121 Scholfield Road
Rochester, NY 14617
icns@seneca-umc.org
icnspreschool.org
Phone: (585) 775-8146

Spring 2017 Early Beginnings Registration Package

Registration Checklist:

Required to reserve your child's place at ICNS:

- ☐ Registration Information Form
- ☐ $25.00 non-refundable registration fee
- ☐ Parent(s) Contract and Tuition Agreement
- ☐ Parent Assisting Information & Availability Form
- ☐ Emergency Medical Permission Form
- ☐ Photo Release Form
- ☐ ICNS Behavior Policy
- ☐ Child's Medical Form

Please feel free to email icns@seneca-umc.org or call (585) 775-8146 with any questions. You are encouraged to attend an open house (see web site for dates) or call to schedule a classroom visit with your child.

Please return completed forms and registration fee by August 15th to the address below (applications are processed in the order they are received until classes are full):

Irondequoit Cooperative Nursery School
Attention: Registrar
121 Scholfield Road
Rochester, NY 14617

Alternatively, you may put them in an addressed and sealed envelope and place them in the locked mailbox to the right of the parking lot entrance to the church.

2017 to 2018 Registration Information Form

Early Beginning (age 2) February 27 to June 1, 2017 9:30-11:30am, one day per week:

Indicate preference of day (1-4): M _____ Tu _____ W _____ Th _____

Child's Name: ____ Nickname: ________________

Date of Birth: ______/______/______ Boy______ Girl______

Mother's Name: ________________________ Father's Name: __________________________

Address: ____
Street City, State & Zip

Phone(s): ____

Email Address: ____

____

Can we share this email with your class? YES_______NO_______

Name and Ages of siblings: ____

Father's Employer: _______________________________________Phone: ________________

Mother's Employer: ______________________________________Phone: ________________

How did you learn about ICNS (if online, where)? _____________________________________

Mother's Signature: ____

Father's Signature: ____

To reserve your child's place at ICNS, please complete the forms in this packet (see check list) and return them with a $50 non-refundable application fee (payable to ICNS) to:

Irondequoit Cooperative Nursery School
Attention: Registrar
121 Scholfield Road
Rochester, NY 14617

The medical forms can be included to complete the Registration process. Enrollment is not complete until all forms are returned to ICNS, no later than August 15th.

Parent(s) Contract and Tuition Agreement

This contract, between Irondequoit Cooperative Nursery School (ICNS), 121 Scholfield Rd., Rochester, NY 14617 and

Parent(s): ____

Address: ____
Street & Apt. No.

____
City State Zip

is entered on _______________ for the purpose of joining ICNS and having their child
Date of Contract

____ be enrolled in ICNS.
First Middle Last

I/We agree to:

a. ______ assist in the classroom when scheduled and pay the normal fees (Section II b)

Or

b. ______ pay the higher Non-Assisting Parent fees (Section II b).

ICNS is administered by the parent(s) of the enrolled children and provides an educational program developed and implemented by a professional teacher, in consultation with the ICNS Board. ICNS will provide a TEACHER appropriately certified in the state of New York, or an appropriate substitute in cases of TEACHER absence, for the class days and times offered during the period of enrollment. ICNS holds classes beginning in September and ending in May. Classes meet as follows (except holidays and school vacation days):

Early Beginnings (age 2) Class: (Two years old by December 1st of 2016)
Monday and Wednesday from 9:30-11:30am
Tuesday and Thursday from 9:30-11:30am

In consideration of enrolling the PARENTS' child in ICNS for the **2017 to 2018** school year and services rendered to the PARENT(S) of the enrolled child during the period of enrollment, the PARENT(S) agree to fulfill their obligations to the ICNS as follows:

I. Cooperative Responsibilities of the Parent

a. I/We agree to assist in the classroom on a rotating schedule in equal proportion to all other families. The actual number of assisting days will depend on final enrollment numbers. Assisting consists of arriving by 8:40 a.m. to help set up the classroom for the day's activities and staying after all the children have been released to help clean

up. Non-Participating Assisting is offered with an increased tuition. Failure to abide by the assisting schedule will result in penalties as outlined in Section III.

b. I/We agree to perform housekeeping duties 1 to 2 times per school year according to the rotating weekly schedule established by the Housekeeping Coordinator.

II. Financial Responsibilities

a. I/We agree to pay the non-refundable $25 application/registration fee ($15 per child if more than one child is enrolled in the same family).

b. I/We agree to pay tuition of $175 in full by March15th. Parents having or anticipating trouble making payments can discuss other options with the Treasurer.

c. I/We agree to participate in one fundraisers. The School Board will set the minimum fundraising level for each fundraiser.

d. I/We understand that tuition is non-refundable. Refunds on a case-specific basis will be considered for reason of loss of job, transfer out of town, serious illness, death, or teacher recommendation. These requests will be considered by the ICNS Board and would then only be given upon enrollments of a replacement child acceptable to ICNS. Refunds, if any, would be pro-rated effective on the date the replacement child enrolls, or as determined by the ICNS Board.

