

# SSU Preschool Program

## Application for Enrollment

Thank you for your interest in the Salem State University Preschool Program! Please complete all forms at home and bring this completed packet to registration. All forms must be on file and child must visit the Preschool before they can attend. Registration is by appointment. Contact us to schedule your tour as well. We look forward to seeing you! Enrollment forms are updated 2-3 times a year, or as needed.

Your appointment time is on \_\_\_\_\_ at \_\_\_\_\_ (time).

New Child: \_\_\_\_\_ Returning Child: \_\_\_\_\_

Term: Fall \_\_\_\_\_ Spring \_\_\_\_\_ Summer \_\_\_\_\_ Year \_\_\_\_\_

Print Please

Child's Name: \_\_\_\_\_  
Last First Middle

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Allergies: \_\_\_\_\_

- Individual Health Care Plan on file
- Partial/Non-Immunization Record Documentation on file

Special Diet: \_\_\_\_\_

<input type="checkbox"/> FT SSU Student	<b>Parent Category:</b>
<input type="checkbox"/> PT SSU Student	If Student, major: _____
<input type="checkbox"/> SSU Faculty	If Faculty, department: _____
<input type="checkbox"/> SSU Staff	If Staff, department: _____
<input type="checkbox"/> SSU Alumni	
<input type="checkbox"/> Community	

### Parent/Legal Guardian information:

Parent name: \_\_\_\_\_

Parent name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Tel. No.: (\_\_\_\_\_) \_\_\_\_\_

Home Tel. No.: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone No.: (\_\_\_\_\_) \_\_\_\_\_

Cell Phone No.: (\_\_\_\_\_) \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_

\_\_\_\_\_ Yes, add my name to the SSU Preschool Listserv.

Listserv is an email list of Preschool parents and teachers to share information, post notices, and get reminders, post questions and ideas.

**CHILD INFORMATION FORM**  
(please print)

**Please attach a recent photo of your child here.**  
**Very important – EEC requirement**

Date of admission \_\_\_\_\_

Age at admission \_\_\_\_\_

Child's name: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Place of birth: \_\_\_\_\_

Primary language of child: \_\_\_\_\_ Language spoken in the home: \_\_\_\_\_

Cultural habits/family issues that may affect the child's behavior: \_\_\_\_\_

Special Needs of parents (inability to climb stairs, lift child, etc.): \_\_\_\_\_

Transportation arrangements to and from the Preschool \_\_\_\_\_

**Parent/Legal Guardian information:**

Parent name: \_\_\_\_\_

Parent name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Tel. No.: \_\_\_\_\_

Home Tel. No.: \_\_\_\_\_

Cell Phone No.: \_\_\_\_\_

Cell Phone No.: \_\_\_\_\_

**Persons living in the household/relationship to child (older and/or younger siblings, grandparents, etc.):**

\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_

Persons who will care for the child when he/she is sick: \_\_\_\_\_

**Business address:**

Parent- Name of Business \_\_\_\_\_

Tel. No. \_\_\_\_\_

Address \_\_\_\_\_

Hrs. at Work \_\_\_\_\_

Parent - Name of Business \_\_\_\_\_

Tel. No. \_\_\_\_\_

Address \_\_\_\_\_

Hrs. at Work \_\_\_\_\_

*Child Information Continued*

**If Parents Cannot Be Contacted, Notify:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Tel. No. \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Tel. No. \_\_\_\_\_

**Child's Usual Source of Medical Care:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_

**Child's Usual Source of Dental Care:**

Name \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_

**Child's Health Insurance**

\_\_\_ **My child** \_\_\_\_\_ **is insured by the following:**

Name of Insurance Plan: \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber's Name (on insurance card): \_\_\_\_\_

Employer/Company: \_\_\_\_\_

\_\_\_ **My child** \_\_\_\_\_ **is not insured.**

**Identifying Information (required by the Office for Early Education and Care)**

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Sex: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Race: \_\_\_\_\_

Ethnicity: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

**Important Court Records:**

Copies of any custody agreements, court orders, and or restraining orders pertaining to child.

**Parent's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# AUTHORIZATION AND CONSENT FORM

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child \_\_\_\_\_.

