2018-2019 REGISTRATION FORM

James Morris School Pre-Kindergarten

10 East Street • Morris, CT 06756 • 860-567-7420

APPLICATIONS ARE DUE BY APRIL 1, 2018

Child's Name:____

Date of Birth:_________________________ Age as of August 2018__________

Address:___________________________________Zip:________________

Home Phone:_________________Email:_____________________________

Location: **JAMES MORRIS SCHOOL**

Please indicate your preferred session by identifying your session preferences, in order, using "1", "2" or "3". Make sure to choose 3 options, otherwise your registration will not be reviewed and your child will not be considered for placement.

Preferred Session	Sessions: (A.M.)	Preferred Session	Sessions: (P.M.)
	2 sessions per week-Tuesday, Thursday morning		2 sessions per week-Tuesday, Thursday afternoon
	3 sessions per week-Monday, Wednesday, Friday morning		3 sessions per week-Monday, Wednesday, Friday afternoon
	5 sessions per week-Monday, Tuesday, Wednesday, Thursday and Friday morning		5 sessions per week-Monday, Tuesday, Wednesday, Thursday and Friday afternoon

Session Hours:

- Morning Session- 8:55 a.m.- 11:35 a.m.
- Afternoon Session- 12:50 p.m.- 3:30 p.m.

Pre-kindergarten students are eligible for transportation if they reside on the regular bus routes in Goshen. A.M. students will have the option to ride the bus to school in the morning. P.M. students will have the option to ride the bus home in the afternoon. It will be parents responsibility to pick up A.M. students at 11:35 A.M. or to drop off P.M. students at 12:45 P.M.

Do you wish to have your child ride the bus? _______Yes ________No

Please see the back of this sheet for tuition fees.

REGIONAL SCHOOL DISTRICT No. 6

Goshen Center School
50 North Street
Goshen, CT 06756
Tracy Keilty, Principal

James Morris School
10 East Street
Morris, CT 06763
KC Chapman, Principal

Warren School
21 Sackett Hill Road
Warren, CT 06754
Angela Rossbach, Principal

February 2018

Dear Parents of Prekindergarten students:

We are excited for your child to join us in Prekindergarten this coming school year. Prekindergarten tuition is as follows:

	Annual Rate	Monthly Rate	Students Who Qualify for Husky B or Reduced Lunch	Students Who Qualify for Husky A, Free Lunch or with Special Services
Two half-day sessions per week	$792.00	$79.20	$39.60/month $396.00/annual	$0
Three half-day sessions per week	$1,188.00	$118.80	$59.40/month $594.00/annual	$0
Five half-day sessions per week	$1980.00	$198.00	$99.00/month $990.00/annual	$0

Payments can be made in ten monthly installments and will be due before the first of each month. Please make checks out to Regional School District No. 6 and mailed to 98 Wamogo Road Litchfield CT 06759. Please include your child's name and the month on the check.

PAYMENT SCHEDULE

Payment Due Date	For Month
August 18	September
September 10	October
October 10	November
November 10	December
December 10	January
January 10	February
February 10	March
March 10	April
April 10	May
May 10	June

Thank you,
Tracy Keilty, Prekindergarten Director
Goshen Center School Principal
860-491-6020

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name ______________________ Birth Date ____________ (mm/dd/yyyy) Date of Exam ____________ (mm/dd/yyyy)

❑ I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT_____in/cm_____% *Weight_____lbs._____oz /_____% BMI_____/_____% *HC_____in/cm_____% (Birth – 24 months) *Blood Pressure_______/_____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**
❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess
❑ Referral made to: ____________

***Hearing Screening**
❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess
❑ Referral made to: ____________

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** *Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5μg/dL ❑ No ❑ Yes

*Result/Level: *Date

***TB:** High-risk group? ❑ No ❑ Yes Test done: ❑ No ❑ Yes Date: ________
Results: ____________________
Treatment: ____________________

***Dental Concerns** ❑ No ❑ Yes
❑ Referral made to: ____________
Has this child received dental care in the last 6 months? ❑ No ❑ Yes

Other:

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

***IMMUNIZATIONS** ❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: ______________________________
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II

Seizures ❑ No ❑ Yes: Type: ____________

Other Chronic Disease: ____________________

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* ____________________

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑ No ❑ Yes This child may fully participate in the program.
❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.) ____________________
❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed Stamped ***Provider*** Name and Phone Number

Child's Name: ______________________ Birth Date: ______________ REV. 3/2015

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) ______________________

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) ______________________
(Date) (Confirmed by)

Exemption: Religious _____ Medical: Permanent _____ †Temporary _____ Date _____

†Recertify Date _________ †Recertify Date _________ †Recertify Date ________

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[1]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born on or after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed Stamped *Provider* Name and Phone Number

Regional School District No. 6 James Morris School

PRE-KINDERGARTEN REGISTRATION

Name: ______________________________ Date of Birth: ______________
(Last) (First) (Middle)

Place of Birth: ______________________________ Male (**M**) or Female (**F**) ________

Address: ____

Mailing address *if different* than address listed above:

____

Child Resides With: ________Father/Mother ______ Father ______ Mother ______Other

Alternate mailing Name/Address: ______________________________
(For non-custodial parent, guardian or separated household)

Parent's Name: ______________________ Parent's Name: ______________________

Home Phone: ______________________ Home Phone: ______________________

Work Phone: ______________________ Work Phone: ______________________

Cell Phone: ______________________ Cell Phone: ______________________

Email Address: ______________________ Email Address: ______________________

Names of Brothers/Sisters: ______________________ DOB: ______________

______________________ DOB: ______________

______________________ DOB: ______________

Please list those we may contact in case we are unable to reach you during the day.

Name of Contact	Relationship to Child	Phone Number(s)	Cell Number

Do you give the school nurse permission to contact your child's Pediatrician or the School Doctor in an emergency if you or your contacts cannot be reached? _____ Yes _____ No

Does your child have any allergies or special needs we should be aware of? ______ Yes ______ No

If yes, please explain: ____

Child's Pediatrician: ______________________ Phone: ______________________

Name of previous school attended (if applicable). ______________________________

Regional School District No. 6

98 WAMOGO ROAD • LITCHFIELD, CT 06759-3204 • (860) 567-7400
SERVING THE TOWNS OF WARREN, MORRIS AND GOSHEN

Welcome to our school!

We have a few questions about languages spoken at home. We are required by the US Department of Education to ask for this information because it will help us know how we can best support your child. The language information also helps us know how we can best communicate with you. Please share with us the language(s) spoken by your family and in your home.

Student information
Student first name: Student last name:

Date of birth:

1) What is the primary language used in the home, regardless of the language spoken by the student?

2) What is the language most often spoken by the student?

3) What is the language the student first acquired?

Parent/guardian name (please print)____

Parent/guardian signature____

Date__________________________________

Thank you for answering these questions. We look forward to working with your child.

10-11-17

Regional School District No. 6 does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. The following people have been designated to handle inquiries regarding the non-discrimination policies:

Title IX Contact
Debbie Delisle
98 Wamogo Road, Litchfield, CT 06759
860-567-7400

Section 504 Contact
Debra Foley
98 Wamogo Road, Litchfield, CT 06759
860-567-6642

REGIONAL SCHOOL DISTRICT No. 6

Goshen Center School
50 North Street
Goshen, CT 06756
Tracy Keilty, Principal

James Morris School
10 East Street
Morris, CT 06763
KC Chapman, Principal

Warren School
21 Sackett Hill Road
Warren, CT 06754
Angela Rossbach, Principal

Student's Name: ____________________________ Date: ________________ Grade:_____________

State of Connecticut law requires that each school district conduct a preliminary assessment of the Dominant Language in each household for all public school students. This assessment is used by the state to determine whether a need exists to provide bilingual education programs for students who are limited in English proficiency.

What language did your child learn to speak first? ______________________

What is the primary language spoken by you or other persons in your home? _______________

What is the primary language spoken by your child when he / she is at home? _________________

****

Student Race and Ethnicity Questionnaire

Please check all that apply to your child. Please note that you may refuse to answer these questions, but in this event a school district staff member will need to make the identification for you.