III. I/We agree with the fine schedule outlined below:

Arrival after 8:40 am on Assisting Day	1st Offense – Written Warning
Arrival after 8:40 am on Assisting Day	2nd Offense - $25 Fine
Arrival after 8:40 am on Assisting Day	3rd Offense - $50 Fine
No Show on Assisting Day	$50 Fine
Failure to accept a job by school opening	$25 Fine per month assessed on the first day of school, and the 1st day of each subsequent month in violation
Failure to clean up classroom	$25 Fine
Unexcused absence from Parent Meeting	$25 Fine
Tuition Late Charges	$10 per week, child may become ineligible to attend class after 4 weeks.
Bad Check Fee	$35 Fee

IV. I/We give permission for my child to go on all field trips for the school year. I further understand that if I cannot attend a field trip, it is my responsibility to make arrangements for another responsible adult to provide transportation and supervision for my child. I will provide an age appropriate child safety seat for the trip.

V. I/We understand that my child will only be allowed to attend class after all Health Forms are received by the Health & Safety Coordinator.

VI. I have read, understand, and agree to abide by the Constitution and Bylaws of Irondequoit Cooperative Nursery School and all items included in this contract. I understand that failure to meet my financial or cooperative responsibilities may result in expulsion from the school.

VII. This contract becomes effective after the PARENT(S) and ICNS Registrar (or Chairperson) has signed below and Registration fee is paid. It remains effective for the school year designated previously. It may be terminated by mutual consent of PARENT(S) and ICNS Board.

Parent #1: ____ Date: _______________

Parent #2: ____ Date: _______________

Registrar: ____ Date: _______________

Please return this form to the registrar. You will receive a copy for your records.

Parent Assisting Information & Availability Form

Parent Name: ____

Child: ____

Child Allergies: ____

If you want to assist on your child's birthday, indicate date: ___________________________

Specific date(s) you would like to assist (holidays):________________________________

____

Date(s) you cannot assist: ____

Specific weekday(s) that is inconvenient for you to assist: ___________________________

Name(s) of person(s) carpooling with: ____

Parent's hobbies, interests, musical talent, skills: ___________________________________

____

If you are unable to assist on your scheduled day, you are responsible for finding a substitute as far in advance as possible. We plan to have a list of emergency substitutes for those mornings that an emergency may arise (sick child, etc…).

_____I will be an emergency substitute (An emergency sub does not assist more, but they are available "on call" to switch days)

Emergency Medical Permission

Child's Name: ____________________________________ Date of Birth: _________________

Address: ____ Home Phone: _________________

Father's Name: ____________________________________Work Phone: __________________

Mother's Name: ___________________________________ Work Phone: __________________

Pediatrician: ______________________________________ Phone: _______________________

Emergency Contact: _______________________________Phone: _______________________

Emergency Contact: _______________________________Phone: _______________________

Type of medical insurance coverage and policy number:

Provider: _________________________________ Policy #: _____________________________

Special medical or emergency instructions:

____

____

Please list any food allergies here, and ALSO notify the teacher directly: ___________________

____

Pediatrician's Hospital Affiliation: ____

I give my permission for the teacher or other agents of the preschool to seek emergency medical treatment for my child.

Print Name: ________________________________

Signature: __________________________________ Date: ____________________

Photo Release Form

The Irondequoit Cooperative Nursery School (ICNS) would like to take photographs and/or videos of the children to illustrate learning activities in our facility on our website, our Facebook page, in newsletters, yearbooks, promotions, pamphlets and news releases for the preschool. We would also like to use the children's original artwork in those promotional materials.

Before taking and publishing any photographs or videos of your child, or publishing their artwork, we need your permission. ICNS will not use names or other personal or identifying information with published images. Please select an option below, then sign and date at the bottom.

Grant Permission to Use Photographs, Videos, and Artwork

__________I hereby authorize ICNS to use my child's photograph, video, and original artwork to illustrate educational activities in publicity materials produced by ICNS, including electronic and printed publications, ICNS websites, and the ICNS Facebook page. I give this consent with no claim for payment. I hereby release and discharge ICNS from any and all claims arising out of the photograph, videos and artwork that I or my child might have.

I understand that these photographs, videos and artwork will not be sold, distributed, or placed on other internet web sites by ICNS.