However, if I cannot be reached, I hereby authorize the Salem State University Preschool Program to transport my child to the North Shore Children's or Salem Hospital (the nearest hospital) and to secure for my child the necessary medical treatment.

I understand that the teachers in the Preschool are trained in the basics of First Aid and CPR and I authorize them to give my child First Aid when appropriate.

I understand that upon each arrival and departure, I and the people I authorize are required to sign in and out of the preschool.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

I hereby authorize the Salem State University Preschool to release my child to the following persons (other than parents, in order to be contacted):

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_

Tel. No. \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

At this time, I do not have any other persons authorized to pick up my child.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

SSU Preschool Program

Child's Name \_\_\_\_\_  
(first and last name)

**Off-Site Activities Permission Form**

Section 102 CMR 7.34

I \_\_\_\_\_, give permission for my child to walk accompanied by  
(parent/guardian's name)  
teachers to the following locations (as part of classroom activities):

1. Forest River Conservation Area
2. Walk around South Campus area- upper and lower levels
3. Walk to South Campus Gym and use facility

The children will learn pedestrian safety by role modeling and verbal reinforcement. Designated teachers will supervise the front of the line and end of the line. Children will be counted on a regular basis as teacher requires.

You have my permission to take \_\_\_\_\_ on walking trips that the SSU Preschool Program plans.  
(child's name)

I understand that I will be notified in writing of all trips requiring transportation in advance. I also understand that all necessary precautions will be taken to ensure his or her safety, and I will not hold the SSU Preschool Program responsible for any accident, which may occur on such a trip.

**Parent/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

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**Salem State University Preschool Program Transportation Plan**  
102CMR 7.12 (1)

*Parents are advised to follow State Law requirements on appropriate car seat and seat belt laws for children and adults. No child will be left alone in a vehicle unsupervised by an adult.*

My child will arrive at the SSU Preschool Program by:  
\_\_\_\_ Parent Drop Off by Car  
\_\_\_\_ Supervised Walk (Who \_\_\_\_\_ )  
\_\_\_\_ Other (Describe \_\_\_\_\_ )

My Child will depart from the SSU Preschool Program by:  
\_\_\_\_ Parent Pick Up by Car  
\_\_\_\_ Supervised Walk (Who \_\_\_\_\_ )  
\_\_\_\_ Other (Describe \_\_\_\_\_ )

**Parent/Guardian Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

### EMERGENCY CARD INFORMATION

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Please print neatly

Child's Home Address: \_\_\_\_\_  
\_\_\_\_\_ Phone #: \_\_\_\_\_

#### INSTRUCTIONS TO REACH PARENT/GUARDIAN

1. \_\_\_\_\_ cell # \_\_\_\_\_  
(Name, Address, Phone #)

2. \_\_\_\_\_ cell # \_\_\_\_\_  
(Name, Address, Phone #)

#### PEDIATRICIAN OR SOURCE OF HEALTH CARE

1. \_\_\_\_\_  
(Doctor's Name, Address, Phone #)

#### EMERGENCY CONTACT PERSON(S) IF PARENT CAN'T BE REACHED (in order to be contacted)

1. \_\_\_\_\_  
(Name, Address, Phone #)

2. \_\_\_\_\_  
(Name, Address, Phone #)

#### MEDICAL EMERGENCY TREATMENT

I hereby give **Salem State University Preschool Program** permission to administer basic first aid and/or CPR to my child \_\_\_\_\_ and/or take my child \_\_\_\_\_,  
(Name) (Name)

to a hospital for medical treatment when I cannot be reached or when delay would be dangerous to my child's health.

\_\_\_\_\_  
(Parent Signature)

\_\_\_\_\_  
(Date)

#### INSURANCE INFORMATION

Name of Insurance Plan \_\_\_\_\_ Policy # \_\_\_\_\_

Subscriber's Name on card \_\_\_\_\_

Employer/ Company \_\_\_\_\_

## Salem State University Preschool Program

Date \_\_\_\_\_ Summer \_\_\_\_\_

Parent's Name \_\_\_\_\_ Child's Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
Street City Zip

Email Address \_\_\_\_\_ @ \_\_\_\_\_ Cell phone (\_\_\_\_) \_\_\_\_\_

Check one: Student: \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time Day \_\_\_\_\_ Part-time Night  
 \_\_\_\_\_ SSU Faculty \_\_\_\_\_ SSU Staff \_\_\_\_\_ SSU Alumni \_\_\_\_\_ Community

