

Stepping Stones Learning Center
Registration Form for RETURNING Students
Special Needs
2008-2009 School Year

OFFICE USE ONLY	
INT: _____	COM <input type="checkbox"/>
<i>W. Iron.</i> <input type="checkbox"/>	AUT <input type="checkbox"/>
<i>FRC</i> <input type="checkbox"/>	Date _____
	Time _____

REGISTRATION FEE – N/A

Child's Name _____ Date of Birth _____ Age _____
 Street Address _____ City _____ Zip _____
 Evening Phone (____) _____ Daytime Phone (____) _____ Cell (____) _____
 E-Mail Address _____ Boy Girl Ethnicity _____
 Referred by: _____ District/County _____

Parent/Guardian Information

Mother's Name _____ check if legal guardian
 Mother's Employer _____ Work Phone (____) _____
 Father's Name _____ check if legal guardian
 Father's Employer _____ Work Phone (____) _____
 Married Single Separated Divorced Joint Custody Separate Custody with whom _____
 Does child live with both parents? Yes No If no, state with whom _____

Child's Physician _____ Phone (____) _____ Fax _____
 Address _____ City _____ State _____ Zip _____

Medical Restrictions: _____
 Allergies: _____
 Diet Restrictions: _____
 Alert /limitations: _____

Emergency Contacts - star (*) those that are also authorized escorts

Name _____	Phone (____) _____	Alt.Phone (____) _____
Address _____	City _____ State _____ Zip _____	Relationship _____
Name _____	Phone (____) _____	Alt.Phone (____) _____
Address _____	City _____ State _____ Zip _____	Relationship _____
Name _____	Phone (____) _____	Alt.Phone (____) _____
Address _____	City _____ State _____ Zip _____	Relationship _____

Authorized escorts other than parents: (identification required prior to pick-up) _____

Additional comments: _____

PLEASE SEE/COMPLETE THE BACK SIDE

Over →

What are your goals for this program? _____

Parent Involvement: I would like to be involved in this capacity Yes No

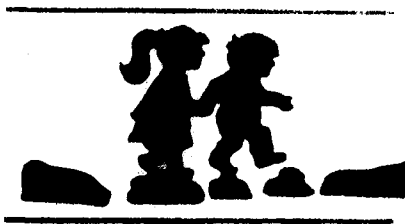
Class Options - Check your possible choices: AM PM

2 days per week 3 days per week 4 days per week 5 days per week

Days Requested (not guaranteed): Monday Tuesday Wednesday Thursday Friday

Parent Signature

Date



Stepping Stones Learning Center

A Family Centered Early Learning Program

41 Colebrook Drive
Rochester, NY 14617

585-467-4567

PERMISSION FOR HEALTH CARE

2008-2009

Child's Name _____ Date _____

Child's Physician _____

Address _____ City _____ Zip _____

Phone (____) _____ Alt. Phone (____) _____ Fax (____) _____

Child's Dentist _____

Address _____ City _____ Zip _____

Medical Insurance _____ Policy Number _____

Primary Policy Holder _____

Specialist _____ Phone (____) _____

AUTHORIZED ADULTS

In the event of an emergency, please indicate your name and phone number where you and another authorized person can be reached.

Father's Name _____ Phone (____) _____ Alt. Phone (____) _____

Mother's Name _____ Phone (____) _____ Alt. Phone (____) _____

Additional Authorized Person _____ Phone (____) _____

Alt. Phone (____) _____ Address _____

Additional Authorized Person _____ Phone (____) _____

Alt. Phone (____) _____ Address _____

FIRST AID

In the event of an emergency, I authorize the staff to provide first aid care deemed necessary for my child.

Signature/Date

EMERGENCY CARE

In the event of an emergency in which I cannot be reached, the physician listed above and the local hospital are hereby authorized to provide any emergency care deemed necessary for my child. Preferred Hospital (if medically safe):

Signature/Date

HEALTH RECORD TRANSFER

In the event of an emergency, I hereby authorize the transfer of my child's health record to the local hospital.

Signature/Date

PLEASE SEE/COMPLETE THE BACK SIDE

Over →

Stepping Stones Learning Center 2008-2009

Field Trip/ Walk Permission

I (we), the parent(s) and/or guardian(s) of _____
request that Stepping Stones Learning Center allow my child to participate in field trips or walks
conducted by staff. I understand that all field trips will be properly supervised and my child may
be riding in cars of fellow classmates' parents. **I will be notified of the time and date of each
field trip.** I hereby release and save harmless any person that transports my child to and from the
school on field trips. I also release them from any and all liability for injuries resulting from trips
or walks.

