

St. Patrick's Preschool

Application for Admission

2011-2012



Accepting Children
Ages 2 ½ to 5 Years

Please Return Forms to
St. Patrick Catholic Church
Parish House
221 West Nelson Street
Lexington
(540) 463-6219

www.stpatrickspreschool.com

St. Patrick's Preschool

On the first day of school your child should bring the forms indicated below. Where documents, such as birth certificates, are requested, please bring the original and we will make copies in the office to keep in your child's file. Forms should be completed and signed by the parent (where applicable).

- Application for enrollment (unless already submitted)
- Birth Certificate (certified copy)
- Baptismal Certificate (if applicable)
- Prior program enrollment documentation (if applicable)
- Current Physical
- Immunization Record
- Emergency Treatment Authorization
- Medication Policy
- Picture Policy and Permission

St. Patrick's Preschool Agreement

This agreement is between St. Patrick's Preschool and the family of _____ beginning on _____ and ending on _____ will attend the following class: (Please circle)

<u>2 ½ year olds</u>	<u>3 year olds</u>	<u>4 year olds</u>
Tuesday & Thursday	Mon./Wed./Fri.	Monday - Friday
\$115	\$168	\$260

Optional extra days: (Please circle day(s) desired if applicable)

Monday Tuesday Wednesday Thursday Friday

The cost is _____ payable in advance on a weekly, biweekly, or monthly basis. Payments are due on the 1st of each month. I/We understand this contract may be amended at any time. A meeting will be held between St. Patrick's Preschool administration and the family to document changes. I/We understand and agree to the above statements.

Parent/Guardian Signature: _____
Date: _____

St. Patrick's Administrator: _____
Date: _____

St. Patrick's Preschool

The 1998 General Assembly passed legislation to help identify missing children in child day care settings. In order to comply with this law, please send the following information within 7 days of initial attendance. Thank you very much for your cooperation in this matter.

Name of Student:

Last	First	Middle
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Date of Birth: _____

Name of Last School Attended: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Parental Release:

I hereby give my permission for the above information to be released to St. Patrick's Preschool.

Parent Signature

Date

St. Patrick's Preschool - Part I HEALTH INFORMATION FORM

Part I to be completed by parents of guardians of entering students. Ref. Code of Virginia 22.1-270.1

Student's Name _____
Last First Middle

Student's Date of Birth _____ Sex _____ Number of children in Family: _____
State or Country of Birth _____ Student's Social Security # _____ or
ID# _____

Student's Address: _____ City: _____
State: _____ Zip: _____

Name of School: _____ Grade: _____

Name of Mother or Legal Guardian: _____

Home Phone: _____ Work Phone: _____

Name of Father or Legal Guardian: _____

Home Phone: _____ Work Phone: _____

In case of emergency – if parent or guardian cannot be contacted – contact the following:

1. Name _____ Complete Phone Number: _____

2. Name _____ Complete Phone Number: _____

Birth History (weight, premature, and any other problems at birth): _____

ALLERGIES (food, medicine, insect bites, and any other allergies): _____

Chronic, Recurring, and Special Health Conditions (Check all that apply and explain below)

- _____ Arthritis (rheumatoid)
- _____ Asthma
- _____ Attention-Deficit/Hyperactivity Disorder
- _____ Behavioral or Developmental Problems
- _____ Cerebral Palsy
- _____ Cystic Fibrosis
- _____ Dental Problems
- _____ Encopresis (involuntary discharge of stool)
- _____ Enuresis (involuntary discharge of urine)
- _____ Head or Spinal injury
- _____ Hearing Impairment
- _____ Heart Disease
- _____ Kidney Disease
- _____ Muscular Dystrophy
- _____ Seizures
- _____ Sickle Cell Disease (not trait)
- _____ Spina Bifida
- _____ Visual Impairment
- _____ Other:

Specialized Health Care Needed

List names of medical specialists or special clinics caring for your child: _____

Has your child ever been seen by a dentist? Yes ___ No ___ If yes, date of last appointment

Name of dentist: _____ . List all prescription and over-the-counter medications
taken regularly by your child: _____

Describe your child's operations and hospitalizations, if any (reason and date): _____

Describe any other important health-related information about your child: _____

St. Patrick's Preschool

Part II - PHYSICAL EXAMINATION REPORT

Student's Name _____

Last First Middle

Date of Birth: _____ Height: _____ Weight: _____ Head Circumference: _____ Blood Pressure: _____

Vision Screening

Distance visual acuity screening results, without correction: Right Eye 20/____ Left Eye 20/____ Both Eyes 20/____

Distance visual acuity screening results, with correction: Right Eye 20/____ Left Eye 20/____ Both Eyes 20/____

If performed, stereopsis screening results: Pass _____ Fail _____

Child to be rescreened? Yes _____, No _____ Child to be referred? Yes _____, No _____

Hearing

Hearing screening results: Right Ear _____ Left Ear _____ Equipment Used: _____

If performed, hearing evaluation results: Right Ear _____ Left Ear _____

If indicated, Tympanogram: Normal _____ Abnormal _____

Child to be rescreened? Yes _____, No _____ Child to be referred? Yes _____, No _____