Student ID: \_\_\_\_\_

The following schedule is to be filled out by *SSU students and faculty only*. Please fill in appropriate time slots with **CLASS TIME, COURSE TITLE, and ROOM/BUILDING.**

Community parents need only to complete **ARRIVAL** and **DEPARTURE** times.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Time					
Course					
Bldg/Rm					
Time					
Course					
Bldg/Rm					
Time					
Course					
Bldg/Rm					
Time					
Course					
Bldg/Rm					

Arrival – 8	Arrival – 8	Arrival – 8	Arrival – 8	Arrival - 8
Departure – 1	Departure – 1	Departure – 1	Departure – 1	Departure – 1
Total Hours – 5	Total Hours – 5	Total Hours – 5	Total Hours – 5	Total Hours – 5

Total Number of Hours: \_\_\_\_\_

Full 6 week program:

5 days= \$1050  
 3 days= \$630  
 2 days= \$420

# Salem State University Preschool Program

Date \_\_\_\_\_ Fall \_\_\_\_\_ Spring \_\_\_\_\_

Parent's Name \_\_\_\_\_ Child's Name \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_  
 Street City Zip

Email Address \_\_\_\_\_ @ \_\_\_\_\_ Cell phone \_\_\_\_\_

Check one: Student: \_\_\_\_\_ Full-time \_\_\_\_\_ Part-time Day \_\_\_\_\_ Part-time Night \_\_\_\_\_  
 \_\_\_\_\_ SSU Faculty \_\_\_\_\_ SSU Staff \_\_\_\_\_ SSU Alumni \_\_\_\_\_ Community \_\_\_\_\_

Student ID: \_\_\_\_\_

The following schedule is to be filled out by *SSU students and faculty only*. Please fill in appropriate time slots with **CLASS TIME, COURSE TITLE, and ROOM/BUILDING.**

Community parents need only to complete **ARRIVAL** and **DEPARTURE** times.

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
Time					
Course					
Bldg/Rm					
Time					
Course					
Bldg/Rm					
Time					
Course					
Bldg/Rm					
Time					
Course					
Bldg/Rm					
	Arrival – Departure –	Arrival – Departure –	Arrival – Departure –	Arrival – Departure –	Arrival – Departure –

**Block Enrollment**

SSC Students will receive 10% discount from the rates below

Community members will be charged an additional 5%.

**Hours of Operation**

7:30 a.m. -5:30 p.m.

Monthly rates are calculated by multiplying the weekly rate by 4

**Core Academic Day**

8:00 a.m. -4:00 p.m.

Number of Days	8:00-4:00		8:00-12:00		1:00-4:00	
	weekly	monthly	weekly	monthly	weekly	monthly
5	\$ 240.00	\$ 960.00	\$ 120.00	\$ 480.00	\$ 90.00	\$ 360.00
4	\$ 208.00	\$ 832.00	\$ 104.00	\$ 416.00	\$ 78.00	\$ 312.00
3	\$ 168.00	\$ 672.00	\$ 84.00	\$ 336.00	\$ 63.00	\$ 252.00
2	\$ 120.00	\$ 480.00	\$ 60.00	\$ 240.00	\$ 45.00	\$ 180.00

Early Drop Off:			
7:30-8:00			
Days	weekly	monthly	
5	\$ 35.00	\$ 140.00	
4	\$ 28.00	\$ 112.00	
3	\$ 21.00	\$ 84.00	
2	\$ 14.00	\$ 56.00	

Late Pick Up			
4:00-5:30			
Days	weekly	monthly	
5	\$ 60.00	\$ 240.00	
4	\$ 48.00	\$ 192.00	
3	\$ 36.00	\$ 144.00	
2	\$ 24.00	\$ 96.00	

