Summer Registration Instructions:

INITIAL REGISTRATION: In order to secure a spot for your child, simply….

Turn in the completed packet. This includes:

- ☐ Summer Program Registration Form.
- ☐ Care4Kids Paperwork (if necessary).
- ☐ Parent Financial Agreement
- ☐ Parent Permission Form
- ☐ Health Assessment- Completed by Parent. (1st Page of Physical) (Kindergarten-5th Grade)
- ☐ Immunization Record and Physical within last 12 months (Kindegarten-5th Grade)
- ☐ Related Medical Care Plans- Must be completed by Guardian & Physician.
- ☐ Medication Authorization- Must be completed by Guardian & Physician.

☐ Pay a deposit of half of the total cost of all sessions registered for and a $25 per child registration fee.

Your child's spot will *NOT* be confirmed for our Summer Program until this packet is 100% completed and submitted with payment.

ADDING/CHANGING SESSIONS:

You have until May 31st to make any changes requiring a partial or full refund.
After May 31st no refunds will be issued.

Please contact me with any questions you may have: 860.285.1420
Casey@townofwindsortct.com

IMPORTANT DEADLINES

Session Dates	Care4Kids Deadline (In order to apply for Care4Kids, we ask for your paperwork to be completed by these dates)	Half of Total Tuition & $25 Reg Fee Due	Second Half of Tuition Due
June 22 - 26	5/22/2020	At Registration	5/31/2020
June 29- July 2	5/29/2020		
July 6 - 10	6/6/2020		
July 13 - 17	6/13/2020		
July 20 - 24	6/20/2020		
July 27 - 31	6/27/2020		
August 3 - 7	7/2/2020		
August 10 - 14	7/10/2020		
August 17 – 21	7/17/2020		

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

Child & Parent Information

Child's First Name:	Last Name:

Address: _____
Street City State Zip Code

Grade (Fall 2020): School Attending:

Birth Date: Age: Gender: Male Female

Can your Child Swim? ☐ Yes ☐ No
If NO, I will provide a US Coast Guard Certified Lifejacket _____ (please initial)

Child's T-Shirt Size (Youth): ☐ X-Small ☐ Small ☐ Medium ☐ Large ☐ X-Large

1.Parent Legal/Guardian First Name:	Last Name:

Address:
Street City State Zip Code

Phone (Cell/Home) #:	Work #:
Employer:	Address:

Email Address:

2. Parent/Legal Guardian First Name:	Last Name:

Address:
Street City State Zip Code

Phone (Cell/Home) #:	Work #:
Employer:	Address:

Email Address:

Next Page →

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

Summer Program Sessions

Please select the Summer Program and Sessions you wish to attend:

☐ Session # 1: June 22 – 26, 2020	☐ Session # 5: July 20 – 24, 2020
☐ Session # 2: June 29 – July 2, 2020 (Closed July 3rd)	☐ Session # 6: July 27 – 31, 2020
☐ Session # 3: July 6 – 10, 2020	☐ Session # 7: August 3 – 7, 2020
☐ Session # 4: July 13 – 17, 2020	☐ Session # 8: August 10 – 14, 2020
☐ Session # 9: August 17 – 21, 2020	

☐ CHILD CARE WEEK INTERNAL FAMILIES ONLY August 24 - 28

Primary (Ages 3 & 4/***Fully Potty Trained***)	☐ 8:30 -12:00 $165	☐ 6:45-5:30 $290
K-1st Grade (Must be 5 Years Old)	☐ 8:30 - 4:30 $240	☐ 6:45-5:30 $260
2nd-3rd Grade	☐ 8:30 - 4:30 $240	☐ 6:45-5:30 $260
4th-5th Grade	☐ 8:30 - 4:30 $240	☐ 6:45-5:30 $260

****Please note payment schedule on registration packet cover sheet****

We offer a 10% sibling discount off the lower tuition.

Emergency Contacts

1. First Name:	Last Name:
Relationship:	Phone #:

Address: _____
Street City State Zip Code

☐ Yes, the person above can pick my child up. ☐ No, the person above can't pick my child up.

2. First Name:	Last Name:
Relationship:	Phone #:

Address: _____
Street City State Zip Code

☐ Yes, the person above can pick my child up. ☐ No, the person above can't pick my child up.