Systems Examination		Examined	Not Examined	Comments About Findings
General Appearance				
Nutritional Status				
Posture/ Motor Behavior				
Skin				
Head				
Eyes:	External Fundi			
Ears:	External and Canal Tympanic Membrane			
Nose				
Throat				
Mouth/Teeth				
Neck				
Heart				
Lungs				
Abdomen				
Genitalia (Tanner Stage)				
Bones, Joints, Muscles				
Neurological				
Estimated Developmental Level:	Cognitive Development			
	Speech/Language Development			
	Social/Emotional Development			
	Health Behaviors/Health Habits			
Other:				

Summary of abnormal physical findings, if any: _____

Medical diagnoses: _____

Describe specifically what, if any, conditions are found that would identify the child as having a disability, including conditions that might require (1) educational evaluation, (2) environmental adjustment, or (3) activity limitation: _____

Assessment: _____

Recommendations and referrals made, if any: _____

Physician's Address: _____ City: _____ State: _____ Zip: _____

Physician's Name (print) _____ Phone No.: _____

Signature of physician: _____ Date: _____

St. Patrick's Preschool
PERMISSION FOR EMERGENCY CARE

To be completed by parent/guardian at beginning of school year

Name of Student _____ Grade _____

Address _____
Street City Zip

Student's Date of Birth _____ Male ___ Female ___ Home Phone _____

Father's Name _____ Work Phone _____ Hours _____

Mother's Name _____ Work Phone _____ Hours _____

Names(s) of Person(s) or Agency having legal custody*

Address _____ Home Phone _____

Child's Allergies (if any)

Child's Doctor Phone

Outstanding medical history (ie: diabetes, heart disease, contact lenses, hearing aids, etc.)

Medication child is taking _____

Date of last tetanus shot _____

Insurance company _____ Policy No. _____

Persons NOT authorized to pick up child from school (*if parent)

Emergency contacts: In the event a parent cannot be reached, please give name and phone number of two persons who could pick up and take home your child in a timely manner.

1. _____
Name Relationship Phone

2. _____
Name Relationship Phone

I agree to pick up my sick or injured child in a timely manner when contacted. If I cannot be reached, the above emergency contacts can be called to pick up my child. Additionally, if I cannot be contacted in an emergency, the school has my permission to take my child to the emergency room of the nearest hospital and I hereby authorize its medical staff to provide treatment which a physician deems necessary for the well-being of my child.

*Appropriate custody paperwork must be attached.

St. Patrick's Preschool Medication Policy

St. Patrick's staff will not administer over the counter medication to students.

St. Patrick's will administer prescription medication if the scheduled time for that medication falls during school hours. Whenever possible, medication should be given prior to or after school. Written authorization from the child's physician and parents is required before medication can be administered.

If the physician and parents request that medication be given, the following rules apply:

1. The medication authorization shall be available to staff during the entire time it is in effect.
2. Medications shall be labeled with the child's name, the name of the medication, the dosage amount and the times to be given.
3. Medications shall be in the original container with the prescription label or directions attached.
4. When needed, medications shall be refrigerated. Medications must be stored separately from food.
5. Medications will be stored in a locked place which is inaccessible to children.
6. A medication record of administration will be kept and signed by two staff members to assure proper administration.
7. The record of medication administration shall include the following:
 - A. Name of child receiving medication.
 - B. Amount and type of medication administered.
 - C. Signature of staff member distributing medication and signature of one other staff member as a witness.
 - D. Description of any adverse reaction.
 - E. Description of any medication or administration error.
8. Parents shall be informed immediately of any adverse reaction to medication or any error in administration.
9. Medication shall be returned to the parents as soon as the medication is no longer being administered.

**St. Patrick's Preschool
Day Care Medication Permission Sheet**

Child's Name: _____ Address: _____
Name of Provider: _____
Name of Medication: _____
Condition for which prescribed: _____
Possible side effects: _____

INSTRUCTIONS:

Dosage Amount: _____ Begin Date: _____ End Date: _____
Times of day to be administered: _____
Date: _____ Signature _____
Parent
Address: _____
Phone: _____

IF PRESCRIPTION:

Pharmacy: _____ Phone: _____ RX NO: _____

Fill in date, time and initials whenever medication is dispensed

Monday Tuesday Wednesday Thursday Friday

Medication was returned to parents: _____
or Medication was disposed of: _____

Parent's Signature: _____

Provider's Signature: _____

**St. Patrick's Preschool
Photo Release Form**

I, being the parent/guardian of _____
hereby consent that the videotape, photograph, motion
picture film in which the above child may appear, and/or
audio recording of said child's voice may be used by St.
Patrick's Preschool, their assigns or successors, in
whatever way they desire.

Furthermore, I hereby consent that such photographs, films,
recordings, and the plates and/or tapes from which they are
made shall be their property, and they shall have the right
to sell, duplicate, reproduce, and make other uses of such
photographs, films recordings, plates and tapes as they may
desire free and clear of any claim whatsoever on my part.

In witness whereof I have hereunto set my hand, in the
state of Virginia, on the date of: _____

Child's Name: _____

Parent/Guardian: _____
Signature

Address: _____