Monday	Tuesday	Wednesday	Thursday	Friday
<input type="checkbox"/> 7:30- 8:00 (0.5) Early Drop Off	<input type="checkbox"/> 7:30- 8:00 (0.5) Early Drop Off	<input type="checkbox"/> 7:30- 8:00 (0.5) Early Drop Off	<input type="checkbox"/> 7:30- 8:00 (0.5) Early Drop Off	<input type="checkbox"/> 7:30- 8:00 (0.5) Early Drop Off
<input type="checkbox"/> 8:00-4:00 (8.0) Core Academic Day	<input type="checkbox"/> 8:00-4:00 (8.0) Core Academic Day	<input type="checkbox"/> 8:00-4:00 (8.0) Core Academic Day	<input type="checkbox"/> 8:00-4:00 (8.0) Core Academic Day	<input type="checkbox"/> 8:00-4:00 (8.0) Core Academic Day
Actual Drop Off:	Actual Drop Off:	Actual Drop Off:	Actual Drop Off:	Actual Drop Off:
Actual Pick Up:	Actual Pick Up:	Actual Pick Up:	Actual Pick Up:	Actual Pick Up:
<input type="checkbox"/> 8:00-12:00 (4.0) Morning Block	<input type="checkbox"/> 8:00-12:00 (4.0) Morning Block	<input type="checkbox"/> 8:00-12:00 (4.0) Morning Block	<input type="checkbox"/> 8:00-12:00 (4.0) Morning Block	<input type="checkbox"/> 8:00-12:00 (4.0) Morning Block
<input type="checkbox"/> 1:00 -4:00 (3.0) Afternoon Block	<input type="checkbox"/> 1:00 -4:00 (3.0) Afternoon Block	<input type="checkbox"/> 1:00 -4:00 (3.0) Afternoon Block	<input type="checkbox"/> 1:00 -4:00 (3.0) Afternoon Block	<input type="checkbox"/> 1:00 -4:00 (3.0) Afternoon Block
<input type="checkbox"/> 4:00-5:30 (1.5) Late Pick Up	<input type="checkbox"/> 4:00-5:30 (1.5) Late Pick Up	<input type="checkbox"/> 4:00-5:30 (1.5) Late Pick Up	<input type="checkbox"/> 4:00-5:30 (1.5) Late Pick Up	<input type="checkbox"/> 4:00-5:30 (1.5) Late Pick Up
Actual Pick Up:	Actual Pick Up:	Actual Pick Up:	Actual Pick Up:	Actual Pick Up:

Date \_\_\_\_\_ Fall \_\_\_\_\_ Spring \_\_\_\_\_

Parent Name: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Monthly Rate	
Student Discount (10%)	
Community Increase (5%)	
Total	

## The Preschool Program

### DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION

Our program does not exclude children with special needs if we can provide a safe and developmentally appropriate environment. The following information is requested to help us plan care for your child.

Child's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

### DEVELOPMENTAL HISTORY

Type of birth: \_\_\_\_\_

Age began sitting: \_\_\_\_\_ crawling: \_\_\_\_\_ walking: \_\_\_\_\_ talking: \_\_\_\_\_

Age weaned from breast/bottle: \_\_\_\_\_

Any speech difficulties? Explain. \_\_\_\_\_

Special words to describe needs? \_\_\_\_\_

Disability or special needs of child (conditions, behaviors, etc.) no \_\_\_\_\_ yes \_\_\_\_\_

If yes, please describe: \_\_\_\_\_

*(If Needed, Complete Individual Health Care Plan and Authorization for Release of Information Form)*

### HEALTH

Serious illness and/or hospitalizations: \_\_\_\_\_

Special physical conditions, disabilities, or allergies: \_\_\_\_\_

Does your child take any medication daily? If so, please explain: \_\_\_\_\_

### EATING HABITS

Special characteristics or difficulties: \_\_\_\_\_

Favorite foods: \_\_\_\_\_ Foods refused: \_\_\_\_\_

Child eats with: hands \_\_\_\_\_ spoon \_\_\_\_\_ fork \_\_\_\_\_

Usual eating schedule: \_\_\_\_\_

**TOILET HABITS**

How does child indicate bathroom needs? (Include special words): \_\_\_\_\_

\_\_\_\_\_

Is child ever reluctant to use the bathroom? \_\_\_\_\_

Does child have accidents? \_\_\_\_\_

Does child wear diapers? daytime \_\_\_\_\_ nighttime \_\_\_\_\_

Does child wear pull-ups? daytime \_\_\_\_\_ nighttime \_\_\_\_\_

**SLEEPING HABITS**

Does child become tired or nap during the day? How long? \_\_\_\_\_

When does child go to bed at night? \_\_\_\_\_ and get up in the morning? \_\_\_\_\_

