THOMAS JEFFERSON HIGH SCHOOL

FAMILY AND CONSUMER SCIENCES

CHILD DEVELOPMENT NURSERY SCHOOL

APPLICATION PAPERS

2017-2018

THOMAS JEFFERSON HIGH SCHOOL
FAMILY AND CONSUMER SCIENCES DEPARTMENT
CHILD DEVELOPMENT NURSERY SCHOOL

Dear Parents/Guardians:

A nursery school is conducted every fall at Thomas Jefferson High School to provide an enrichment experience for our Child Development students. This year the nursery school will run on **Tuesday, Wednesday, and Thursday**, from **8:45 a.m. to 10:45 a.m.** The nursery school will begin **Tuesday, October 3, 2017** and will end **Thursday, January 11, 2018**, unless school has been cancelled for snow.

We are seeking 12 children between the ages of 2 years 6 months to 4 years old to attend our nursery school. Transportation to and from the high school is to be provided by the parent. To cover the cost of operating the nursery school, there is a charge of $35.00 per child.

During each session, the children will be under supervision of the students of the Child Development II classes and Mrs. Moore, Family and Consumer Science teacher. The program includes periods of supervised play and planned activities in music, art, science, and story time. A nutritious snack will be provided each day.

If you have a child or children in this age group and would like him or her to participate in this program, please pick up a form in the high school office or visit www.wjhsd.net to download and print forms. Please return completed forms as soon as possible. Acceptance will be on a first come basis. If you have any questions, please call Mrs. Moore at 655-8610 ext. 6275 or 6317 or email at lmoore@wjhsd.net

Thank you,

Mrs. Moore

THOMAS JEFFERSON HIGH SCHOOL
FAMILY AND CONSUMER SCIENCES DEPARTMENT
CHILD DEVELOPMENT NURSERY SCHOOL

CONSENT FORM

I give consent for my child_____ to participate in the Family and Consumer Sciences Department Child Development Nursery School operating at Thomas Jefferson High School.

I hereby grant permission for my child to use all of the play equipment and to participate in all of the activities of the school. I understand that lunch, planned and prepared by students, will be served as part of this program.

I hereby grant permission for my child to be included in evaluations, pictures, and video recordings connected with the school program.

I understand that in case of illness, I will be called upon and required to pick up my child as soon as possible.

I hereby grant permission for staff members to take whatever steps may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to the following:

1. Attempt to contact a parent or guardian
2. Take the child to our school nurse at the high school for consultation
3. Attempt to contact you through any of the persons listed on the information form you have completed for us.
4. Attempt to contact the child's physician.
5. If we cannot contact you or your child's physician, we will contact the paramedics.
6. Any expenses incurred under number 5 above will be the responsibility of the child's family.
7. The school will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

Signature of Parent_____
Date: _____

EMERGENCY CONTACT INFORMATION

Parent/Guardian Name_____

Address_____

Phone Number_____

Work Hours_____

Work Phone Number_____

Child's Physician_____

Physician Phone Number_____

Health Insurance Carrier and Policy Number_____

Emergency Contact if Parent/Guardian Unavailable_____

Relationship to Parent/Guardian_____

Phone Number of Emergency Contact_____

Child's Medical History:

Food or other allergies_____

Special medical conditions or concerns_____

_____

Daily medications taken_____

THOMAS JEFFERSON HIGH SCHOOL
FAMILY AND CONSUMER SCIENCES DEPARTMENT
CHILD DEVELOPMENT NURSERY SCHOOL

ENROLLMENT INFORMATION

Child's Name_____
(First) (Middle) (Last)
Child's nickname_____Birthdate____/____/___Sex_____
Address_____
City_____Zipcode_____Home phone_____

Father's name_____Daytime phone_____
Email Cell phone_____
Mother's name_____Daytime phone_____
Email Cell phone_____
Child lives with: Mother Father Both Guardian Other _____
If there are custody papers, please supply a copy. Please notify us of any possible conflicts or problems._____
Other person's living in the home: age sex relationship

_____

_____

_____

Has the child ever been separated for any length of time from the parents (such as vacations, illness, etc.)?_____
How did he/she adjust?

_____

Are there any health concerns about your child?_____Please state them_____

_____

What is your child's usual bed time?_____Waking time?_____
Does your child take a morning or afternoon nap?_____How long?_____
Is your child usually hungry at meal times? _____
What are his/her favorite lunchtime foods?

