

THOMAS JEFFERSON HIGH SCHOOL

FAMILY AND CONSUMER SCIENCES
CHILD DEVELOPMENT NURSERY SCHOOL

APPLICATION PAPERS

2016-2017



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

Dear Parents/Guardians:

To give our students in Thomas Jefferson High School's Child Development classes an enrichment experience, a nursery school is conducted every fall. This year the nursery school will run on **Tuesday, Wednesday, and Thursday**, from **8:45 a.m. to 10:45 a.m.** School will begin **Tuesday, October 4, 2016** and will end **Thursday, January 5, 2017**, unless school has been cancelled for snow days. In the event of a two hour delay, students will follow a modified schedule.

We are seeking 15 children ages 2½ to 4 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. All students enrolled in the Child Development II classes have up to date clearances. The program includes periods of supervised play and planned activities in music, physical education, 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 and return it 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

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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 from 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

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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 a snack, 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 _____

CHILD HEALTH ASSESSMENT

Parents & Child Care Providers fill-in this part.

CHILD'S NAME: (LAST)	(FIRST)	PARENT/GUARDIAN:
DATE OF BIRTH:	HOME PHONE:	ADDRESS:
CHILD CARE FACILITY NAME:		
FACILITY PHONE:	COUNTY:	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): <input type="checkbox"/> NONE	Date of most recent well-child exam: _____
Allergies to food or medicine (describe, if any): <input type="checkbox"/> 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.

GROWTH/HEIGHT	WEIGHT	HEAD CIRCUMFERENCE	BLOOD PRESSURE
IN/CM %ILE	LB/KG %ILE	IN/CM %ILE	(BEGINNING AT AGE 3) ____ / ____
PHYSICIAN EVALUATION		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
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)			
<input type="checkbox"/> NONE		NEXT APPOINTMENT - MONTH/YEAR: _____	
MEDICAL CARE PROVIDER: _____		SIGNATURE OF PHYSICIAN OR CRNP: _____	
ADDRESS: _____		_____	
PHONE: _____		LICENSE NUMBER: _____	DATE FORM SIGNED: _____