NORTH SYRACUSE EARLY EDUCATION PROGRAM
205 SOUTH MAIN STREET, NORTH SYRACUSE, NY 13212
PRESCHOOL APPLICATION - SCHOOL 2022-2023

****IN ORDER TO PROVIDE YOUR CHILD WITH THE MOST APPROPRIATE CLASSROOM PLACEMENT AND TO BE FULLY ENROLLED, PLEASE COMPLETE AND RETURN THIS APPLICATION AT LEAST 3 WEEKS PRIOR TO START DATE****

In order to appropriately place your child, please be as accurate as possible in completing all sections of the application.

Child's Name:_____ Date of Birth:_____ Sex:_____

Address:_____

Parent(s) or Guardian(s): _____

Home Phone:_____ Email Address: _____

Mother's Cell Phone:_____ Father's Cell Phone:_____

Mother's Place of Employment:_____ Phone:_____

Father's Place of Employment:_____ Phone:_____

The person who will be transporting your child to and from school:

Name:_____ Telephone:_____

Alternate person:_____ Telephone:_____

EmergencyPerson/Relationship:_____Phone:_____

EmergencyPerson/Relationship:_____Phone:_____

EmergencyPerson/Relationship:_____Phone:_____

***Please note**: The designated emergency people should be nearby and able to pick up your child from school in case of emergency or illness. Please be sure to keep this information up-to-date in case of an emergency.

Has your child ever been evaluated? ☐ Yes ☐ No If yes, when: _____

Does your child receive any related or been recommended for any related services such as speech, vision, hearing, physical or occupational therapy? If yes, please elaborate. Please include information about any past services. _____

Evaluations your child has had:_____

Is your child waiting to be evaluated? _____

If yes, areas of concern: ☐ Social/Emotional ☐ Communication ☐ Motor

Child's Physician:_____

Brothers and Sisters:

Name	Sex	Age	School or Occupation

Other individuals living in the home:

Name(s)	Relationship to Child

Medical conditions and concerns (past and present):_____

Are there other people with whom we can share information with about your child?_____

Does your child have any allergies (i.e. food, environmental, drugs)?_____

Does your child have seizures? Please describe._____

Does your child take any medications at home? If yes, list medication and dosage._____

Is your child to receive any medication in school? List medication, dosage and reason._____

List any childhood diseases your child has had:_____

Are there any restrictions on your child's activities (i.e. allergies)?_____

Has your child had surgery or accident/injury requiring a doctor's care?_____
**We need a doctor's written statement regarding permission to return to school and any limitations.

In the space below, briefly describe your child (i.e., likes, dislikes, play skills, temperament, activity level, etc.) Please feel free to elaborate._____

_____

_____

Briefly explain your child's speech and language skills:_____

What is the primary language spoken at home: _____

What other languages are used at home:_____

Toileting skills:_____

Dressing Skills:_____

Napping:_____

Eating:_____

Play interest/skills:_____

Interaction with other children:_____

_____

Behavior (challenging/tantrums, etc.):_____

_____

Do you have any concerns regarding your child (physical, emotional, speech)_____

_____

Are there any family situations/concerns that you would like us to be aware of?_____

_____

What kind of involvement would you like in your child's program?_____

_____

How did you find out about our program? ☐ Family Times ☐ Preschool fair ☐ Website

☐ School signage ☐ Heard about us from a friend ☐ Returning family (Teacher_____)

_____ _____ _____

Signature of Mother Date Signature of Father

_____

Signature of person completing this form (if other than parent)

NORTH SYRACUSE EARLY EDUCATION PROGRAM
TUITION AGREEMENT FOR THE 2022-2023 SCHOOL YEAR

Tuition is set annually. It may be paid in one payment, or it may be paid in monthly installments. Vacations, illnesses, or cancellation due to the weather or a pandemic **do not reduce** the monthly payment.
The annual/monthly tuition rate for the 2022-2023 school year is based upon the following scale:

2 Half Days AM (Tues/Thurs)	$1,450.00 annually ($145.00/Month)
3 Half Days AM (Mon/Wed/Fri)	$1,750.00 annually ($175.00/Month)
5 Half Days AM (Mon-Fri)	$2,550.00 annually ($255.00/Month)
2 Half Days PM (Tues/Thurs)	$1,400.00 annually ($140.00/Month)
3 Half Days PM (Mon/Wed/Fri)	$1,700.00 annually ($170.00/Month)
5 Half Days PM (Mon-Fri)	$2,500.00 annually ($250.00/Month)
3 Full Days (Mon/Wed/Fri)	$3,150.00 annually ($315.00/Month)
5 Full Days (Mon-Fri)	$4,550.00 annually ($455.00/Month)