_____

What fruits will your child eat? _____
What vegetables will your child eat? _____
Is your child allergic to any foods?

_____

Is there anything else you would like us to know about his/her eating habits? _____

_____

_____

Is your child potty trained?

_____

If not would you please supply us with diapers etc? Please make sure that they are in a bag with his/her name on it. It is also wise to send a change of clothes with ALL children.
Will your child let us know if he/she has to go to the potty? _____

Does your child have any fears? If so, please list them._____

_____

Does your child play alone? Always_____ Often_____ Seldom_____
Does he/she prefer quiet activities or physical activities? _____
What are his/her favorite activities? _____
Does your child play with others? _____ Who? _____
Are the playmates girls or boys? _____ Are they younger, older, or the same age?

_____

How often do they play together? _____
What do they play? _____
If there is a conflict with another child how does he/she handle the conflict?

_____

Does your child have an imaginary playmate? _____Its name? _____
Has your child attended any other social groups or preschools? _____
If so where?_____

TRANSPORTATION TO AND FROM THE PROGRAM:

To: (with whom) _____
From: (with whom) _____

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

_____

_____

Do you have any objections to us having a Christmas party? _____
What would you rather we call it? _____
Any objections to a visit from Santa? _____

All of the above information is accurate and answered to the best of my knowledge.

Parent signature _____Date_____

_____Emergency card _____Tuition
_____ Doctor signed child health assessment
_____Consent form

ATTENDING: TUESDAY WEDNESDAY THURSDAY
(please circle all that apply)

CHILD HEALTH ASSESSMENT

Parents & Child Care Providers fill-in this part.

CHILD'S NAME: (LAST)	(FIRST)
DATE OF BIRTH:	HOME PHONE:
CHILD CARE FACILITY NAME:	
FACILITY PHONE:	COUNTY:

PARENT/GUARDIAN:
ADDRESS:
WORK PHONE:

PA child care providers must document that enrolled children have received age appropriate health services and immunizations that meet the current schedule of the American Academy of Pediatrics 141 Northwest Point Blvd., Elk Grove Village, IL 60007. The schedule is available at < www.aap.org > or Faxback 847/758-0391 (document #9535 and #9807). Print copies provided by DPW have the schedule on the back of the form.

Health history and medical information pertinent to routine child care and emergencies (describe, if any): ☐ NONE	Date of most recent well-child exam:
Allergies to food or medicine (describe, if any): ☐ NONE	Do not omit any information. This form may be updated by health professional. (Initial and date new data.) Child care facility needs 2 copies.

Parents may write immunization dates, health professionals should verify and complete all data.

LENGTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
_____IN/CM %ILE _____	_____LB/KG %ILE _____	_____ IN/CM %ILE _____	(BEGINNING AT AGE 3) _____ / _____

PHYSICAL EXAMINATION	☑ NORMAL	IF ABNORMAL, COMMENTS
HEAD/EARS/EYES/NOSE/THROAT		
TEETH		
CARDIORESPIRATORY		
ABDOMEN/GI		
GENITALIA/BREASTS		
EXTREMITIES/JOINTS/BACK/CHEST		
SKIN/LYMPH NODES		
NEUROLOGIC & DEVELOPMENTAL		

IMMUNIZATIONS	DATE	DATE	DATE	DATE	DATE	COMMENTS
DTaP/DTP/Td						
POLIO						
HIB						
HEP B						
MMR						
VARICELLA						
PNEUMOCOCCAL						
INFLUENZA						
OTHER						

SCREENING TESTS	DATE TEST DONE	NOTE HERE IF RESULTS ARE PENDING OR ABNORMAL
LEAD		
ANEMIA (HGB/HCT)		
URINALYSIS (UA) at age 5)		
HEARING (subjective until age 4)		
VISION (subjective until age 3)		
PROFESSIONAL DENTAL EXAM		

HEALTH PROBLEMS OR SPECIAL NEEDS, RECOMMENDED TREATMENT/MEDICATIONS/SPECIAL CARE (ATTACH ADDITIONAL SHEETS IF NECESSARY)

☐ NONE

NEXT APPOINTMENT - MONTH/YEAR:

MEDICAL CARE PROVIDER:		SIGNATURE OF PHYSICIAN OR CRNP:	
ADDRESS:			
	PHONE:	LICENSE NUMBER:	DATE FORM SIGNED:

CY 51 8/05