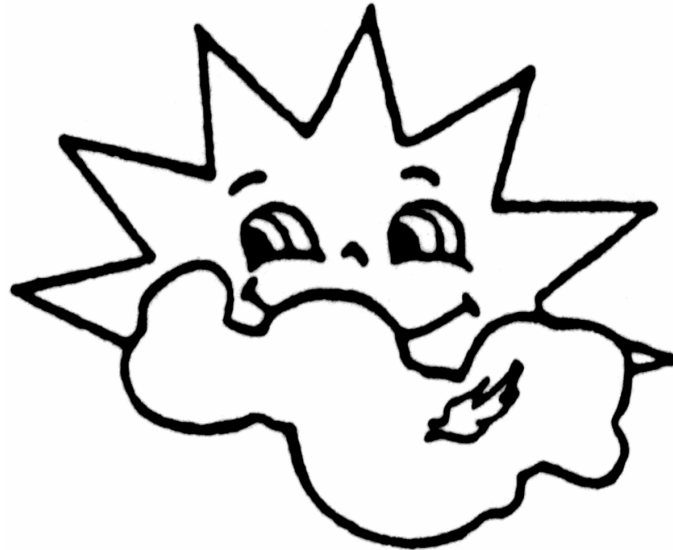


Sonshine Preschool & Day Care

REGISTRATION PACKET

2012-2013



*Jesus Loves the Little Children,
All the Children of the World.
Red and Yellow, Black and White,
They are Precious in His Sight,
Jesus Loves the Little Children of the World.*

A Ministry of
Trinity Assembly of God
53 North Main St. • Derry, NH 03038
603-434-6987

<http://www.tagderry.com/spd>

School Program

3N/4K AM Class: 8:30am-11:30am

5K AM Class: 8:30am-12:30pm

Daycare Hours:

6:30am-8:30am & 11:30am-5:30pm

TRINITY EDUCATIONAL MINISTRIES 2009 - 2010
(603) 434-6987 · 53 North Main Street, Derry, NH 03038

===== **FOR OFFICE USE ONLY** =====

GRADE PLACEMENT _____ **TEACHER** _____
Full-time student _____ School Only _____ Needs hourly daycare _____
3N class _____ 4K class _____ 5K class _____

=====

SONSHINE PRESCHOOL & DAYCARE
APPLICATION FOR ADMISSION

Student's Full Name _____ Date _____

Address _____

Home Phone _____ Date of Birth _____ Age _____ Sex _____

I grant permission to release my name and number to other Sonshine parents? Yes No

Father's Name _____ Soc. Sec. # _____

Father's Home Address (if different) _____

Email _____ Phone: Day _____

Occupation _____ Night _____

Employer _____ Cell _____

Business Address _____ Work _____

Mother's Name _____ Soc. Sec. # _____

Mother's Home Address (if different) _____

Email _____ Phone: Day _____

Occupation _____ Night _____

Employer _____ Cell _____

Business Address _____ Work _____

Marital Status

- Married Remarried
 Divorced Widowed
 Separated Single

Child Living With

- Both Parents Guardian
 Mother Other
 Father

Pediatrician _____ Phone _____

Address _____

Family dentist _____ Phone _____

Address _____

Health Insurance Company _____ Policy # _____

Sign in-out Card I will use last year's I need a new card I don't need one

With regard to the statements on page 26 of the Bureau of Child Care Standards & Licensing:

1. "The licensing authority for this child day care agency is the Bureau of Child Care Standards and Licensing. Information regarding recent licensing and monitoring visits for this child day care agency is available by calling the Bureau at 271-4624 or 1-800-852-3345, extension 4624."
2. "During licensing, monitoring, and complaint investigation visits to licensed child day care agencies, the department shall interview children regarding the care they received at the child day care agency, if in the judgment of the licensing specialist the children's response would be valuable in determining the quality and level of care provided. If you do not want your child interviewed, or if you wish to be informed prior to your child being interviewed, you shall provide a signed, dated statement to agency director indicating your preference." This statement shall be updated annually.

I have read and understand the above statement.

Date

Child(ren)'s Name(s)

Signature of Parent/Guardian

I grant permission for my child to be interviewed during a monitoring visit by the State Licensing Inspector? Yes No (This is for the protection of your child)

Personal Information:

Does the child have any special needs or handicaps for which (s)he will need special help now or later in his/her schooling? Yes No

If yes, explain below: _____

Please list the names of other children living at home.

Name	Age	Name	Age	Name	Age
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Does your family attend church regularly? Yes No

If so, which one? _____

How did you initially hear of Trinity Educational Ministries?