Child's Health Information

Does your child have any Allergies? ☐ No ☐ Yes
List allergy(ies): _____

Is your child currently taking Medication? ☐ NO ☐ Yes For what condition: _____
If YES, will your child need this medication at Summer Program? ☐ NO ☐ Yes
If medication is needed a Medical Authorization form completed by a doctor is required to register.
A Care Plan completed by a doctor is required for Asthma/Allergy treatment.

Please review and complete Pages 10-12 as medically necessary.

Medication name: Next Page →

Student Physical Pages 7-9 Required for all enrollees
Medical authorizations pages 10-12 complete as necessary.

Please tell us about your child.

Who does your child live with_____

Siblings: Please list all siblings (including step-siblings), current ages and gender:
1._____ M F AGE _____
2._____ M F AGE _____
3._____ M F AGE _____

Are there any family events or recent changes that you feel have impacted your child? NO YES
If yes, please describe:_____
_____

Any reasons you feel your child might have difficulty functioning in a group size with a 1 to 10 ratio?
NO YES If yes, please describe
_____
_____

Please describe the nature of your child's personality and observed self-esteem:
_____
_____

What are your child's favorite activities/interests?
_____
_____

How does your child respond to chores?
_____
_____

What are your child's strengths?
_____
_____

Does your child have any challenges or behaviors that may be difficult to handle? YES NO
If yes, please describe how you address them: _____
_____
_____

Does your child have a 504, IEP and/or Behavioral Plan at their current school? YES NO
If yes, please describe (This information is required by our license.) :
_____
_____
_____

Please use space below to include any additional information that you think we should know to ensure your child has a successful summer experience:

_____

_____

_____

_____

_____

_____

_____

_____

_____.

Emergency Care Authorization

I certify that I am the parent or legal guardian of the child named above and give consent for emergency medical care, surgical treatment, and/or transportation to a care facility should my child's condition require it in my absence. I understand that, time and conditions permitting, reasonable attempts will first be made to contact me and any designated representatives in such case. I hereby assume all financial responsibility for such actions taken on the behalf of my child.

Parent/Legal Guardian's Signature: _____ Date: _____

Office Use Only

Please check all forms are completed.

- ☐ Registration Form
- ☐ Physical
- ☐ Medication Authorization
- ☐ Parent Permission
- ☐ Allergy Care Plan NA
- ☐ Asthma Care Plan NA

Payment at Registration

Number Of Sessions	Weekly Rate	½ Total & Registration Fee Due ($25 per child)	Amount Due 5/31/2020

☐ Sibling discount applied 10% _____

Received by: _____ Date: _____

Parent/Guardian Permission

I _____, grant the following permissions for my child _____.

☐ **FIELD TRIP PERMISSION:** To participate in field trips, on foot or in an authorized vehicle, as scheduled and posted by Windsor Discovery Center.

☐ **RELEASE OF INFORMATION:** I hereby give permission for my child's name, address, and telephone number to be included in the classroom list distributed to other Windsor Discovery Center parents.

☐ **PHOTO PERMISSION**: I hereby consent that Windsor Montessori School and Discovery Center and the Town of Windsor or any person authorized by the Town may use photographic, social media, videotape images and/or voice recordings, and classroom work in which my child may be included in whole or in part for any purpose they find appropriate such as promotional marketing material and posts on social media like Facebook, Twitter, Instagram, and Youtube.

Parent's Signature:_____ Date: _____

☐ **MEDICAL/FIRST AID TREATMENT:** I hereby give permission for my child to receive first aid treatment for minor injuries from Windsor Discovery Center staff. Written permission is required for the application of any topical ointments and all prescription medications.

Parent's Signature:_____Date:_____

☐ **BEHAVIOR PLAN/CHILD DISCIPLINE POLICY:** The schools behavior plan (Parent Handbook Pg. 17) has been discussed with me upon registration. I've had an opportunity review and ask any related questions. I understand the school uses a positive discipline approached and redirection. If my child's behavior requires additional support, I will be involved in the process of creating an individualized behavior plan for my child. I understand my child may be asked to leave the program as a result of "Serious Acts of Aggression" as outlined in the Behavior Management Procedures.