I understand that I do not own the copyright on my child's photographs, videos, or artwork.

Do not Grant Permission to Use Photographs, Videos, or Artwork

__________ I do not give ICNS my permission to use my child's photographs, videos, or artwork in promotional materials.

I understand that choosing this option may result in my child being asked to step outside the range of a group photo or in his/her image being blurred out of photos by the editor.

Name of Child: ___________________________________ Date: __________________________

Name of Parent/Guardian (please print): ____

Signature of Parent/Guardian: ____

ICNS Behavior Policy

In order to provide a safe and happy place for all our students, ICNS has established some general rules to insure classroom management. These rules have been discussed, role-played, and modeled with the students during the first week of school and will be reviewed other times during the school year, if necessary. Please help us in providing a safe and happy learning environment by talking to your child about good choices and good behavior and let's have a WONDERFUL year!!!

Classroom Rules

1. Walking feet
2. Be kind to others
3. Inside voice
4. Clean your mess
5. hands/feet to self

Rewards – appropriate behavior is reinforced with positive rewards

1. Verbal praise from the teacher
2. Sticker for hand
3. Get to hold Mr. Dog/stuffed animal at circle times
4. Sunshine note home
5. Class reward system being used, changes during the year

Consequences – inappropriate behavior receives a consequence

First time- the child will receive a reminder of the rule
Second time- The child will receive a verbal warning from the teacher
Third time - The child will sit in the "thinking chair" for 2 minutes. Note home
Fourth offense- The child will be removed from the class activity area until behavior is appropriate, parent may be contacted.

**For severe discipline issues, these steps may be bypassed and the parent may be contacted.*

Please don't worry if your child receives a few warnings or a visit to the "thinking chair", remember we are ALL learning and we all have "uh-oh" days. Warnings and the "thinking chair" are just a reminder to a student when they break a rule, students WILL NOT lose their stamp for the day or any other privileges for warnings.

Thank you in advance for your support and cooperation.
Name of Child: ____________________________________ Date: __________________________

Name of Parent/Guardian (please print): ____

Signature of Parent/Guardian: ____

CHILD & ADOLESCENT HEALTH EXAMINATION FORM

Please Print Clearly Press Hard

NYC DEPARTMENT OF HEALTH & MENTAL HYGIENE — DEPARTMENT OF EDUCATION

STUDENT ID NUMBER OSIS

TO BE COMPLETED BY PARENT OR GUARDIAN

Child's Last Name | First Name | Middle Name | Sex ☐ Female ☐ Male | Date of Birth (Month/Day/Year) __ __ / __ __ / __ __ __ __

Child's Address | Hispanic/Latino? ☐ Yes ☐ No | Race (Check ALL that apply) ☐ American Indian ☐ Asian ☐ Black ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other ______

City/Borough | State | Zip Code | School/Center/Camp Name | District Number __ __ | Phone Numbers: Home ______ Cell ______ Work ______

Health insurance (including Medicaid)? ☐ Yes ☐ No | ☐ Parent/Guardian ☐ Foster Parent | Last Name | First Name

TO BE COMPLETED BY HEALTH CARE PROVIDER *If "yes" to any item, please explain (attach addendum, if needed)*

Birth history *(age 0-6 yrs)*

☐ Uncomplicated ☐ Premature: ________ weeks gestation

☐ Complicated by ____________

Allergies ☐ None ☐ Epi pen prescribed

☐ Drugs *(list)* ____________

☐ Foods *(list)* ____________

☐ Other *(list)* ____________

Does the child/adolescent have a past or present medical history of the following?

☐ Asthma *(check severity and attach MAF/Asthma Action Plan)*: ☐ Intermittent ☐ Mild Persistent ☐ Moderate Persistent ☐ Severe Persistent

If persistent, check all current medication(s): ☐ Inhaled corticosteroid ☐ Other controller ☐ Quick relief med ☐ Oral steroid ☐ None

☐ Attention Deficit Hyperactivity Disorder
☐ Chronic or recurrent otitis media
☐ Congenital or acquired heart disorder
☐ Developmental/learning problem
☐ Diabetes *(attach MAF)*
☐ Orthopedic injury/disability
☐ Seizure disorder
☐ Speech, hearing, or visual impairment
☐ Tuberculosis *(latent infection or disease)*
☐ **Other** *(specify)* ____________

Explain all checked items above or on addendum

Medications *(attach MAF if in-school medication needed)* ☐ None ☐ Yes *(list below)*

Dietary Restrictions ☐ None ☐ Yes *(list below)*

PHYSICAL EXAMINATION

Height	______ cm	(__ __ %ile)
Weight	______ kg	(__ __ %ile)
BMI	______ kg/m^2	(__ __ %ile)
Head Circumference *(age ≤2 yrs)*	______ cm	(__ __ %ile)
Blood Pressure *(age ≥3 yrs)*	______ / ______	

