2023-2024 REGISTRATION FOR PRE-K3 AND PRE-K4

Please return the REGISTRATION FORM on the next page with a $50 registration fee. The fee is waived if forms submitted by Monday, April 24, 2023.

PRE-K3

Students must be 3 years old by December 1, 2023. Through our small groups; socialization, cooperation, and creativity are encouraged. Language development will be stimulated through individual and small group situations.

PRE-K4

Your child will grow in his/her gross and fine motor skills while developing emotionally, socially, and academically. Our Pre-K4 program offers a diverse curriculum which incorporates computers, arts and crafts, music, and science. This program integrates Kindergarten readiness skills by introducing basic math, reading, and writing concepts into our daily routine. Your child must be 4 years old by December 1, 2023 to register.

REQUIRED PAPERS

New York State requires proof of immunization. Please include a **copy of your child's immunization records**. A **copy of your child's birth certificate** will be required as proof of age and eligibility for either Pre-K3 or Pre-K4. Please have the Health Certificate filled out by your child's physician. A copy of your child's Baptismal certificate is optional.

AFTER SCHOOL CARE

After School Care is offered to our Pre-K families. After School Care begins at 2:00p.m. for Pre-K3 and Pre-K4 students. ASC ends at 4:30p.m. Monday through Thursday, 4:00p.m. on Fridays. The fee is $5.00 for one child in the family, $7.00 for two children, $8.00 for three children. Billing will be once a month.

CALENDAR

We follow the Wellsville Central School calendar. In case of school closings due to bad weather or any other reasons, if Wellsville schools are closed Immaculate Conception School is closed.

DISMISSAL

Dismissal is a hectic time for our Pre-K classes; therefore, we ask your cooperation. Please be prompt in picking up your child. If your child is being picked up by someone different, please send a note in that morning to the teacher. Parents are to wait at the back door of school and the teachers will bring the children to meet you. We realize that there are emergencies but we ask that you try NOT to call during the dismissal time. The little ones are anxious to see Mom and Dad but safety is our top priority.

CLASS TIMES AND TUITION

Pre-K3 & Pre-K4	5 Half Days	Monday-Friday, 8:00a.m.-11:30a.m. $2000.00/10 payments of $200.00
	5 Full Days	Monday-Friday, 8:00AM-2:00PM $4000.00/10 payments of $400.00

All above sessions include "lunch time" from 10:50a.m.-11:30a.m.

There is a **$50 non-refundable registration fee** payable with your child's registration **unless submitted by April 24, 2023.**

TUITION, FEES, CHARGES, AND COLLECTION OF DELINQUENT PAYMENTS

Tuition may be paid with one of the following plans:

PRE-K3 AND PRE-K4 – 10 PAYMENTS: Due by the 15th of each month
Payments begin September 15, 2023 and end June 15, 2024

ONE PAYMENT – FOR THE ENTIRE SCHOOL YEAR – RECEIVE A 5% DISCOUNT
Due by September 1, 2023

It is noted that the above programs require a minimum of 10 students per session to make them viable. If the minimum is not met, we reserve the right to adjust the program schedule.

REGISTRATION/APPLICATION FEES:
$50.00 per student paid at time of registration. Fee is non-refundable.
Fee is waived if forms submitted by April 24, 2023.

CHARGES: **$35.00 for bad checks**
$35.00 for monthly late charges

COLLECTION OF DELINQUENT PAYMENTS: Two weeks following payment due date delinquent accounts will be sent a letter soliciting payment for the balance due, including late fees. If payment is not probable within one week of this notification, the notified parties are to arrange for an appointment to meet with the Pastor. The results of this meeting should resolve current and potential future delinquency.

FAILURE TO COMPLY WITH THIS PROCESS MAY RESULT IN:

A. Referring the account to a collection agency, with all collection fees and charges being assessed to your account.
B. If your payments are consistently late, the Pastor may require payment for the semester ***in advance***.

REGISTRATION FORM

2023-2024 Pre-K3 and Pre-K4 Program

Return this form along with a **$50 non-refundable registration fee per child*, the Tuition Agreement, a copy of your child's immunization record, a copy of the birth certificate, a copy of the baptismal certificate** (if applicable) and the completed Health Certificate.

PERSONAL INFORMATION

Name of Student _____

Date of Birth _____ Place of Birth _____

Address _____ Town/State/Zip _____

Mom's Email Address_____ Dad's Email Address_____

Mom's Cell _____ Dad's Cell _____

School District in which you reside _____

Mother's Name (include maiden name)_____

Father's Name _____

PLEASE CHECK THE PROGRAM YOU ARE INTERESTED IN:

PRE-K3	____	Mondays-Friday (5 half days)	8:00AM-11:30AM
	____	Mondays-Fridays (5 full days)	8:00AM-2:00PM
PRE-K4	____	Monday-Friday (5 half days)	8:00AM-11:30AM
	____	Monday-Friday (5 full days)	8:00AM-2:00PM

SIBLINGS (Please list full name and birthdates of all.)