I will complete this tuition agreement and return it to the Pre-k Office at the Early Education Program with a deposit of one month's tuition to assure my child a position in the Early Education Program. I understand that this one-month's tuition will be applied as tuition to the last month (June) of the 2022-2023 school year, and that **September's tuition is due on August 1st**. I understand that if September's tuition is not paid when due, my spot in the Early Education Program will be filled. I further understand that I am responsible for making eight additional equal monthly payments on the first of the month per the payment schedule on this form. A **$10.00 late fee** will be charged for payments over **10 days past due**. In addition, there will be a $15.00 charge for returned checks.

I will inform the Program Administrator of my intent to withdraw my child from the North Syracuse Early Education Program **at least three weeks** before the intended date of withdrawal. In the event of withdrawal, I understand I am responsible for paying tuition for all the weeks up to the withdrawal date and if I fail to give at least three weeks notice I will forfeit a full month's tuition. On or before the withdrawal date, I will pay all the tuition I/we owe to the North Syracuse Early Education Program.

I agree to make 10 monthly payments to the North Syracuse Early Education Program at the monthly rate specified above per payment schedule on this form. If my child remains enrolled in the North Syracuse Early Education Program for the entire year, I will pay the equivalent of 10 monthly payments regardless of the number of days my child attends or number of days school is in session during a given month.

SIGNED:_____ DATE:_____

SIGNED:_____ DATE:_____

NORTH SYRACUSE EARLY EDUCATION PROGRAM

2022-2023 PAYMENT SCHEDULE

****Keep this schedule as a record of your monthly payments****

****Keep all monthly receipts, may be able to use them at tax time****

Total Monthly Tuition: _____

Checks payable to **NSEEP**.

Payment #	Due Date	For Month Of	Date Paid	Check #
1 (To be sent with application)		June	_____	_____
2	8/1/22	September	_____	_____
3	9/1/22	October	_____	_____
4	10/1/22	November	_____	_____
5	11/1/22	December	_____	_____
6	12/1/22	January	_____	_____
7	1/1/23	February	_____	_____
8	2/1/23	March	_____	_____
9	3/1/23	April	_____	_____
10	4/1/23	May	_____	_____

2 Half Days AM (Tues/Thurs)	$1,450.00 annually ($145.00/Month)
3 Half Days AM (Mon/Wed/Fri)	$1,750.00 annually ($175.00/Month)
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PARENT NOTIFICATION (Revised June 2010)

During the school year, your son or daughter may have the opportunity to have his/her photo taken, video image and voice recorded, and/or art and written work published in connection with a school district activity or program. Your child's photo (image,) school work and/or name may be published in local newspapers, posted (displayed) on the district's Internet site, or used by the requesting organization (local TV or print media) for their programming, i.e., backup and their news stories.

If you DO NOT want your child's picture, name or schoolwork to be used in newspaper articles, video, and/or district publications, including our district's website, please inform your school principal in writing.

Dear Parent or Guardian:

New York State Education Law requires a health certificate or health appraisal for all students **entering the school district for the first time and when entering Pre-K or K, 1st, 3rd, 5th, 7th, 9th and 11th grade.** The examination must be completed by a New York State licensed physician, physician assistant or nurse practitioner.

A dental certificate which states your child has been seen by a dentist or dental hygienist is also asked for at the same time.

- A copy of the health examination must be provided to the school within 30 days from when your child first starts at the school. If a copy is not given to the school within 30 days, the school will contact you.
- If your child has an appointment for an exam during this school year that is after the first 30 days of school, please notify the Health Office with the date.
- For your convenience, a NYS Required Health Examination Form and dental certificate for your health care providers is enclosed.

*Please note that effective 2/1/21, all health examinations performed for school entrance must be documented on the **NYS Required Health Examination Form** or an electronic health record equivalent form - pursuant to Education Law.*

We suggest you make copies of the completed forms for your own records before sending them to the school health office. Forms may also be faxed to the number below.

Thank you for your cooperation in this endeavor. Our students benefit when we work together to promote the health and achievement of all students.

Please call the school's health office if you have any questions or concerns.