Is this child Hispanic/ Latino	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or other Pacific Islander	White

****

The *Strategic School Profile* for the State of Connecticut also requires the following information on your child's pre-Kindergarten experience.

If your child regularly attended any one of the following programs, please indicate which one by checking the box next to the correct program.

- ❑ Head Start Program
- ❑ Family Day Care Center
- ❑ Nursery School
- ❑ Licensed Day Center
- ❑ Public Preschool Program
- ❑ My child did **NOT** regularly attend a pre-Kindergarten Program before entering Kindergarten at Warren School.

________________________________ Date: ____________

(Parent/Guardian Signature)

Regional School District No. 6

Registration & Residency Checklist

Student's Name: ________________________________

PROOF OF RESIDENCY

Homeowners (Choose one)

_______ Mortgage Statement

_______ Property Tax Statement

_______ Insurance Policy

Renters

_______ Current Rental Agreement

AND

_______ Current Utility Bill

(electric, gas, or cable television, no telephone bills. All documentation must be in the same name and same address.)

________________________________ ________________

(Principal's Signature) (Date)

Regional School District No. 6

Registration & Residency Information Sheet

DOCUMENTATION TO VERIFY YOUR CHILD'S AGE

Please provide documentation from one of the following that applies to your child's place of birth:

If your child was born in the U.S.:

- Child's **FULL SIZE** birth certificate (original)

If your child was NOT born in the U.S.:

- Child's passport or permanent resident alien card.

If your child resides with a legal guardian other than the parent:

The legal guardian must provide:

- Valid Photo ID
- Child's **FULL SIZE** birth certificate (original)
- State of Connecticut issued documentation that they are the student's legal guardian.

(Notarized letters from the biological parent is NOT acceptable).

PROOF OF RESIDENCY DOCUMENTATION

HOMEOWNERS: (Choose one of the following)

- Current mortgage statement
- Homeowner's property tax statement
- Homeowner's insurance policy

RENTERS:

- Current lease/rental agreement (original)

AND

- Current Utility Bill
  (electric, gas, or cable television, no telephone bills. All documentation must be in the same name and same address.)

5118
APR #2

REGIONAL SCHOOL DISTRICT NO. 6

Goshen – Morris - Warren

AFFIDAVIT FOR PURPOSES OF RESIDENCY
(Local Resident)

STATE OF CONNECTICUT)
)ss:
COUNTY OF ______________)

Personally appeared ________________________________, who made oath to the following:

1. I am a resident of the Town of ______________________, State of Connecticut. My residence is located at ______________________________.
(street address)

2. A child by the name of ______________________________ currently resides with me at the address stated above.

3. I receive ________(pay) (no pay)______________for provided such residence.
(cross out inapplicable response)

4. I intend such residence to be ______(temporary) (permanent).__________
(cross out inapplicable response)

____

Subscribed and sworn to
before me, this ____________
day of ___________, 20_____

____
Notary Public Signature

Notary Seal

5118
APR #3

REGIONAL SCHOOL DISTRICT NO. 6
Goshen - Morris - Warren

AFFIDAVIT FOR PURPOSES OF RESIDENCY
(Parent of Guardian)

STATE OF CONNECTICUT)
)ss:
COUNTY OF ______________)

1. I am a (parent) (guardian) ______________ of ______________
(cross out inapplicable response) (name of child)

2. I reside at ______________ in the Town of
(street address)
______________, State of Connecticut.

3. ______________ currently (does not) (does) ______________
(name of child) (cross out inapplicable response)
reside with me.

4. It is my intention that ______________ reside with
______________ of the Town of ______________, State of
(name of person)
Connecticut, and that such residence be (permanent) temporary) ______________.
(cross out inapplicable response)

5. I (do) (do not) ______________ now pay nor do I intend to pay
(cross out inapplicable response
______________ for allowing ______________
(name of person)
to reside with ______________ (him/her) ______________

____
Parent or Guardian

Subscribed and sworn to
before me, this ______________
day of ______________, 20____

____
Notary Public Signature

Notary Seal