Signature

Date

Photo Release

I (we), the parent(s) and/or guardian(s) of _____
give permission for my child to be photographed/videotaped during activities at the program for
educational and promotional purposes.

Signature

Date

Personal Data Release

I (we), the parent(s) and/or guardian(s) of _____
give permission for my name, telephone number, and address to be released to other families in
the program.

Signature

Date



Stepping Stones Learning Center

A Family Centered Early Learning Program

41 Colebrook Drive
Rochester, NY 14617

585-467-4567

***Only Complete if your child receives any type of service at 41 Colebrook Dr.**

Request Notification of School Pesticide Application 2008-2009

Effective July 1, 2001 New York State Education Law Section 409-h requires that certain information be provided to parents and guardians regarding the use of pesticides in schools attended by their children. If you would like to be notified of any pesticide applications on Stepping Stones Learning Center's property, please complete this request form.

As the parent or guardian of _____ who attends Stepping Stones Learning Center, I understand a new state law will require every school to maintain a list of parents who wish to receive advanced notice of pesticide applications at the school their child attends. Each time pesticides are scheduled to be applied at the school, parents on the list must be provided with a written notice at least 48 hours in advance specifying the specific date and location of the application, the name and EPA registration number of the product being applied, the name and number of a person at the school who can be contacted to discuss the precautions being taken to protect children from exposure, and telephone numbers of information services that can provide specific information about the pesticides being applied.

A list of pesticide applications which are not subject to prior notification requirements are included below:

- a school remains unoccupied for a continuous 72-hours following an application;
- anti-microbial products;
- nonvolatile rodenticides in tamper resistant bait stations in areas inaccessible to children;
- silica gels and other nonvolatile ready-to-use paste, foams, or gels in areas inaccessible to children;
- boric acid and disodium octaborate tetrahydrate;
- the application of EPA designated bipoestices;
- the application of EPA designated exempt materials under 40CFR152.25;
- the use of aerosol products with a directed spray in containers of 18 fluid ounces or less when used to protect individuals from an imminent threat from stinging and biting insects including venomous spiders, bees, wasps, and hornets.

Pesticide Notification Request

Child's Name _____ Parent/Guardian Name _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone _____

E-Mail _____ Fax (_____) _____

Parent/Guardian Signature _____

Date _____

(This form is required by the Monroe County Health Department
if your child receives Medicaid.)

SCHOOL DISTRICT

CHILD'S NAME: _____

**CONSENT FOR RELEASE OF INFORMATION
TO ACCESS MEDICAID REIMBURSEMENT
FOR HEALTH RELATED SUPPORT SERVICES**

_____ as parent/guardian of
(parent or person in parental relationship)

_____ gives permission to disclose
(child's name) (date of birth)

information from my child's educational records to local, state and federal agency representatives for the sole purpose of claiming Medicaid reimbursement for health related support services included in my child's Individualized Education Program (IEP).

Signature: _____ **Date:** _____
(parent or person in parental relationship) (month-day-year)



Stepping Stones Learning Center

A Family Centered Early Learning Program

41 Colebrook Drive
Rochester, NY 14617

585-467-4567

ASSESSMENT RELEASE FORM
2008-2009 School Year

I hereby give permission for _____ DOB:

(Child's Name)

to be tested in the areas of speech, language, hearing, motor, audiological, psychological and cognitive development, as part of the Stepping Stones Learning Center's program. These assessments will be both formal utilizing standardized testing and informal utilizing clinical judgment.

Parent/Guardian

Date



Stepping Stones Learning Center

A Family Centered Early Learning Program

41 Colebrook Drive
Rochester, NY 14617

585-467-4567

***Only complete if your child is part of a child care arrangement**

Consent For Release of Information Child Care Arrangement **2008-2009**

I hereby give permission to: Stepping Stones Learning Center
41 Colebrook Dr.
Rochester, New York 14617

To obtain information from: _____

or

To communicate with: _____

In order to provide Stepping Stones Learning Center with those records and/or information pertinent to the care, treatment and education of:

(Name of Child)

(Date of Birth)

I further give permission for Stepping Stones Learning Center to release pertinent reports and discuss their findings with professionals of the office/agency/school/practice noted above.

I also understand that I may revoke this release of information at any time. I also understand that my consent for release of information will expire 90 days after my child's last visit or one year from today's date, whichever comes first.

