ST. ALBAN'S PRE-SCHOOL
APPLICATION FOR ADMISSION

Child's Name _____ Boy [ ] Girl [ ] Birth Date_____

Home Address _____ Phone _____

_____ Zip Code _____

Preferred E-Mail Contact_____

Class: 2's ( ) 3's ( ) 4's ( ) TK ( )

CARE CLUB: (circle)	**Mon.**	**FULL DAYS:** (circle)	**Mon.**	**HALF DAYS:** (circle)	**Mon.**	**AM**	**PM**
	Tue.		**Tue.**		**Tue.**	**AM**	**PM**
	Wed.		**Wed.**		**Wed.**	**AM**	**PM**
	Thu.		**Thu.**	**AM: 9-12**	**Thu.**	**AM**	**PM**
	Fri.		**Fri.**	**PM: 1-4**	**Fri.**	**AM**	**PM**

How did you learn about St. Alban's Pre-School? _____

For Emergency Contact (If parents/guardians cannot be reached):

Name _____ Phone _____

Name _____ Phone _____

FAMILY INFORMATION

Parent/Guardian's Name _____ Phone_____

Home Address_____

Occupation & Business Address_____

Business Phone _____

Parent/Guardian's Name _____ Phone _____

Home Address _____

Occupation & Business Address_____

Business Phone _____

Other Children in the Family

Name _____ Date of Birth _____ Sex _____

Name _____ Date of Birth _____ Sex _____

Name _____ Date of Birth _____ Sex _____

_____ _____

(Date) (Parent/Guardian's Signature)

Pre-Enrollment Conference Date _____

07/15/25

ST. ALBAN'S PRE-SCHOOL

FINANCIAL POLICY

I hereby contract enrollment for my child _____ at St. Alban's Preschool for the school year covering September 2025 through June 2026.

I enclosed a check for the registration fee with this form. I understand that this amount is not refundable.

Tuition for all students is due by the first (1st) of each month. St. Alban's Pre-School reserves the right of refusal to class if tuition is not received. Should tuition be received after the fifth (5th) of the month, St. Alban's shall charge a $20.00 late fee. If a check is returned from the bank, St. Alban's shall charge a $30.00 late fee. Any collection agencies costs incurred due to a delinquent tuition account will be the responsibility of the account holder.

Extended care costs are not included in the regular tuition, and, when needed, will be billed separately at the end of each month.

St. Alban's Pre-School reserves the right to refuse or discontinue enrollment of a child when the association is not conducive to the welfare of the school, its teachers, and the other children, as determined by the school administration. All health forms must be returned by the first day of school. Further, the Director reserves the right to dismiss any child from the school upon non-payment of tuition on time or for any other reason. If such action ever becomes necessary, St. Alban's Pre-School will refund a pro-rated amount of the prepaid tuition. Refer to the Expulsion Policy for more information.

No credit or make-up days will be allowed for absences due to illness, withdrawal, religious or legal holidays, snow days or any other reasons. In this unprecedented time, this includes closure of school by federal, state or local authority due to emergent pandemic status.

I contract for this 10-month school program in ten monthly tuition installments. Withdrawal prior to the completion of the school year will result in a contract termination fee equal to 50% of regular tuition due for the remainder of the contracted year and is due and payable in full within 15 days of withdrawal. This termination fee may be appealed to the Rector, Wardens, and Vestry of St. Alban's Episcopal Church whose decision is final.

_____ _____

(Date) (Parent's Signature)

Please circle or list the holiday your family celebrates. We will be learning about all holidays.




Other:_____

07-15-25

ST. ALBAN'S PRE-SCHOOL
STUDENT ENROLLMENT INFORMATION

Child's Name: _____ DOB: _____

Physician Name & Phone: _____

Physician Address: _____

EATING HABITS

Does the child feed himself? _____ _____

Does the child violently dislike any foods? _____

Has feeding ever been a problem? _____

SLEEPING HABITS

Does the child tire easily? _____ If so, responding how? _____

Does the child nap every day? _____ At what time? _____

Does the child awaken easily? _____

TOILET HABITS

Is the child toilet trained? _____ Night? Daytime? _____ Naptime? _____

Does the child ask to go to the toilet? _____ If so, how? _____

IN GENERAL

Has your child been evaluated by Early Intervention or a Developmental Pediatrician? Yes ___ No ___

