

Stepping Stones Learning Center
Registration Form for NEW STUDENTS
West Irondequoit Early Childhood Program
REGISTRATION FEE – \$50(non-refundable)

OFFICE USE ONLY
Date _____
Time _____

2008-2009 School Year

Child's Name _____ Date of Birth _____ Age _____
Street Address _____ City _____ Zip _____
Evening Phone () _____ Daytime Phone () _____ Cell Phone () _____
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 and those listed above: (identification required prior to pick-up):

PLEASE SEE/COMPLETE THE BACK SIDE

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Sibling

Age

School Sibling Attends

Other family member's child has consistent contact with? _____

Pets? _____

List child's special interests, hobbies and talents _____

Describe your child's personality _____

How does your child typically behave when playing with other children? Please be as honest as possible so our program may be individualized to fit your child's needs.

Yes No Don't know

- ____ ____ _____ Shares toys without fussing
- ____ ____ _____ Takes turns without fussing
- ____ ____ _____ Is a leader
- ____ ____ _____ Follows rules of a game easily
- ____ ____ _____ Sticks up for himself when bullied
- ____ ____ _____ Is rough, pushes other children around
- ____ ____ _____ Is afraid of being hurt
- ____ ____ _____ Is afraid of other children
- ____ ____ _____ Cries easily
- ____ ____ _____ Gets angry easily
- ____ ____ _____ Is left out or ignored by others
- ____ ____ _____ Seems to be without sense of danger; needs to be watched

Additional comments:

What are your goals for this program? _____

Parent Involvement: I would like to be involved: Yes No Capacity _____

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/Guardian Signature

Date

**STEPPING STONES LEARNING CENTER
WEST IRONDEQUOIT PAYMENT OPTIONS 2008-2009**

REGISTRATION FEE - \$50.00 per year-Non-refundable (\$25 after 1/1/09)

Please check and initial the option you choose

<p>TUITION: 2 DAYS PER WEEK - \$1200.00 <i>Payments received after the 10th of the month will incur a 10% late fee for each month a balance is due.</i></p> <p>Monthly Payments of \$120.00 _____ Due by the 1st of each month. A \$25.00 Service Charge will be added to the First Payment.</p> <p>Semi-Annual Payments of \$600.00 _____ Due 7/01/08 and 1/01/09 Annual Payment of \$1200.00 _____ Due 7/01/08</p>
<p>TUITION: 3 DAYS PER WEEK - \$1700.00 <i>Payments received after the 10th of the month will incur a 10% late fee for each month a balance is due.</i></p> <p>Monthly Payments of \$170.00 _____ Due by the 1st of each month. A \$25.00 Service Charge will be added to the First Payment.</p> <p>Semi-Annual Payments of \$850.00 _____ Due 7/01/08 and 1/01/09 Annual Payment of \$1700.00 _____ Due 7/01/08</p>
<p>TUITION: 4 DAYS PER WEEK - \$2400.00 <i>Payments received after the 10th of the month will incur a 10% late fee for each month a balance is due.</i></p> <p>Monthly Payments of \$240.00 _____ Due by the 1st of each month. A \$25.00 Service Charge will be added to the First Payment.</p> <p>Semi-Annual Payments of \$1200.00 _____ Due 7/01/08 and 1/01/09 Annual Payment of \$2400.00 _____ Due 7/01/08</p>
<p>TUITION: 5 DAYS PER WEEK - \$3000.00 <i>Payments received after the 10th of the month will incur a 10% late fee for each month a balance is due.</i></p> <p>Monthly Payments of \$300.00 _____ Due by the 1st of each month. A \$25.00 Service Charge will be added to the First Payment.</p> <p>Semi-Annual Payments of \$1500.00 _____ Due 7/01/08 and 1/01/09 Annual Payment of \$3000.00 _____ Due 7/01/08</p>

Payment of two month's tuition for monthly option or semi-annual/annual payment is required at the time of enrollment, or July 1st for the new school year for your child's spot to be guaranteed. One month will be held as a security deposit and will be credited to the June payment. *If your child will be leaving the program before year end, a month's notice is required to ensure deposit refund.* Tuition payments are prorated if child begins programming at any time other than the first day of school. After 90 days, the account will be turned over to a collection agency, and all costs for collection will be the responsibility of the parent/guardian/payer.