Gayle Vinette, RN
School Nurse
Phone: 218-2203
Fax: 218-2288

NORTH SYRACUSE CENTRAL SCHOOL DISTRICT
HEALTH RECORD AND HISTORY FORM

Name:	DOB: Grade: Age:	Gender: □ M □ F
Parent/Guardian: *(person completing this form)*	Home Phone: Cell Phone:	Date:
Physician:	Phone #:	Date of last physical exam:

Has your child ever:	YES	NO	If YES, please explain and include date:
Had an ongoing medical condition			
Seen a medical specialist			
Had allergies: *Food, Environment, Insect, Medication or Other*			
Been hospitalized			
Had an operation			
Had an injury requiring an Emergency Room Visit			
Missed 5 days of school in a row due to illness/injury			
Had a bone/muscle injury			
Passed out, had a concussion or serious head injury			
Had a convulsion/seizure			
Had a vision problem or condition: *Glasses, Contacts or Color Blind*			
Had a hearing problem or condition: *Hearing Aid or Cochlear Implant*			
Worn dental bridge, braces or mouthpiece			
Have any family members under the age of 50 ever:	**YES**	**NO**	**If YES, please specify:**
Had a heart attack or other serious health Issues			

CHECK ALL THAT APPLY TO YOUR CHILD:

- □ ADHD
- □ Asthma/Trouble Breathing
- □ Autism/Asperger
- □ Dental Injuries
- □ Diabetes
- □ Ear Infections
- □ GI Conditions (Ulcer, Reflux, IBS)
- □ Headaches/Migraines
- □ Heart Conditions
- □ High Blood Pressure
- □ Mental Health Condition: (Depression, Eating Disorder, Anxiety, OCD, ODD, etc.)
- □ Scoliosis
- □ Single Organ (Kidney, Testicle)
- □ Skin Condition
- □ Speech Condition
- □ Urinary Condition

History of:

- □ Rheumatic Fever
- □ Chicken Pox
- □ Reoccurring Strep Throat
- □ Scarlet Fever
- □ Tuberculosis

CURRENT MEDICATIONS	YES	NO	Please list: NAME/DOSE/TIME(S)
Given at School			
Taken at Home			
ASSITIVE EQUIPMENT at SCHOOL	**YES**	**NO**	**Please Check All That Apply**
During or Outside of School:			□ Crutches □ Walker □ Wheelchair □ Other
TREATMENTS	**YES**	**NO**	**Please Check All That Apply**
During or Outside of School			□ Insulin □ Blood Glucose Monitoring □ Inhaler/Nebulizer/Peak Flow Monitoring □Special Diet

Has your child tested positive for COVID-19:

Yes: ____ No: ____ Date: _____

Is there any condition that would prevent your child from participating in physical education or sports? □ YES □ NO

_____

Please list any additional concerns: (Use back of sheet if necessary):_____

PARENT/GUARDIAN SIGNATURE_____ **DATE:** _____

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM

TO BE COMPLETED BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

IF AN AREA IS NOT ASSESSED INDICATE NOT DONE

Note: NYSED requires a physical exam for new entrants and students in Grades Pre-K or K, 1, 3, 5, 7, 9 & 11; annually for interscholastic sports; and working papers as needed; or as required by the Committee on Special Education (CSE) or Committee on Pre-School Special education (CPSE).

STUDENT INFORMATION

Name	Sex: ☐ M ☐ F	DOB:
School:	Grade:	Exam Date:

HEALTH HISTORY

Allergies ☐ No ☐ Yes, indicate type	Type: ☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
Asthma ☐ No ☐ Yes, indicate type	☐ Intermittent ☐ Persistent ☐ Other : ☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
Seizures ☐ No ☐ Yes, indicate type	Type: Date of last seizure: ☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
Diabetes ☐ No ☐ Yes, indicate type	Type: ☐ 1 ☐ 2 ☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached

Risk Factors for Diabetes or Pre-Diabetes: *Consider screening for T2DM if BMI% > 85% and has 2 or more risk factors: Family Hx T2DM, Ethnicity, Sx Insulin Resistance, Gestational Hx of Mother, and/or pre-diabetes.*

BMI_____kg/m2

Percentile (Weight Status Category): ☐ <5th ☐ 5th-49th ☐ 50th-84th ☐ 85th-94th ☐ 95th-98th ☐ 99th and>

