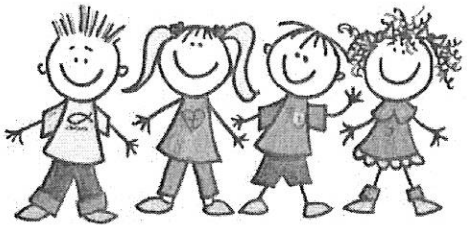
Trinity Lutheran Preschool



July 2020

Dear Families,

We thank you for considering Trinity Lutheran Preschool as one of your choices. It's an exciting and anxious time for your family as you choose a preschool for your child.

Attached please find the registration form you will need to enroll your child. Return this form along with a $115.00 non-refundable registration fee.

Classes will be offered MWF for 2 year olds, MWF or T/Th for 3 year olds and 4 or 5 days for 4 year olds. You may chose either the morning class from 9:00am – 12:00pm or the full day class from 9:00am – 3:00pm. Please specify your days and times on the registration form. Morning care available upon request.

All spaces will be filled on a first come first served basis until all classes are filled.

If you have any further questions or concerns, please feel free to contact us at the number below. The staff at Trinity look forward to working in partnership with you and your child during their preschool years.

God's blessings,

Diane Prudente
Preschool Director

Corrine Spano
Assistant Director

111 Nassau Avenue
Islip, New York 11751
(631) 277-5855
trinitypreschoolislip@gmail.com

OCFS-LDSS-0792 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)

PROGRAM NAME:	ADDRESS:	PHONE NUMBER:
Trinity Lutheran Preschool	111 Nassau Ave Islip NY 11751	(631) 277 - 5855

CHILD'S FULL NAME:
PREFERRED NAME/NICKNAME:
DATE OF BIRTH: / /
GENDER:

CHILD'S HOME ADDRESS:

NAME OF PERSON ENROLLING CHILD:

RELATIONSHIP TO CHILD:
☐ Parent ☐ Guardian ☐ Caretaker ☐ Relative _____
☐ Other _____

PHONE NUMBER(S) OF PERSON ENROLLING CHILD:
( ) -
☐ ok to text
EMAIL ADDRESS:

ADDRESS OF PERSON ENROLLING CHILD (IF DIFFERENT THAN CHILD):

EMERGENCY INFO

EMERGENCY CONTACT NAMES / ADDRESSES	Authorized to Pick Up Child	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
PRIMARY CONTACT:	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text
	☐ Yes ☐ No	( ) - ☐ ok to text	( ) - ☐ ok to text

FOR PROGRAM USE ONLY
DATE OF ENROLLMENT: / /

FOR PROGRAM USE ONLY
DATE OF DISENROLLMENT: / /

OCFS-LDSS-0792 (08/2019) REVERSE

CHILD'S FULL NAME:
DATE OF BIRTH: / /

Check boxes below to indicate if your child has any special needs/services: ☐ None

☐ Early Intervention/Special Education ☐ Occupational Therapy ☐ Speech/Language ☐ Physical Therapy

☐ Allergies (Please list) _____

☐ Other _____

Please provide information here **AND** discuss with your child care provider:

CHILD'S PRIMARY CARE PHYSICIAN'S NAME/ GROUP:	PHONE NUMBER: ( ) -
PREFERRED HOSPITAL:	PHONE NUMBER: ( ) -
CHILD'S DENTAL CARE:	PHONE NUMBER: ( ) -

Child health care information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/

AGREEMENTS

- I consent to emergency medical treatment for my child..... ☐ Yes ☐ No
- I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision..... ☐ Yes ☐ No
- I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips..... ☐ Yes ☐ No
- I provided information on my child's special needs to the program to assist in caring for my child..... ☐ Yes ☐ No
- I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation..... ☐ Yes ☐ No
- I agree to review and update this information whenever a change occurs and at least once every year..... ☐ Yes ☐ No

SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:
DATE: / /

TRINITY LUTHERAN PRESCHOOL 2020-2021 Family Information/Class Request Form

Registration Fee: $115.00 Tuition Costs: on reverse side

Child's Full Name: _____ **Preferred Name:** _____

Date of Birth: _____ **Email:** _____

Home phone # _____ **Cell phone #** _____

Previous School Expierence: _____

PLEASE CIRCLE EACH ITEM

2 year olds*	3 year old*	4year old*
How many days:	**How many days:**	**How many days:**
Select Days: M Tu W Th F	**Select Days:** M Tu W Th F	**Select Days:** M Tu W Th F
Select Session: 9:00 am -12:00pm or 9:00 am-3:00pm	**Select Session:** 9:00 am -12:00pm or 9:00 am-3:00pm	**Select Session:** 9:00 am -12:00pm or 9:00 am-3:00pm

*official class schedule will be formed in August based on enrollment

IF OFFERED, WOULD YOU USE BEFORE CARE/AFTER CARE? Yes/No **Times Needed:** _____

FAMILY MEMBERS:

Sibling's Name _____ **Date of Birth** _____

Sibling's Name _____ **Date of Birth** _____

Sibling's Name _____ **Date of Birth** _____

Religious Affiliation: _____ **Home Church:** _____

Parent or Guardian
Name:
Occupation:
Business Number:

Parent or Guardian
Name:
Occupation:
Business Number:

Parent's Signature: _____ **Date:** _____

Date enrolled_____ Doctor/Immunizations _____ Age/Day/Time enrolled:

Payment method Preschool office initial:_____ _____

Registration fee:_____

*One month deposit

Two Year Old Classes

Mon/Wed/Fri	9:00 am - 12:00 pm or 9:00 am - 3:00 pm
Tues/Thurs	9:00 am - 12:00 pm or 9:00 am - 3:00 pm

Three Year Old Classes

Mon/Wed/Fri	9:00 am - 12:00 pm or 9:00 am - 3:00 pm
Tues/Thurs	9:00 am - 12:00 pm or 9:00 am - 3:00 pm

Four Year Old Classes

Mon-Thurs	9:00 am - 12:00 pm or 9:00 am - 3:00 pm
Mon-Fri	9:00 am - 12:00 pm or 9:00 am - 3:00 pm

Additional before/after care hours available upon request

Annual Tuition Fees (divided into 10 monthly installments)

1st Month Tuition due August 1st

2020/2021

Tuition Fees - Half Day Program (9:00 am - 12:00 pm)

2 Days	$2,380.00	($238/month)
3 Days	$3,180.00	($318/month)
4 Days	$3,900.00	($390/month)
5 Days	$4,220.00	($422/month)

Tuition Fees – Full Day Program (9:00 am - 3:00 pm)

2 Days	$4,280.00	($428/month)
3 Days	$5,640.00	($564/month)
4 Days	$6,690.00	($669/month)
5 Days	$7,890.00	($789/month)

Registration Fee

$115.00 per child ($95.00 for second child)

All registration fees are non-refundable.

OCFS-LDSS-4433 (Rev. 06/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician Assistant or Nurse Practitioner

Name of Child:	Date of Birth: / /	Date of Examination: / /

Immunizations required for entry into day care

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s). ☐ Yes ☐ No

Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	5th Date / /
Polio (IPV or OPV)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Haemophilus influenzae type B (Hib)	1st Date / /	2nd Date / /	3rd Date / /	4th Date **OR** 1st Date (if given on or after 15 months of age) / /	
Pnuemococcal Conjugate (PCV) for those born on or after 1/1/08)	1st Date / /	2nd Date / /	3rd Date / /	4th Date / /	
Hepatitis B	1st Date / /	2nd Date / /	3rd Date / /		
Measles, Mumps and Rubella (MMR)	1st Date / /	2nd Date / /			
Varicella (also known as Chicken Pox)	1st Date / /	2nd Date / /			

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /
Type of Immunization:	Date: / /	Type of Immunization:	Date: / /

Tests

Tuberculin Test Date: ____ / / ____ Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: ____ / / ____

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year ____ / / ____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years ____ / / ____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

____ / / ____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

(Continued on reverse side)

CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) - Phone

/ / Date