Close proximity Word of Mouth Yellow Pages Internet Other

I'm transferring from another Preschool/Daycare. Which one? _____

PARENT'S ENROLLMENT AGREEMENT

In this contract between Trinity Educational Ministries and

_____, we hereby enroll _____
parent/guardian child

with the following agreement:

1. In pledging our loyalty to the aims and ideals of TRINITY EDUCATIONA MINISTRIES, we agree to bring any questions and criticisms to the Administrator so that they may be properly considered.
2. TRINITY EDUCATIONAL MINISTRIES agrees to work closely with us in helping our child(ren) to learn and to solve their problems. This include provision of competent teachers, a full and balanced curriculum, regular reporting, supervision of the children and the program, and cooperation with the home.
3. All children are accepted on a one-month trial basis.
4. TRINITY EDUCATIONAL MINISTRIES reserves the right to dismiss any student who is not able or not willing to cooperate with our policies, who does not respect its spiritual standards or cooperate in the educational process. In the event of dismissal for any reason, the tuition will be based on the financial policies stated in the Parent Handbook.
5. All knowledge will be taught in the light of God's Word. This is a Bible-centered school and day care center, and we understand that our child will be taught that Jesus Christ is Lord.
6. There is a discount for official tithing members of Trinity Assembly of God. If this applies, please indicate so. I am an official tithing member of Trinity Assembly of God.
7. Parents must notify the school in writing two weeks prior to withdrawing student. If notice is not given, you may be responsible for two weeks of tuition/day care. Student records will not be released until student's account is paid in full.
8. We understand that we are responsible for any expenses incurred in collecting any unpaid debt on our child's account.
9. You will receive a copy of the Parent Handbook which includes the written policies of the school at Parent Orientation.
10. Registration fee: \$ _____ Tuition fee: \$ _____ per hour week year (circle one)
Payment breakdown: _____
11. We have read this contract carefully and hereby agree to its terms.

Parent/Guardian Date Administrator Date
Desired Entrance Date: _____ Expiration Date: _____

TRINITY EDUCATIONAL MINISTRIES
MEDICAL AUTHORIZATION FORM

State of New Hampshire
ss: { County of Rockingham

We, _____ and _____ of
parent/guardian parent/guardian

_____ of
city county state

do hereby state that we are the natural parents legal guardians, having legal custody of

_____, a minor, age _____, born on _____
child's name age date of birth

in _____,
city state

If the child is ill or shows signs of a contagious disease, we will not bring our child to school. We understand that it is Sonshine's policy to call 911 if there is an emergency where our child may need to be transported to the hospital. We consent to any x-ray, examination, anesthetic, medical or surgical treatment and hospital care to be rendered to the minor under the general or special supervision and on the advice of any licensed physician or surgeon when the need of such treatment is immediate. It is understood that we are responsible for any charges incurred in transporting/treating our child. We give permission for our child to engage in the activities of Trinity Educational Ministries. This includes indoor play, outdoor play, special activities and field trips, including transportation. We absolve Trinity Educational Ministries from any liability to us or our child because of injury to him/her at school or any activity outside of Trinity Educational Ministries.

Pediatrician _____ Phone _____

Health Insurance Company _____ Policy # _____

Phone: Home _____ Mom's Work _____ Dad's Work _____

Emergency Numbers:

1. Name _____ Relationship _____ Phone _____

Address _____

2. Name _____ Relationship _____ Phone _____

Address _____

3. Name _____ Relationship _____ Phone _____

Address _____

Parent/Guardian Signature

10. List your hobbies, interests, and talents.
11. Have you taken any family trips you would like to share with Sonshine class?
12. Do you have a pet you would like to bring to Sonshine? Yes No Thanks Please list.
13. Would you like to help during classroom party time? Yes No Thanks
14. Do you play any musical instruments? Yes No
15. Would you like to help with class visual aid preparations (cutouts, etc.)? Yes No Thanks
16. Would you be willing to help on Sonshine projects? (e.g., Campbell's labels, school pictures, luncheons, fund raisers, etc.) Yes No Thanks
17. Do you enjoy cooking? Yes No
18. Would you like to share an ethnic favorite or family traditional recipe? Yes No Thanks

Thank you for the effort you have put into answering and returning this questionnaire!

CHILD HEALTH FORM (TO BE COMPLETED BY PARENT/GAURDIAN)

CHILD'S LSAT NAME _____ FIRST NAME _____ M.I. _____ DOB: ____ / ____ / ____
MO DAY YEAR

CHILD'S ADDRESS

WE/I _____ give permission to obtain or release necessary information on the
SIGNATURE OF PARENT/GUARDIAN above child.

PLEASE RETURN TO: Sonshine Preschool & Daycare
NAME OF CHILD CARE PROGRAM

HISTORY: TO BE COMPLETED BY PHYSICIAN (THIS INFORMATION WILL BE HELD CONFIDENTIAL AND WILL BE USED ONLY FOR THE BENEFIT OF THIS CHILD).