If so, what was the outcome? _____

What are your child's principal interests? _____

(OVER)

ST. ALBAN'S PRE-SCHOOL
STUDENT ENROLLMENT INFORMATION

Does the child have habits such as thumb-sucking, throwing tantrums? _____

_____

Does your child have any noteworthy fears? Examples (such as noise, the dark) _____

When did your child start talking? _____Does your child like to talk?_____

Does your child get along well with other children? _____

With whom does your child play? _____ Playmates' ages _____

Does child have any behavior problems? _____

_____

Does child have any special problems when it comes to you? _____

_____

Do you have pets? _____Type? _____ Names? _____

Does your child have any allergies/medical conditions? _____ What are they? _____

Symptoms & Medications? _____

Discuss any special circumstances tending to affect your child's progress at school:

07/15/2025

ST. ALBAN'S PRE-SCHOOL

PERMISSION FOR WALKING TRIPS

I hereby give permission for my child _____ to participate in walking trips within the neighborhood. I understand these walks: (1) do not involve entrance into any facility; (2) are supervised by a teacher; and (3) involve no known safety hazards along the way. This includes walking to our emergency evacuation site which is Manito School.

_____ _____

(Date) (Parent's Signature)

AUTHORIZATION FOR CHILD PICK-UP

I authorize the following people to pick up my child from St. Alban's Pre-School. All others must present a written request from me for my child to be discharged into their hands, and such in writing absolves St. Alban's Pre-School from responsibility after the child leaves the school. All written request will remain on file at the school. St. Alban's Pre-School has the right to verify identification by asking for proof, such as a driver's license.

_____ _____

(Date) (Parent's Signature)

Full Name & Phone #:_____

Address:_____

Relationship to Child: _____

Full Name & Phone #:_____

Address: _____

Relationship to Child: _____

Full Name & Phone #:_____

Address: _____

Relationship to Child: _____

Full Name & Phone #:_____

Address: _____

Relationship to Child: _____

07/15/25

ST. ALBAN'S PRE-SCHOOL

PARENTAL CONSENT TO ADMINISTER MEDICINE

Medication shall only be administered by St. Alban's Pre-School personnel upon my written request and will only be that prescribed by a physician. When I authorize St. Alban's Pre-School personnel to administer medication to my child during school hours, I hereby absolve St. Alban's Pre-School from any responsibility for any ill effects that may occur from the administration of such medication.

_____ _____

(Date) (Parent's Signature)

PARENTAL CONSENT FOR EMERGENCY TREATMENT

I hereby authorize St. Alban's Pre-School to call an emergency ambulance in case of accident or acute illness, and to allow possible emergency care if I am not immediately available. In the case of an emergency, if I and/or my physician cannot be reached, I hereby authorize the staff of St. Alban's Pre-School to provide any necessary medical treatment. It is understood that I will be advised of the nature and extent of such treatment.

_____ _____

(Date) (Parent's Signature)

07/15/25

St. Alban's Pre-School
1 Church Lane
Oakland, New Jersey 07436
(201) 337-5928
Teresa M. Ercan, *Director*

PARENT
RECEIPT OF INFORMATION:

- **General Information Letter**
- **Information to Parents Document**
- **Policy on the Release of Children**
- **Positive Guidance and Discipline Policy**
- **Policy on Communicable Disease Management**
- **Expulsion Policy**
- **Policy on the Use of Technology, Social Media and Methods of Parental Notification**
- **Health Screening Policy**

I have read and received a copy of the information/policies listed above.

_____

Child(ren)'s Name:

_____

Parent/Guardian's Name

_____ _____

Signature ***Date***

07/15/25

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860. The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration.

      Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)*	*(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier		
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -	

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No	
Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

Preschool Directory Information

We hope that you will find the school directory to be helpful when planning play dates or mailing party invitations.

We would like to remind you that this directory is issued to you as a personal service. This directory is not for commercial use and is not to be released to any other individual, organization or promotional enterprise.

Thank you for your cooperation.

Please fill out the information that you would like included in the directory and return it to the school immediately.

PLEASE PRINT

Child's Name: _____

Parent/Guardian(s) Name:

_____

Address: _____

Phone #: _____

Email Address: _____

[ ] Please check the box if you do not want to be included in the St. Alban's Directory.