Hyperlipidemia: ☐ No ☐ Yes ☐ Not Done **Hypertension:** ☐ No ☐ Yes ☐ Not Done

PHYSICAL EXAMINATION/ASSESSMENT

Height: **Weight:** **BP:** **Pulse:** **Respirations:**

Laboratory Testing	Positive	Negative	Date
TB- PRN	☐	☐	
Sickle Cell Screen-PRN	☐	☐	
Lead Level Required Grades Pre- K & K			**Date**
☐ Test Done ☐ Lead Elevated ≥ 5 µg/dL			

List Other Pertinent Medical Concerns (e.g. concussion, mental health, one functioning organ)

☐ **System Review and Abnormal Findings Listed Below**

☐ HEENT	☐ Lymph nodes	☐ Abdomen	☐ Extremities	☐ Speech
☐ Dental	☐ Cardiovascular	☐ Back/Spine	☐ Skin	☐ Social Emotional
☐ Neck	☐ Lungs	☐ Genitourinary	☐ Neurological	☐ Musculoskeletal

☐ Assessment/Abnormalities Noted/Recommendations:

☐ Additional Information Attached

Diagnoses/Problems (list) ICD-10 Code*

*Required only for students with an IEP receiving Medicaid

Name:	DOB:

SCREENINGS

Vision (w/correction if prescribed)	**Right**	**Left**	**Referral**	**Not Done**
Distance Acuity	20/	20/	☐ Yes ☐ No	☐
Near Vision Acuity	20/	20/		☐
Color Perception Screening ☐ Pass ☐ Fail				☐
Notes				

Hearing Passing indicates student can hear 20dB at all frequencies: 500, 1000, 2000, 3000, 4000 Hz; for grades 7 & 11 also test at 6000 & 8000 Hz.				**Not Done**
Pure Tone Screening	**Right** ☐ Pass ☐ Fail	**Left** ☐ Pass ☐ Fail	**Referral** ☐ Yes ☐ No	☐
Notes				

Scoliosis Screen Boys in grade 9, and Girls in grades 5 & 7	**Negative**	**Positive**	**Referral**	**Not Done**
	☐	☐	☐ Yes ☐ No	☐

RECOMMENDATIONS FOR PARTICIPATION IN PHYSICAL EDUCATION/SPORTS/PLAYGROUND/WORK

☐ **Student may participate in all activities without restrictions.**

☐ **Student is restricted from participation in:**

- ☐ **Contact Sports:** Basketball, Competitive Cheerleading, Diving, Downhill Skiing, Field Hockey, Football, Gymnastics, Ice Hockey, Lacrosse, Soccer, and Wrestling.
- ☐ **Limited Contact Sports:** Baseball, Fencing, Softball, and Volleyball.
- ☐ **Non-Contact Sports:** Archery, Badminton, Bowling, Cross-Country, Golf, Riflery, Swimming, Tennis, and Track & Field.
- ☐ **Other Restrictions:**

Developmental Stage for Athletic Placement Process ONLY required for students in Grades 7 & 8 who wish to play at the high school interscholastic sports level **OR** Grades 9-12 who wish to play at the modified interscholastic sports level.

Tanner Stage: ☐ I ☐ II ☐ III ☐ IV ☐ V Age of First Menses (if applicable) : _____

☐ **Other Accommodations*:** (e.g. Brace, orthotics, insulin pump, prostectic, sports goggle, etc.) Use additional space below to explain. *Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

MEDICATIONS

☐ **Order Form for Medication(s) Needed at School Attached**

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS

HEALTH CARE PROVIDER

Medical Provider Signature:

Provider Name: *(please print)*

Provider Address:

Phone: Fax:

Please Return This Form To Your Child's School When Completed.

North Syracuse Early Education Program

Dental Health Certificate

Parent/Guardian: New York State law (Chapter 281) permits schools to request a dental examination in the following grades: school entry, Preschool, K, 1, 3, 5, 7, 9 &11. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your dentist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ☐ Male ☐ Female

Will this be your child's first visit to a dentist? ☐ Yes ☐ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ☐ Yes ☐ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature_____ Date

Section 2. To be completed by the Dentist

I. The Dental Health condition of _____ on _____ (date of exam) The date of the exam needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's name and address (please print or stamp)	Dentist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

☐ Yes ☐ No **Caries Experience/Restoration History –** Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

☐ Yes ☐ No **Untreated Caries –** Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

☐ Yes ☐ No **Dental Sealants Present**

Other problems (Specify):_____

III. Treatment Needs (check all that apply)

☐ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

☐ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

☐ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.