Describe any special characteristics, needs, or bedtime routines (stuffed animal, story, songs, etc.):

\_\_\_\_\_

Does your child sleep: in a bed? \_\_\_\_\_ in a crib? \_\_\_\_\_

*Please note: The American Academy of Pediatrics has determined that placing a baby on his/her back to sleep reduces the risk of Sudden Infant Death Syndrome (SIDS). SIDS is the sudden and unexplained death of a baby under one year of age. If your child does not usually sleep on his/her back, please contact your pediatrician immediately to discuss the best sleeping position for your baby. Please also take the time to discuss your child's sleeping position with your caregiver.*

**SOCIAL RELATIONSHIPS**

How would you describe your child socially? \_\_\_\_\_

\_\_\_\_\_

Previous experience with other children: where \_\_\_\_\_ when \_\_\_\_\_

Is this your child's first formal group experience? yes \_\_\_\_\_ no \_\_\_\_\_

If not, list school and date attended: school \_\_\_\_\_ date \_\_\_\_\_

Reaction to strangers: \_\_\_\_\_

Ability to play alone: \_\_\_\_\_

Favorite toys and activities: \_\_\_\_\_

\_\_\_\_\_

Fears (the dark, animals, rough children, loud noises, etc.): \_\_\_\_\_

How do you comfort child? \_\_\_\_\_

How do you discipline child? \_\_\_\_\_

Describe your child's schedule on a typical day: \_\_\_\_\_

\_\_\_\_\_

*Developmental History continued*

What would you like your child to gain from this preschool experience? \_\_\_\_\_

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What learning experiences and educational goals do you have for your child? \_\_\_\_\_

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Is there anything else you would like us to know about your child? \_\_\_\_\_

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Did someone refer you to the SSU Preschool?    yes \_\_\_\_\_    no \_\_\_\_\_

If yes, who? \_\_\_\_\_

If no, how did you hear about the program? \_\_\_\_\_

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Parent's Signature \_\_\_\_\_    Date \_\_\_\_\_

**SSU Preschool Program**

Child's name \_\_\_\_\_ DOB \_\_\_\_\_ Current age \_\_\_\_\_  
months years

**SLEEP INFORMATION**

1. How many hours of sleep does your child receive on an average each night?  
\_\_\_\_\_ 10-12 hour's \_\_\_\_\_ 8-10 hours \_\_\_\_\_ 6-8 hours \_\_\_\_\_ less than 6 hours
2. Does your child wake up during the night on a regular basis? If no skip, to # 7  
\_\_\_\_\_ Yes \_\_\_\_\_ No
3. If yes, approximately, how many times during the night? \_\_\_\_\_
4. How long is your child up during these waking times? \_\_\_\_\_
4. Describe what your child does during these waking times?
5. What strategies do you use to get your child back to sleep?
6. Do you feel your child has a sleeping problem? \_\_\_\_\_ yes \_\_\_\_\_ no  
  
If yes, have you discussed this with your pediatrician?
7. Do you feel your child's lack of sleep during the night affects his/her behavior during the day? \_\_\_\_\_ yes \_\_\_\_\_ no
8. Does your child nap during the day? \_\_\_\_\_ yes- most days \_\_\_\_\_ no \_\_\_\_\_ sometimes
9. If yes, how many hours does child nap and approx at what times?  
  
regular time of nap \_\_\_\_\_ am-for \_\_\_\_\_ hrs  
\_\_\_\_\_ pm-for \_\_\_\_\_ hrs
10. Additional comments/questions

**Please complete the questionnaire below. Mark the number which best describes how often your child's recent and current behavior reflects the scale from 1 – 6.**

Child's Name \_\_\_\_\_

Parent(s) completing forms \_\_\_\_\_ Date \_\_\_\_\_

1 = almost never  
4 = usually does

2 = rarely  
5 = frequently

3 = usually does not  
6 = almost always

My child...

\_\_\_\_\_ is moody for more than a few minutes when corrected or disciplined.

\_\_\_\_\_ seems not to hear when involved in a favorite activity.

\_\_\_\_\_ can be coaxed out of a forbidden activity.

\_\_\_\_\_ runs ahead when walking with a parent.

