neighbor or a local relative

_____ _____
Name Phone #

PHYSICIAN _____ _____
Name Phone #

****

ADMINISTRATIVE FEE: $200.00/family (Non-Refundable) **CUT-OFF DATE: OCTOBER 31**

3 HALF-DAY SESSIONS	**(M-W-F)**	**8:00 am - 11:00 am**	**$275. monthly**
3 FULL-DAY SESSIONS	**(M-W-F)**	**8:00 am - 2:00 pm**	**$395. monthly**
5 HALF-DAY SESSIONS	**(M-F)**	**8:00 am - 11:00 am**	**$330. monthly**
5 FULL-DAY SESSIONS	**(M-F)**	**8:00 am - 2:00 pm**	**$550. monthly**

<u>There are 10 equal tuition payments due on the first of each month, August through May</u>

O.L.O.L. PRE-KINDERGARTEN

PARENT SURVEY/STUDENT ASSESSMENT

STUDENT'S NAME_____ **DATE**_____

Fill out this achievement checklist as best you can. We do not expect your child to be proficient in these categories, but it will give us a beginning to better organize and plan for your child.

PLEASE INDICATE A FOR ALWAYS, S for SOMETIMES, N for NEVER.

1. _____Can use the toilet without help.
2. _____Puts on coat alone.
3. _____Buttons coat.
4. _____Zippers jacket.
5. _____Ties shoelaces.
6. _____Leaves parent with one goodbye.
7. _____Puts away toys when finished.
8. _____Jumps.
9. _____Skips.
10. _____Catches a ball.
11. _____Climbs steps.
12. _____Sits and listens to a story.
13. _____Puts puzzles together.
14. _____Can hold scissors.
15. _____Knows his/her name.
16. _____Writes his/her name.
17. _____Recognizes four basic shapes.
18. _____Can name colors.
19. _____Able to count 1 – 5.
20. _____Able to count 5 – 10.
21. _____Can write numbers.
22. _____Recognizes numbers.
23. _____Can write letters.
24. _____Recognizes letters.
25. _____Can match sound to letters.

Does your child have a pet?_____
Is your child right or left handed?_____
Is your child shy or fearful?_____
Does your child like to color/draw?_____
Is there anything else that we could benefit from knowing about your child?

_____

If your child attended pre-school before, how did he/she adjust to the situation?

_____

Would you be interested in participating as a

a) field trip chaperone_____
b) class parent_____
c) art class volunteer_____

Do you have any pre-school toys/equipment in good condition that you could donate to the program?

_____

THANK YOU FOR TAKING THE TIME TO HELP US HELP YOUR CHILD!

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health and Senior Services

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

Dear Parents and Guardians,

Our Lady of Lourdes School is going green!

The School Advisory Council recommended a policy, which Father Ed approved, that the School sends all non-confidential or sensitive notices, announcements or other information electronically. The purpose of this policy is to create economic savings to the School and its families through decreased paper purchases and also to promote environmental stewardship.

Toward this goal, we ask each family to submit an e-mail address that may be used to receive such information. All non-confidential information will also be available on our website, www.ololschoolnj.org under the "information tab" on the left side of the home page.

Thank you for your cooperation!

****

_____ Our family is willing to continue to help our school and the environment by receiving flyers via e-mail. Please use the email address that is currently on file with the school office.

_____ Our family is willing to help our school by receiving flyers via e-mail. Our e-mail address is: _____

Please PRINT legibly!

_____ At this time, our family is not willing to receive flyers via e-mail. We will contact the school as soon as this becomes an option.

Family Name: _____

Parent's Signature: _____ Date: _____