



The Scarsdale Congregational Church Nursery School

**2019-2020 Registration Form**

Name of Child: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Occupation: \_\_\_\_\_ Business/Cell Phone: \_\_\_\_\_

Mother's Occupation: \_\_\_\_\_ Business/Cell Phone: \_\_\_\_\_

Email Address(es): \_\_\_\_\_

Emergency Contacts

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Does your child have allergies to take medications on a regular basis?

\_\_\_\_\_

Are there any special conditions or characteristics of your child about which we should be informed? \_\_\_\_\_



## 2019-2020 Registration Form

<input type="checkbox"/> 4's Class (5 days)	\$5,450
<input type="checkbox"/> 3's Class (5 days)	\$5,400
<input type="checkbox"/> 3's Class (3 days: M, W, F)	\$4,200
<input type="checkbox"/> 3's Class (2 days: Tu, Th)	\$3,200
<input type="checkbox"/> 2's Class (3 days: M, W, F)	\$4,200
<input type="checkbox"/> 2's Class (2 days: Tu, Th)	\$3,200

A check for **\$500** is required at the time of registration, \$200 of which is the non-refundable registration fee, and \$300 is a deposit applied towards tuition.

In so registering my child, I recognize my responsibility to cooperate with the school by observing all health regulations and financial obligations.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent or legal guardian)

### To register:

- Return all registration forms
- Include a check for \$500 -- this must accompany this signed application in order to register your child
- Please make all checks payable to: **SCC Nursery School**
- Applications will not be accepted unless everything is included

Occasionally a child will require more care and attention than the staff can reasonably provide. We reserve the right to decide whether such child's admittance or continued attendance in the program is appropriate.



## 2019-2020 Registration Form

### PERMISSION SLIPS

#### **1. Medical**

I hereby give my permission for my child \_\_\_\_\_ to participate in the  
 2's  3's  4's class at Scarsdale Congregational Church Nursery School. I have disclosed all known allergies and relevant past medical history in this application form. In the event of an emergency, and I cannot be reached, I hereby give my permission to the Director or her designate to secure proper medical treatment for my child. I agree to hold harmless from any liability the staff and volunteers of the Scarsdale Congregational Church Nursery School for securing such treatment for my child.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (parent or legal guardian)

#### **2. Permission to Change**

I hereby give the staff permission to change my child's diaper or clothing, if needed.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (parent or legal guardian)

#### **3. Field Trip (for 3's and 4's Classes only)**

During the school year, the Nursery School takes the class on class trips to nearby places of interest, such as: The Scarsdale Library, the Firehouse, and the Duck Pond on Heathcote Road, the Greenburgh Nature Center, Ramsey's Farm and the Eastchester A&P.

The class goes on these trips with their teachers and several parent volunteers. Transportation is provided by the parent volunteers in their private vehicles. The 3's and 4's must each have a car/booster seat.

Childs Name: \_\_\_\_\_ has my permission to take local Nursery School Field Trips. When transportation is necessary, it will be provided by private car.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (parent or legal guardian)



## 2019-2020 Registration Form

### PERMISSION TO RECEIVE EMERGENCY MEDICAL CARE

I hereby grant permission for the Director or Acting Director to take whatever steps may be necessary to obtain emergency care if warranted. These steps may include, but are not limited to the following:

- Attempt to contact a parent or guardian
- Attempt to contact child's physician
- Attempt to contact you through any of the persons listed on the emergency information form you completed for us

If we cannot contact you or your child's physician we will do any or all of the following:

- Call another physician or paramedics
- Call an ambulance
- Have the child taken to an emergency hospital in the company of a staff member

Any of the expenses incurred for above, will be borne by the child's family. The school will not be responsible for anything that may happen as a result of false information given at the time of enrollment.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Mother or legal guardian)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Father or legal guardian)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Witness)

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
 (Witness)

**Confidential information for Teachers**  
*(Please return at home visit or at the start of school)*



## 2019-2020 Registration Form

How does your child tend to react to new experiences?

---

Has your child established a hand preference?  Left  Right  None

Allergies: \_\_\_\_\_

Medications: \_\_\_\_\_

Please describe any unusual habits (e.g. eating or sleeping problems, toilet training, fears?)

---

---

Does your child have any physical and/or emotional limitations or conditions, or has he/she ever received special services (e.g. occupational, physical or speech therapy, psychologist, learning specialist)?

---

---

Please write any additional information for teachers below:

---

---

---

---

---

---

---

---

---

---



## 2019-2020 Registration Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BP: \_\_\_\_\_

	Physical Exam (Leave blank if normal)	Past Medical History (Leave blank if normal)
Skin		
Eyes		
Ears		
Throat		
Heart		
Lungs		
Abdomen		
Genitourinary		
Hernia		
Orthopedic		
Neurologic		
Scoliosis		
Allergy		

Blood Lead Level: \_\_\_\_\_ Vision:  Pass  Fail

Immunization Dates:

SCCNS follows NYS Public Health Vaccination Law 2164 regarding immunizations

	Initial	Booster(s)
Polio (OPV or IPV)		
DPT		
Diphtheria-Tetanus		
MMR		
HIB		
Hepatitis B		
Varicella		
Pneumococcus		
TB (Tine or PPD)		

Regular Medications:  None \_\_\_\_\_

Can child participate in all activities?  Yes  No

Physician/Healthcare Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_