\_\_\_\_\_ laughs and smiles when playing.

\_\_\_\_\_ moves slowly when working on a project or activity.

\_\_\_\_\_ responds intensely to disapproval.

\_\_\_\_\_ needs a period of adjustment to get used to change in school or home.

\_\_\_\_\_ enjoys games that involve running or jumping.

\_\_\_\_\_ is slow to adjust to change in household rules.

\_\_\_\_\_ has bowel movements about the same time each day.

\_\_\_\_\_ is willing to try new things.

\_\_\_\_\_ sits calmly while watching television or listening to music.

\_\_\_\_\_ leaves or wants to leave the table during mealtime.

\_\_\_\_\_ changes in plans bother the child.

\_\_\_\_\_ notices minor changes in parents dress or appearance (clothing, hair).

\_\_\_\_\_ responds to mild disapproval by the parent (frowns, shakes head, etc.).

\_\_\_\_\_ settles arguments with playmates within a few minutes.

\_\_\_\_\_ shows strong reaction to things, both positive and negative.

\_\_\_\_\_ has trouble leaving parent(s).

\_\_\_\_\_ falls asleep as soon as he/she is put to bed.

\_\_\_\_\_ moves about actively when he/she explores a new place.

\_\_\_\_\_ likes to go to new places rather than familiar ones.

\_\_\_\_\_ sits quietly while waiting.

- Continued on next page-

1 = almost never  
4 = usually does

2 = rarely  
5 = frequently

3 = usually does not  
6 = almost always

My child...

- \_\_\_\_\_ spends over an hour reading or looking at books.
- \_\_\_\_\_ learns new things at his/her level quickly and easily.
- \_\_\_\_\_ smiles or laughs when he/she meets visitors at home.
- \_\_\_\_\_ is easily excited by praise.
- \_\_\_\_\_ is outgoing with strangers.
- \_\_\_\_\_ fidgets when he/she is has to stay still.
- \_\_\_\_\_ says he/she is bored with toys or games.
- \_\_\_\_\_ is annoyed at interrupting play to comply with parental requests.
- \_\_\_\_\_ practices an activity until he/she masters it.
- \_\_\_\_\_ eats about the same amount at dinner from day to day.
- \_\_\_\_\_ shows an interruption of behavior when unusual notices sound (sirens, thunder, etc.).



## The Preschool Program Contract

Please read the following and sign **two copies**: one copy for the Preschool and one for your records.

I hereby agree to and understand the following policy:

1. To give the Preschool fourteen days written notice in the event that I will need to withdraw my child. If I fail to comply with this requirement, I will be charged two (2) weeks tuition to cover any monetary loss incurred by the Preschool.
2. To give the Preschool Director any changes in my child's schedule by making an appointment at the Preschool Office two (2) weeks prior to the effective change in schedule.
3. To pay a non-refundable registration fee of \$50.00 per year, per child, made payable to SSU Preschool. NO CASH. Payable at registration.
4. Fees are based on a weekly rate and **no tuition refunds** due to illness, inclement weather, labor strikes, power and/or water outages, holiday closings or other legitimate conditions beyond the control of the University or the Preschool.
5. To pay tuition by check payable to SSU Preschool due on the first of each month unless specified differently. **A late fee of \$25.00 will be charged to me if my tuition is seven (7) calendar days late.** After 30 days, failure to pay will result in termination unless a payment plan is negotiated.
6. An **overtime charge of \$10.00 for every fifteen (15) minutes late** in picking up my child. Payment is due immediately on pick up and child cannot return until fee is paid. (Lateness will be judged on the Preschool clock.)
7. Charges for additional pre-approved **extra hours** will be computed by parents and added to the monthly tuition check.
8. To give a minimum of four (4) hours a month on one of the Parent Committees (except during the Summer Program). A description of each committee is included in the Parent Handbook. I will select a committee within seven (7) days after my child is enrolled.
9. I have received a copy of the Parent Handbook and agree to abide by all the rules and regulations.
10. I understand the policy to keep my child at home according to the Preschool Health Care Policy. Children too sick to participate in full program (indoor and outdoor) need to be kept at home. **Parents are to call the Preschool by 7:45 A.M. should the child not be attending. (978) 542-6409 – Preschool Number**
11. To notify the staff when my child is ill or any family member has a contagious disease.
12. To provide morning and afternoon snack (following nutritional guidelines), a complete set of **labeled extra clothes, a recent photo**, and to send each day a rest matt for rest time (12:30 – 1:00) purchased through Kaplan item #46905 [www.kaplanco.com](http://www.kaplanco.com)..
13. To provide information on how to contact me in an emergency situation (including address, phone number, employment, and other emergency information) which **I will update when changes occur and every four months.**
14. I give authorization for Preschool Director, Lead Teacher, Teacher and designated Assistant Teachers to have access my child's records, including health information on file in his/her folder.