Name _____ Birthdate _____

Name _____ Birthdate _____

Name _____ Birthdate _____

**Registration fee waived if forms received by April 24, 2023.*

SCHOOL INFORMATION

To help us plan an individual program for your child, please fill out the following the best that you can:

Favorite type of play _____

Family activities _____

Any previous preschool experience? _____

DISMISSAL INFORMATION

In case of an emergency, who may pick up this student?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

MEDICAL HISTORY

Has your child ever had convulsions? _____ If yes, please explain.

_____

Has he/she ever been hospitalized? _____ If yes, please explain.

_____

Does he/she have a vision problem? _____ If yes, please explain.

_____

Does he/she have a problem hearing? _____ If yes, please explain.

_____

Does your child have any of the following?

___allergies ___anemia ___asthma ___bronchitis ___ heart condition ___other

If yes, please explain.

_____

Is your child on any medication? _____ If yes, please explain.

_____

Please add any additional comments that might aid in better understanding your child.

_____

THE DIOCESE OF BUFFALO CONSENT AND RELEASE FORM

For the Use of Student Photographs(s), Video, Work and Sound Recordings

Throughout the year, there will be numerous occasions when we will be contacting local media outlets (newspapers, television stations, radio stations, Internet sites) in the hope of getting coverage for diocesan and school events. We also hope to use some of the photographs, video images, sound recordings, and work of our students for our own use or use by the secular media. These images may appear during the year on various secular media outlets and diocesan media including, but not limited to, the following:

1. www.buffalodiocese.org – The official diocesan Web site
2. *Western New York Catholic* – The official diocesan newspaper
3. www.wnycatholic@buffalodiocese.org – Web site for Western New York Catholic
4. Television programs produced by Daybreak TV productions of the Diocese of Buffalo including, but not limited to, "Diocesan Conversation," "Matters of Faith," "Our Daily Bread," "The Daily Mass," "The Sunday Televised Mass" and documentaries and other programs produced by Daybreak TV Productions.
5. www.wnycatholicschools.org – The official Web site of the Department of Catholic Education of the Diocese of Buffalo
6. Brochures published by the Diocese of Buffalo, including reports from various diocesan offices (i.e. Catholic Charities, the Foundation of the Roman Catholic Diocese of Buffalo, Catholic Education, etc.)
7. www.ccny.org – The official Catholic Charities Web site
8. Web sites of our affiliated parishes and diocesan-sponsored and independent Catholic elementary schools and high schools

Please note that no financial compensation will be paid for any photo or work product used.

With regard to Catholic elementary school students, unless you specifically authorize us in this release, the published photos and/or documents will not include a child's last name or names of other family members. The addresses and/or phone numbers of students of any age will not be published. Documents will not include any information that indicates the physical location of a student at a given time other than attendance at a particular school or participation in school activities. Please complete the following form and return it to Immaculate Conception School.

I give Immaculate Conception School permission to use my child's photograph, video image, sound recording, and/or work for:

___ School photo and display ___Newspaper articles ___Television Coverage ___Diocesan and/or school reports
___ Radio coverage ___Web sites ___Brochures

RELEASE OF NAME:

_____I **do** give permission for the use of my child's last name and names of other family members.
_____I **do not** give permission for the use of my child's name and names of other family members.

TERM
This Consent and Release shall remain in effect for a period of one year from the date hereof unless sooner revoked as hereinafter provided.

COPY
The signing parent or guardian will receive a copy of this Consent and Release

Please print

Child's name _____ Grade _____ Child's name _____ Grade _____

Child's name _____ Grade _____ Child's name _____ Grade _____

Parent's signature _____ Date _____

REVOCATION
The parent or guardian who has signed this form may revoke the consent, permission, and release granted herein at any time by signing and delivering to Immaculate Conception School the revocation statement below.

Please detach and save if in the future you decide to revoke your consent.

REVOCATION

I,_____, the parent or guardian who signed the Consent and Release on behalf of_____ hereby revoke and withdraw my consent and release. I understand that this revocation will not affect publications published prior to the receipt of this notice of revocation or to publications in the process of being printed at the time this revocation is delivered.

Parent or Guardian Signature _____ Date _____

DIRECT PAYMENTS

No more worries about remembering to pay tuition on time, no hassles with writing checks, etc.
ICS sets this up and automatically debits your tuition on either the 15th or 27th of the month.

NO MATTER WHO YOU BANK WITH!

Authorization Agreement for Direct Payments (ACH Debits)

Company Name: **Immaculate Conception School of Allegany County**

I herby authorize Immaculate Conception School of Allegany County, hereinafter called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to debit and/or credit the same to such account. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of New York State and Federal Law.