Signature of Witness

Signature of Parent or Guardian

Date

Address

**Stepping Stones Learning Center
Parent Involvement 2008-2009**

Parents are a vital part of our program at Stepping Stones Learning Center, both within classroom programming and in outside community based services. We strive for excellence and to ensure a high quality experience for everyone. To do this, we need and appreciate your help. Some projects/activities are short in time while others are longer in nature. Active, involved parents make our programs the best they can be.

Child's name: _____ Class/or other program _____

Parent(s)/Guardian(s): _____

Phone: Home _____ Work: _____ Cell: _____

E-Mail: _____ Best time to contact: _____

Please indicate areas you would be interested in volunteering on a regular basis per meeting or assigned duties:

Parent Committee

Serve on parent advisory board to the Co-Founders _____

Suggest new programming/evaluate current programming _____

Organize and assist with fundraisers throughout the year _____

Help at Fundraising activities at school and in community _____

Volunteer

Repair/maintenance projects _____

Curriculum room librarian _____

Playground maintenance _____

Office duties/assistant _____

Computer maintenance/repair _____

Snack organizer _____

Provide contact names for volunteers _____

Create inventory list of all furniture/equipment _____

Other _____

Classroom Guest

Read to the children _____

Share a craft activity _____

Speak on a child related topic _____

Come in and help for a special activity _____

Be your child's room parent _____

PLEASE SEE/COMPLETE BACK SIDE

OVER→

Please indicate areas you would be interested in volunteering on a sporadic or one time basis.

- Special Class Project _____
- Volunteering to help in the classroom _____
- Work place collaborations _____
- General special assignment _____
- General resource Ex. _____

Donator

- Classroom arts and crafts supplies _____
- Tissues, paper towels _____
- Toys/equipment _____
- Snacks/juice _____
- Computers _____
- Office equipment/supplies _____
- Playground equipment _____
- Bikes/children helmets _____
- Copy paper/construction paper _____
- Used paper/misc. paper _____
- Provide contact names for donators _____

Please feel free to describe other ways in which you could help:

STEPPING STONES LEARNING CENTER
2008-2009 MEDICAL REPORT

Phone: (585) 467-4567
 Fax: (585) 467-6973

NAME OF PERSON BEING EXAMINED	DATE OF BIRTH
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The above named child was examined and found to present no hazard from contagious and communicable disease and is in good general health.

Immunizations/Tests etc. (insert dates)				
<u>Polio (IPV/Oral)</u>	<u>DPT/DT</u>	<u>MMR</u>	<u>Hib Vaccine</u>	<u>TB Tests</u>
1. _____	1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____	2. _____
3. _____	3. _____		3. _____	3. _____
4. _____	4. _____	<u>Hepatitis B</u>	<u>Lead Testing</u>	<u>Varicella</u>
5. _____	5. _____	1. _____	1. _____	1. _____
		2. _____		
		3. _____	Other _____	

GIVE SPECIFICS FOR ALL YES RESPONSES AT RIGHT

YES	NO	1. Are there allergic problems?	Specifics
YES	NO	2. Are there allergies to drugs?	
YES	NO	3. Is medication regularly taken? (If yes, specify drug and condition)	
YES	NO	4. Are there any conditions requiring special attention by the provider?	
YES	NO	5. Is a special diet required? (If yes, specify diet and condition)	
6. TEETH		(Condition)	
7. HEARING TESTED	DATE	METHOD	RESULT
8. VISION TESTED	DATE	METHOD	RESULT
9. MENTAL GROWTH & DEVELOPMENT		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	(If abnormal, describe)
10. PHYSICAL GROWTH		<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	(If abnormal, describe)

LIST ANY SPECIAL RECOMMENDATION CONCERNING CHILD'S HEALTH (Use reverse side if necessary)

WHEN SHOULD THIS CHILD RECEIVE NEXT MEDICAL EXAM?			
PHYSICIAN'S SIGNATURE	DATE OF EXAM	ADDRESS	PHYSICIAN'S PHONE
PHYSICIAN'S NAME (Please Print)			ICD9 CODE:

MEDICAL EXEMPTIONS	
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The physical condition of the above named child is such that immunization would endanger life or health.	
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PHYSICIAN'S SIGNATURE	DATE
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RELIGIOUS EXEMPTION	
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Parent of guardian of the above named child adheres to a religious belief whose teaching are opposed to such.	
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PHYSICIAN'S SIGNATURE	DATE
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