*Contract Continued*

15. I give permission to print parent name, \_\_\_\_\_, address, and phone number for the Preschool Directory. (Child's name will not be included.)
16. To notify a teacher and sign in and out every time I, or someone I authorize, enters the Preschool to drop off or pick up my child.
17. To discuss any concerns I may have with the Director, Supervising Lead Teacher or Teacher.
18. I will be asked for written permission for each field trip which may be taken by the Preschool.
19. I understand that in the case of inclement weather or at the discretion of the Lead Teacher, the Preschool staff may walk my child to the South Campus Gymnasium rather than hold outdoor play.
20. I will submit all required registration forms including the School Health Form before my child can attend, and follow up on any abnormal tests.
21. To obtain health assessments for my child annually (required by the Preschool, the NAEYC, and the American Academy of Pediatrics). **School health forms and immunization records must be updated annually to meet requirements.**
22. To notify the Preschool Director when my child is scheduled for routine health visits, and obtain a health form and immunization record to complete and return. My child must be fully immunized or I will provide religious or medical exemption documentation. I understand my child will be excluded immediately if a vaccine preventable disease, to which my child is susceptible, occurs within the program.
23. To cooperate with the Supervising Lead Teacher in the follow up of any medical, dental, or developmental needs of my child.
24. To complete a medication consent form when requesting medication administration.
25. As a parent, I will be provided with information, either verbally or in writing, about my child's development and learning on at least a quarterly basis and with written reports at least two times per year.
26. I understand that my child's Lead Teacher will conduct a developmental screening within three months of enrollment and that the results will be shared with me.
27. I understand that the Preschool will keep ongoing assessments of my child as an integral part of the Program. Assessments are gathered through a variety of methods including observations, checklists, and anecdotal records; all information gathered therein will be collected and maintained in my child's portfolio, which is available to me at any time.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date

Fall \_\_\_\_\_ Spring \_\_\_\_\_ Summer \_\_\_\_\_

# SSU Preschool Health Forms

Dear Physician: \_\_\_\_\_

(Child's Name)

is enrolled in an early childhood program licensed by the Department of Early Education and Care. The Department of Early Education and Care's regulations require at the time of admission a written statement from a physician as evidence of each child's annual physical examination, immunizations and lead screening in accordance with Department of Public Health's recommended schedules. A prompt response is appreciated.

Evidence of a physical exam is valid for one year from the date the child was examined and must be renewed annually thereafter.

## IDENTIFICATION

Name of Child: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Parents: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Examination of Child: \_\_\_\_\_

What is your opinion concerning the child's general health and appearance:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has this child been screened for lead poisoning? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, date screened: \_\_\_\_\_

Does this child have any disabilities or chronic medical problems (allergies, limited vision, etc.) which require special consideration or care by the child care provider? If so, please detail below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please return to Program: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

GCCPhysicianStatment20050701

# CERTIFICATE OF IMMUNIZATION

Name: \_\_\_\_\_ Date of Birth:     /     /     Sex:   M   F

If combination vaccine is administered, please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date/Vaccine Type	Vaccine		Date/Vaccine Type
<b>Hepatitis B</b> (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1		<b>Rotavirus</b>	1	
	2			2	
	3			3	
	4		<b>Measles, Mumps, Rubella</b> (MMR, MMRV)	1	
1		2			
<b>Diphtheria, Tetanus, Pertussis</b> (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, Td, Tdap)	2		<b>Varicella</b> (Var, MMRV)	1	
	3			2	
	4		<b>Meningococcal</b> Conjugate (MCV4) or Polysaccharide (MPSV4)	1	
	5			2	
	6		<b>Influenza</b> Inactivated (Intramuscular) or Live (Intranasal)	1	
	7			2	
1		3			
<b>Haemophilus influenzae type b</b> (e.g., Hib, HepB-Hib, DTaP-Hib)	2		4		
	3		5		
	4		6		
	1		<b>Pneumococcal Polysaccharide</b> (PPV23)	1	
2		2			
<b>Polio</b> (e.g., IPV, DTaP-HepB-IPV)	3		<b>Hepatitis A</b> (HepA, HepA-HepB)	1	
	4			2	
	5		<b>Human Papillomavirus</b> (HPV)	1	
<b>Pneumococcal Conjugate</b> (PCV7)	1			2	
	2			3	
	3		<b>Other:</b>		
	4				