A. PRENATAL, PERINATAL AND POSTNATAL DEVELOPMENT: ANY SIGNIFICANT FINDINGS THAT COULD INFLUENCE THIS CHILD'S ADAPTATIONS TO A CHILD CARE SETTING (I.E., PHYSICAL HANDICAP, SENSORY LOSS, DEVELOPMENTAL IRREGULARITIES)?

B. ANY CHRONIC ILLNESS THAT MAY REQUIRE MEDICATION, PARTICULARLY OBSERVATIONS OR PRECAUTIONS IN A CHILD CARE SETTING (E.G., RECURRENT EAR INFECTIONS, SEIZURE DISORDER, ALLERGIES)?

C. ANY HOSPITALIZATIONS, OPERATIONS, OR SPECIAL TESTS OF WHICH A CHILD CARE PROVIDER SHOULD BE AWARE?

D. PERTINENT FAMILY, SOCIAL OR HEALTH CHARACTERISTICS?

**IMMUNIZATIONS FOR CHILD CARE AGENCY ATTENDANCE
 PARENT MAY SUBSTITUTE A COPY OF CHILD'S IMMUNIZATION RECORD**

VACCINE	DATE	DATE	DATE	DATE	DATE	DATE
DTP/DTAP						
HIB						
DTP-HIB						
TD						
OPV OR IPV						
MMR						
HEP-B						
VARICELLA						
OTHER						

COMMUNICABLE DISEASE HISTORY

RECOMMENDED SCREENING & TESTING OF ATTENDEES

DISEASE	DATE OF DIAGNOSIS	LABORATORY CONFIRMATION	PHYSICIAN		DATE	METHOD	RESULT:
CHICKENPOX		NOT APPLICABLE		TB (FOR HIGH RISK CHILDREN ONLY)			
OTHER:				VISION			
				HEARING			
				SPEECH			
				HBG/HCT		NOT APPLICABLE	
				URINE		NOT APPLICABLE	
				LEAD		NOT APPLICABLE	

HEALTH ASSESSMENT: (TO BE COMPLETED BY LICENSED HEALTH PRACTITIONER)

CHILD'S NAME: _____
PHYSICAL EXAM:

LENGTH/HEIGHT ____ IN/CM %ILE ____	WEIGHT ____ LB/KG %ILE ____	HEAD CIRCUMFERENCE ____ IN/CM %ILE ____	BLOOD PRESSURE ____ / ____
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CHECK () EACH LINE	NORMAL	ABNORMAL-	NEEDS FOLLOW-UP	NOT EXAMINED	CHECK EACH LINE:	NORMAL	ABNORMAL	NEEDS - FOLLOW-UP'	NOT EXAMINED
SKIN/SCALP					NOSE, THROAT, MOUTH				
NUTRITION					TEETH & GUMS				
NEUROLOGY & MUSCULAR					GLANDS INC. THYROID				
ORTHOPEDIC & SPINE					CHEST, BREASTS				
EYE					HEART, LUNGS				
EARS					ABDOMEN				
SPEECH					GENITALIA				

TEMPERMENT ___ EASY-GOING ___ AVERAGE ___ DIFFICULT

COMMENTS: _____

ALLERGIES: INCLUDE ALLERGIES TO FOOD, MEDICATION, OR OTHER SUBSTANCES:

A. ESTIMATE OF LEVEL OF MATURATION:

A. INFANCY (0-2 YEARS)	EARLY: _____	MID: _____	LATE: _____
B. MID-PRESCHOOL (2-4 YEARS)	EARLY: _____	MID: _____	LATE: _____
C. PRESCHOOL (4 YEARS)	EARLY: _____	MID: _____	LATE: _____
D. SCHOOL-AGE (6-10 YEARS)	EARLY: _____	MID: _____	LATE: _____
E. ADOLESCENT (11-18 YEARS)	EARLY: _____	MID: _____	LATE: _____

COMMENTS: _____

B. ESTIMATE OF FUNCTIONAL CAPACITY:

	DELAYED FOR DEVELOPMENT PHASE	CONSISTENT WITH DEVELOPMENT-PHASE	ADVANCED FOR DEVELOPMENT PHASE	COMMENTS
GROSS MOTOR:				
FINE MOTOR:				
LANGUAGE SKILLS:				
SOCIAL SKILLS:				
EMOTIONAL:				

 PHYSICIAN'S SIGNATURE

 DATE OF EXAM

 PHYSICIAN'S NAME - TYPED OR PRINTED DATE

 TELEPHONE NUMBER

DATE OF NEXT SCHEDULED EXAM: _____