Parent's Signature:_____ Date:_____

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental 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	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take **in** school:

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian Date

HAR-3 REV. 4/2017

To be maintained in the student's Cumulative School Health Record

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

HAR-3 REV. 4/2017

Part II — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ 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 under Connecticut State Law

***Height** _____ in. / _____% ***Weight** _____ lbs. / _____% **BMI** _____ / _____% **Pulse** _____ ***Blood Pressure** _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

***Postural** ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings

***Vision Screening**

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

❑ Referral made

***Auditory Screening**

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

❑ Referral made

	Date
History of Lead level ≥ 5µg/dL ❑ No ❑ Yes	
***HCT/HGB:**	
***Speech** (school entry only)	
Other:	

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*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 the **Asthma Action Plan** to School*

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

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:**

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____

This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____

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

ALLERGY ACTION PLAN

Patient Name: _____ Date of Birth: _____ Age: _____

Allergies: _____

Asthma: ☐ Yes (High Risk for Severe Reaction) ☐ No

Additional health problems: _____

Concurrent Medications: _____

SIGNS OF AN ALLERGIC REACTION

MOUTH	Itching, swelling of lips and/or tongue
THROAT*	Itching, tightness/closure, hoarseness
SKIN	Itching, hives, redness, swelling
GUT	Vomiting, diarrhea, cramps
LUNGS*	Shortness of breath, cough, wheeze
HEART	Weak pulse, dizziness, passing out

Only a few symptoms may be present. Severity of symptoms can change quickly.

**Some symptoms can be life-threatening.*

ACT FAST! Initiate Emergency Action Plan if symptoms occur.

Emergency Action Steps – DO NOT HESITATE TO GIVE EPINEPHRINE!

Action for Minor Reaction:

1. If only symptom (s) are: _____,give_____
2. Then call parent/guardian_____Phone#_____

Action for Major Reaction:

1. If symptom(s) are: _____
   _____
2. Give_____
3. CALL **911**
4. Call Parent/Guardian_____ Phone#_____
5. If Parent/Guardian are unreachable, contact emergency contacts on enrollment form.

Medication Requirements: (Check One)

1._____ No medication required while attending program. Physicians initials required:_____

2._____ Medication required at program (Bring original prescription to first day of program, with original prescription label adhered to medication)

ALL MEDICATIONS MUST HAVE A COMPLETED AUTHORIZATION FOR ADMINISTRATION OF MEDICATION.

Health Care Provider Signature_____ Date:_____

Parent/Guardian Signature _____ Date:_____

WINDSOR MONTESSORI SCHOOL & DISCOVERY CENTER

ASTHMA MEDICATION AUTHORIZATION AND ASTHMA ACTION PLAN

Parent/Guardian: Complete and Sign this portion and the medication authorization below **Today's Date:**

Student Name:	Date of Birth	
Address:		
Parent/Guardian:	Home/Cell #:	Work #:
Health Care Provider:	Office #:	

① **KNOWN ASTHMA TRIGGERS**: ❑ Exercise ❑ Pet Dander ❑ Mold ❑ Dust ❑ Pollen ❑ Colds ❑ Strong Odors ❑ Cold Air ❑ Pests

② **ALLERGIES:**

HEALTH CARE PROVIDER: COMPLETE ALL ITEMS IN SHADED AREA, SIGN AND DATE.

Asthma Medication(S) To Be Given:

Student's Asthma Severity Classification: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent

Ⓐ **Exercise Pre-treatment**: ❑ Not Required ❑ Before Recess ❑ Before PE/Sports

Give: (***Circle One***)
Albuterol MDI 90 / Xopenex MDI 45____ Puffs Inhaled (by mouth) ❑ **10-15 minutes before exercise** ❑ **with spacer**
Nebulized Albuterol 2.5mg/Xopenex 0.63mgVial inhaled (by mouth) ❑ **10-15 minutes before exercise** ❑ **with nebulizer**

OTHER:

Ⓑ **RESCUE MEDICINE TO RELIEVE ASTHMA SYMPTOMS: COUGH, CHEST TIGHTNESS, WHEEZING (Follow CAUTION or DANGER ZONES of Asthma Action Plan)**

Give (***Circle One***):

Albuterol MDI 90 / Xopenex MDI 45	____ Puffs Inhaled (by mouth)	❑ **every ___ hours** ❑ **with spacer**
Nebulized Albuterol 2.5mg OR	____ Vial inhaled (by mouth)	❑ **every ___ hours** ❑ **nebulizer**
Nebulized Xopenex 0.63mg		

OTHER:

*** If there is no improvement 20 minutes after taking the Rescue Medication: Notify provider**

HEALTH CARE PROVIDER MEDICATION AUTHORIZATION REQUIRED FOR ALBUTEROL/XOPENEX AS STATED IN ABOVE PLAN, AND IN ACCORDANCE WITH CT LAW AND REGULATIONS 10-212a

④ **Reaction to/or negative interaction with food or drugs:** **or ❑ None**

⑤ **Self–Administration Authorization:** ☐ **This student is capable to safely and properly self-administer medication(s)**

0r ☐ **This student is NOT approved to self-administer medication**

Medication Start Date _____/_____/_____ END Date _____/_____/_____ (One Year maximum)

Heath Care Provider Signature_____Date_____

PARENT/GUARDIAN CONSENT:

- ❑ **I authorize the student to possess and self-administer medication as described and directed above**
- ❑ **I authorize this medication to be administered by school personnel as described and directed above**
- ❑ **I hereby request that the above ordered medication be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication.**
- ❑ **I understand that I must supply the school with no more than a three (3) month supply of medication (school only.)**
- ❑ **I assume full responsibility for providing the school with the prescribed medication and spacer.**
- ❑ **I have administered at least one dose of the medication to my child/student without adverse effects. (For child care only)**

Parent Signature: _____ **Date:**_____

Staff Receiving Written Authorization and Medication _____Title/Position:_____

Windsor Montessori School & Discovery Center
Summer Program Registration 2020
Authorization for the Administration of Medication by Child Day Care Personnel

In Connecticut, licensed Child Day Care Centers, Group Day Care Homes and Family Day Care Homes administering medications to children shall comply with all requirements regarding the Administration of Medications described in the State Statutes and Regulations. Parents/guardians requesting medication administration to their child by daycare staff shall provide the program with appropriate written authorization(s) and the medication before any medications are dispensed. Medications must be in the original container and labeled with child's name, name of medication, directions for medication's administration, and date of the prescription. All unused medication will be destroyed if not picked up within one week following the termination of the authorized prescriber's order.

Authorized Prescriber's Order (Physician, Dentist, Physician Assistant, Advanced Practice Registered Nurse or Podiatrist):

Name of Child _____Date of Birth ____/____/____ Today's Date ____/____/____
Address of Child_____Town_____
Medication Name/Generic or Drug _____Controlled Drug? ☐YES ☐ NO
Condition for which drug is being administered:_____
Special Instructions for Medication Administration_____
Dosage _____ Method/Route _____
Time of Administration_____ If PRN, Frequency_____
Medication Administration Start Date_____/_____/_____ End Date _____/_____/_____
Relevant Side Effects of Medication _____☐ None Expected
Explain any allergies, reaction to/negative interaction with food or drugs_____
Plan of Management for Side Effects_____
Prescriber's Name /Title _____Phone Number (___)_____
Prescriber's Address _____ Town_____
Prescriber's Signature _____
School Nurse Signature (if applicable)_____

Parent/Guardian Authorization:

☐ I request that medication be administered to my child as described and directed above.
☐ I hereby request that the above ordered medication be administered be administered by school, child care and youth camp personnel and I give permission for the exchange of information between the prescriber and the school nurse, child care nurse or camp nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication (school Only).
☐ I have administered at least one dose of the medication with the exception of emergency medications to my child/student without adverse effects. (For Child Care Only)

Parent/Guardian Signature _____Relationship _____Date _____/_____/_____
Parent/Guardian's Address_____Town_____ State _____
Home Phone # (_____)_____-_____ Work Phone # (_____)_____-_____ Cell Phone # (_____)_____-_____

SELF ADMINISTRATION OF MEDICATION AUTHORIZATION / APPROVAL

Self-administration of medication may be authorized by the prescriber and parent/guardian and must be approved by the school nurse (if applicable) in accordance with board policy. In a school, inhalers for asthma and cartridge injectors for medically-diagnosed allergies, students may self-administer medication with only the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Prescriber's authorization for self-administration: ☐ YES ☐ NO _____
Parent/Guardian authorization for self-administration: ☐ YES ☐ NO _____
School Nurse, if applicable, for self-administrati ☐ YES ☐ NO _____
****
Today's Date _____ Printed name of Individual Receiving Written Authorization and Medication _____
Title/Position _____ Signature _____(In INK)