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		

\* Must also check Chickenpox History box.

Chickenpox History
<input type="checkbox"/> Check the box if this person has a physician-certified reliable history of chickenpox.
Reliable history may be based on:
<ul style="list-style-type: none"> <li>• physician interpretation of parent/guardian description of chickenpox</li> <li>• physical diagnosis of chickenpox, or</li> <li>• serologic proof of immunity</li> </ul>

I certify that this immunization information was transferred from the above-named individual's medical records.

**Doctor or nurse's name** (please print): \_\_\_\_\_ **Date:**     /     /     \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Facility name:** \_\_\_\_\_

# Back to School Pup Says

## By Two Years

3 doses of Hep B

4 doses of DTaP/DTP

3 doses of Polio

4 doses of Hib

1 dose of MMR

1 dose of Varicella

## By Kindergarten

3 doses of Hep B

5 doses of DTaP/DTP

4 doses of Polio

2 doses of MMR

1 dose of Varicella

## By 7th Grade

3 doses of Hep B

1 booster dose of Td

3 doses of Polio

2 doses of MMR

1 dose of Varicella\*

(\*2 doses if 13 years of age or older)



## VACCINATE ALL YOUR CHILDREN

For more information, contact your health care provider  
or the regional immunization office in your area:

Central Region: (508) 792-7880

Northeast Region: (978) 851-7261

Western Region: (413) 545-6600

Metro/Boston\* Region: (617) 983-6860

Southeast Region: (508) 977-3709

\* For BOSTON providers/schools only, you may call  
the Boston Health Commission: (617) 534-5611

Massachusetts Immunization Program  
Main Number (617) 983-6800 or Toll-Free 888-658-2850

Visit our Website at: [www.mass.gov/dph/](http://www.mass.gov/dph/)

7/2004

# El Cachorro de Regreso a la Escuela le Dice

## Antes de cumplir los dos años

3 dosis de Hep B

4 dosis de DTaP/DTP

3 dosis de Polio

4 dosis de Hib

1 dosis de MMR

1 dosis de Varicela

DTaP = La difteria, el tétano y la tos ferina

Hib = Hemófilo tipo B

MMR = El sarampión, las paperas y la rubéola

## Antes de empezar el Jardín Infantil

3 dosis de Hep B

5 dosis de DTaP/DTP

4 dosis de Polio

2 dosis de MMR

1 dosis de Varicela

## Antes de empezar el Séptimo Grado

3 dosis de Hep B

1 dosis de refuerzo de Td

3 dosis de Polio

2 dosis de MMR

1 dosis de Varicela\*

(\*2 dosis si el niño tiene 13 o más años de edad)



## VACUNE A TODOS SUS NIÑOS

Para más información, póngase en contacto con su doctor/centro de salud o la oficina regional de inmunización/vacunación:

Región Central: (508) 792-7880

Región Noreste: (978) 851-7261

Región Oeste: (413) 545-6600

Región Metro/Boston\*: (617) 983-6860

Región Sudeste: (508) 977-3709

\* Los proveedores y las escuelas de Boston (solamente) pueden llamar a la Comisión de Salud de Boston: (617) 534-5611

### Programa de Vacunación de Massachusetts

Número Principal (617) 983-6800 ó Número Telefónico Gratuito 888-658-2850

Visite nuestra página en el web: [www.mass.gov/dph/](http://www.mass.gov/dph/)

Deseamos informarle que es posible que la persona que conteste el teléfono no pueda hablar con usted en español. Sin embargo, haremos todo lo posible para encontrar a alguien que pueda hablar con usted en su propio idioma.

7/2004