Name on Tuition Agreement: _____

Address: _____ Routing Number: _____

City: _____ Account Number: _____

State, Zip: _____ Type of Account: _____ Checking

Email: _____ _____ Savings

Financial Institution: _____ First Payment: / /2023

Payment Amount: _____ Last Payment: / /2024

This authorization is to remain in full force and effect until COMPANY has received written notification, any time up to three (3) days before the scheduled date of transfer.

_____ _____

Print Individual Name Signature Date

PLEASE ATTACH COPY OF VOIDED CHECK TO THIS FORM

(If you are currently enrolled in ACH with ICS and there is no change to account information, no voided check is necessary.)

REQUIRED NYS SCHOOL HEALTH EXAMINATION FORM
TO BE COMPLETED IN ENTIRETY BY PRIVATE HEALTH CARE PROVIDER OR SCHOOL MEDICAL DIRECTOR

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
☐ Medication/Treatment Order Attached ☐ Anaphylaxis Care Plan Attached
☐ Food ☐ Insects ☐ Latex ☐ Medication ☐ Environmental

Asthma ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Asthma Care Plan Attached
☐ Intermittent ☐ Persistent ☐ Other : _____

Seizures ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Seizure Care Plan Attached
☐ Type: _____ Date of last seizure: _____

Diabetes ☐ No
☐ Yes, indicate type
☐ Medication/Treatment Order Attached ☐ Diabetes Medical Mgmt. Plan Attached
☐ Type 1 ☐ Type 2 ☐ HbA1c results: _____ Date Drawn: _____

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 **Hypertension:** ☐ No ☐ Yes

PHYSICAL EXAMINATION/ASSESSMENT

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

TESTS	Positive	Negative	Date
PPD/ PRN	☐	☐	
Sickle Cell Screen/PRN	☐	☐	
Lead Level Required Grades Pre- K & K			Date
☐ Test Done ☐ Lead Elevated ≥ 10 µg/dL			

Other Pertinent Medical Concerns
One Functioning: ☐ Eye ☐ Kidney ☐ Testicle
☐ Concussion – Last Occurrence: _____
☐ Mental Health: _____
☐ Other:

☐ System Review and Exam Entirely Normal

Check Any Assessment Boxes *Outside* Normal Limits And Note Below Under Abnormalities

☐ 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

Name:				DOB:
SCREENINGS				
Vision	**Right**	**Left**	**Referral**	**Notes**
Distance Acuity	20/	20/	☐ Yes ☐ No	
Distance Acuity With Lenses	20/	20/		
Vision – Near Vision	20/	20/		
Vision – Color ☐ Pass ☐ Fail				
Hearing	**Right dB**	**Left dB**	**Referral**	
Pure Tone Screening			☐ Yes ☐ No	
Scoliosis Required for boys grade 9	**Negative**	**Positive**	**Referral**	
And girls grades 5 & 7	☐	☐	☐ Yes ☐ No	
Deviation Degree:		Trunk Rotation Angle:		
Recommendations:				

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

☐ **Full Activity** without restrictions including Physical Education and Athletics.

☐ **Restrictions/Adaptations** Use the Interscholastic Sports Categories (below) for Restrictions or modifications

☐ **No Contact Sports** **Includes:** baseball, basketball, competitive cheerleading, field hockey, football, ice hockey, lacrosse, soccer, softball, volleyball, and wrestling

☐ **No Non-Contact Sports** **Includes:** archery, badminton, bowling, cross-country, fencing, golf, gymnastics, rifle, Skiing, swimming and diving, tennis, and track & field

☐ **Other Restrictions:**

☐ **Developmental Stage for Athletic Placement Process ONLY**

Grades 7 & 8 to play at high school level **OR** Grades 9-12 to play middle school level sports

Student is at **Tanner Stage:** ☐ I ☐ II ☐ III ☐ IV ☐ V

☐ **Accommodations:** Use additional space below to explain

☐ Brace*/Orthotic	☐ Colostomy Appliance*	☐ Hearing Aids
☐ Insulin Pump/Insulin Sensor*	☐ Medical/Prosthetic Device*	☐ Pacemaker/Defibrillator*
☐ Protective Equipment	☐ Sport Safety Goggles	☐ Other:

*Check with athletic governing body if prior approval/form completion required for use of device at athletic competitions.

Explain: _____

MEDICATIONS

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

List medications taken at home:		

IMMUNIZATIONS

☐ Record Attached ☐ Reported in NYSIIS Received Today: ☐ Yes ☐ No

HEALTH CARE PROVIDER

Medical Provider Signature:	Date:
Provider Name: *(please print)*	Stamp:
Provider Address:	
Phone:	
Fax:	

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

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment at the same time a health examination is required. 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 registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist 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 oral health assessment? ☐ 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/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment) The date of the assessment 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/ Dental Hygienist's name and address (please print or stamp)	**Dentist's/Dental Hygienist'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):_____

II. 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.