SIGNATURE _____ DATE _____

CHILD'S NAME _____

PLEASE SEE/COMPLETE BACK SIDE

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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



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

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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 injures 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

Monroe County Department of Health
School Health Services
Health Appraisal Form

Name of child: _____ Birthdate: _____ Date: _____
last first Male Female

Address: _____ Telephone: _____

Father: _____ Birthdate: _____ Mother: _____ Birthdate: _____

PERSON TO CONTACT IN CASE OF EMERGENCY:

Name: _____ Relationship: _____ Telephone: _____

Brothers and Sisters:

Name	Sex	Birthdate	Name	Sex	Birthdate
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

*****PLEASE EXPLAIN ALL "YES" ANSWERS*****

A. PREGNANCY AND BIRTH	YES	NO	EXPLAIN
1. Did you have any illness or problems during pregnancy?			
2. Did you take medications during pregnancy? If so, what?			
3. Did you have a difficult labor or delivery?			
4. Is there anything else you want to say about your pregnancy or yourself during pregnancy?			
5. Was the baby born on the due date?			
6. Did your baby have any trouble starting to breath?			
7. Did your baby have any problems while in the hospital?			
8. Did your baby stay in the hospital longer than you?			
9. What was your baby's birth weight?			

B. HEALTH HISTORY	YES	NO	EXPLAIN
1. Does your child have frequent ear aches/ infections?			
2. Does your child have tubes in their ears?			
3. Does your child have a hearing problem?			
4. Does your child have any eye problems?			
5. Does your child wear glasses, hearing aides, other adaptive devices?			
6. Are there any problems with your child's teeth?			
7. Has your child ever had convulsions/ seizures? If yes, date of last one: _____ Does he/ she take medication for seizure control?			
8. Does your child take any medication? If yes, name medication and dose.			
8a. Will SSLC be responsible for dispensing medication? Please list all medications administered: _____ (All medications administered at school require written parental consent and a physician's order. Please obtain a current medication form from the school nurse if/when your child needs medication in school. All medication will be kept in the School Health Office for administration by the nurse.)			
9. Has your child ever had wheezing?			
10. Does your child tend to have a runny nose or constant cold?			
11. Does your child have any problems with his/ her kidneys, bladder or bowels? Such as frequent kidney/ bladder infections, frequent diarrhea or constipation or bed wetting?			
12. Has your child ever had any operation, accident or injury?			
13. Has your child ever been hospitalized and/ or seen in emergency?			
14. Has your child had or does he/ she now have any of the following: (Please check) Asthma _____ Chicken Pox _____ Emotional Problems _____ Joint Disease _____ Meningitis _____ Diabetes _____ Sickle Cell Anemia _____ Lead Poisoning _____ Heart Disease _____ Other _____			

C. DEVELOPMENTAL HISTORY/ DAILY HEALTH HABITS

YES NO EXPLAIN

1. Has your child ever had an eating or appetite problem?			
2. Are you concerned about your child's height and weight?			
3. Does your child have problems sleeping through the night?			
4. Does your child have problems playing with other children?			
5. Please check the age of your child's playmates: Same Age _____ Younger _____ Older _____			
6. At what age did your child do the following:			
Sit Alone _____	Talk/ Single Word _____	Toilet Train/ Bladder _____	
Walk Alone _____	Talk/ 2-3 Word Sentences _____	Toilet Train/ Bowel _____	
7. What activities does your child enjoy? Please list: _____			

D. CHILD'S MEDICAL INFORMATION

Medical Alerts: _____

Allergies and Treatment Required: List all specific allergens. _____

Food: _____

Bees/ Insects: _____

Medications: _____

Environmental/ Other: _____

Are these allergies life threatening? _____

Usual treatment: _____

Diet Restrictions: _____

Restrictions/ Limitations: _____

E. FAMILY HEALTH HISTORY - MEDICAL PROBLEMS OR CHRONIC ILLNESS

Does anyone in the family (mother, father, brother, sister, aunt, uncle and/ or grandparents) have any of the following: (please indicate relationship to child)

CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP	CONDITION	RELATIONSHIP
asthma		heart disease		TB	
allergies		high blood pressure		seizures	
cancer		kidney disease		diabetes	
mental illness		drug abuse		obesity	
alcohol abuse		respiratory		other: specify	

F. COMMENTS:

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

NAME OF HEALTH CENTER/ DOCTOR _____ DATE OF LAST PHYSICAL EXAM _____

SIGNATURE OF PARENT/ GUARDIAN COMPLETING THIS FORM _____

RELATIONSHIP TO CHILD _____

SIGNATURE OF INTERVIEWER _____

**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

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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.

<u>Immunizations/Tests etc. (insert dates)</u>				
<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. _____	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:

PLEASE HAVE COMPLETED BY YOUR CHILD'S PEDIATRICIAN

(See reverse)

MEDICAL EXEMPTIONS	
The physical condition of the above named child is such that immunization would endanger life or health.	
PHYSICIAN'S SIGNATURE	DATE

RELIGIOUS EXEMPTION	
Parent of guardian of the above named child adheres to a religious belief whose teaching are opposed to such.	
PHYSICIAN'S SIGNATURE	DATE