General Appearance:

Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl		Nl	Abnl	
☐	☐	HEENT	☐	☐	Lymph nodes	☐	☐	Abdomen	☐	☐	Skin	☐	☐	Psychosocial Development
☐	☐	Dental	☐	☐	Lungs	☐	☐	Genitourinary	☐	☐	Neurological	☐	☐	Language
☐	☐	Neck	☐	☐	Cardiovascular	☐	☐	Extremities	☐	☐	Back/spine	☐	☐	Behavioral

Describe abnormalities:

DEVELOPMENTAL *(age 0-6 yrs)* ☐ Within normal limits

If delay suspected, specify below

☐ Cognitive *(e.g., play skills)* ____________

☐ Communication/Language ____________

☐ Social/Emotional ____________

☐ Adaptive/Self-Help ____________

☐ Motor ____________

SCREENING TESTS	Date Done	Results
Blood Lead Level (BLL) *(required at age 1 yr and 2 yrs and for those at risk)*	__ __/__ __/__ __ __ __/__ __/__ __	______ µg/dL ______ µg/dL
Lead Risk Assessment *(annually, age 6 mo-6 yrs)*	__ __/__ __/__ __	☐ At risk *(do BLL)* ☐ Not at risk
Hearing ☐ Pure tone audiometry ☐ OAE	__ __/__ __/__ __	☐ Normal ☐ Abnormal
— Head Start Only —		
Hemoglobin or Hematocrit *(age 9–12 mo)*	__ __/__ __/__ __	______ g/dL ______ %

	Date Done	Results
Tuberculosis *Only required for students entering intermediate/middle/junior or high school who have not previously attended any NYC public or private school*		
PPD/Mantoux *placed*	__ __/__ __/__ __	Induration ______ mm
PPD/Mantoux *read*	__ __/__ __/__ __	☐ Neg ☐ Pos
Interferon Test	__ __/__ __/__ __	☐ Neg ☐ Pos
Chest x-ray *(if PPD or Interferon positive)*	__ __/__ __/__ __	☐ Nl ☐ Abnl ☐ Not Indicated
Vision *(required for new school entrants and children age 4–7 yrs)*	__ __/__ __/__ __ ☐ with glasses	Acuity *Right* __ / __ *Left* __ / __ Strabismus ☐ No ☐ Yes

IMMUNIZATIONS – DATES CIR Number of Child

Hep B	__/__/__	__/__/__	__/__/__	__/__/__
Rotavirus		__/__/__	__/__/__	__/__/__
DTP/DTaP/DT		__/__/__	__/__/__	__/__/__
		__/__/__	__/__/__	__/__/__
Hib	__/__/__	__/__/__	__/__/__	__/__/__
PCV	__/__/__	__/__/__	__/__/__	__/__/__
Polio	__/__/__	__/__/__	__/__/__	__/__/__

Influenza	__/__/__	__/__/__	__/__/__
MMR	__/__/__	__/__/__	__/__/__
Varicella	__/__/__	__/__/__	
Td	__/__/__	__/__/__	__/__/__
Tdap __/__/__ Hep A		__/__/__	__/__/__
Meningococcal	__/__/__	__/__/__	
HPV	__/__/__	__/__/__	__/__/__
Other, *specify:* ______	__/__/__ ;	______	__/__/__

RECOMMENDATIONS ☐ Full physical activity ☐ Full diet

☐ Restrictions *(specify)* ____________

Follow-up Needed ☐ No ☐ Yes, for ____________ Appt. date: __/__/__

Referral(s): ☐ None ☐ Early Intervention ☐ Special Education ☐ Dental ☐ Vision

☐ Other ____________

ASSESSMENT ☐ **Well Child** (V20.2) ☐ **Diagnoses/Problems** *(list)* **ICD-9 Code**

Health Care Provider Signature | Date __ __/__ __/__ __

Health Care Provider Name and Degree *(print)* | Provider License No. and State

Facility Name | National Provider Identifier (NPI)

Address | City | State | Zip

Telephone (__ __ __) __ __ __ – __ __ __ __ | Fax (__ __ __) __ __ __ – __ __ __ __

DOHMH ONLY PROVIDER I.D.

TYPE OF EXAM: ☐ NAE Current ☐ NAE Prior Year(s)

Comments

Date Reviewed: __/__/__ I.D. NUMBER

REVIEWER:

Copies: **White** School/Child Care/Early Intervention/Camp, **Canary** Health Care Provider, **Pink** Parent/Guardian