TOWN OF NEWINGTON

200 Garfield Street Newington, Connecticut 06111

Parks & Recreation Department

Creative Playtime Preschool Program **#8E**

Registration Information

Student Information

Child's Name: _____ Date of Birth: _____

*Address: _____ City: _____ Zip Code: _____

**Please note that all correspondence will be mailed to address listed above.*

Child is living with: _____

Allergies/Medical Conditions: _____

_____

Epi-Pen or Emergency Medication required during program hours: _____ Yes _____ No

*If 'Yes' is checked above, **Authorization for the Administration of Medication by Child Day Care Personnel** form must be submitted. See Parent Handbook for more information.*

Other Special Concerns/Notes: _____

Parent/Guardian Information

Parent 1 Name: _____

Parent Address: _____ City: _____ Zip Code: _____

Parent Home Phone: _____ Cell: _____ Work: _____

Parent Email Address: _____

Parent 1 Business/Address: _____ Title: _____

Parent 2 Name: _____

Parent Address: _____ City: _____ Zip Code: _____

Parent Home Phone: _____ Cell: _____ Work: _____

Parent Email Address: _____

Parent 2 Business/Address: _____ Title: _____

Emergency Contact Information

Please provide an additional contact **(not residing with you)** that we can contact in case a parent/guardian cannot be reached. This person is also given authority to remove the child from the program and to make decisions regarding medical treatment in case a parent/guardian cannot be reached.

Name: _____ Relationship to Child: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Pick-Up Authorization

I hereby authorize the individuals named below to pick up my child from the Newington Parks & Recreation Department's Creative Playtime Preschool Program. If there are any changes in these arrangements, I will give written notice. Please note that only the parent/guardian has permission to make changes to the people named below. **Parent/guardian must be included on this release (both parents/guardians may be included), and a total of three authorized persons must be listed.**

Parent 1 Name:_____ Phone:_____ Relationship_____

Parent 2 Name:_____ Phone:_____ Relationship:_____

Name: _____ Phone:_____ Relationship_____

Name:_____ Phone:_____ Relationship:_____

Child's Physician / Primary Health Care Provider

Name:_____ Phone:_____

Emergency Medical and Surgical Treatment Release

Release: The information contained herein is accurate to the best of my knowledge. By my signature below, I consent to the following:

Release any and all medical, insurance and/or other records to third party, which are in the possession of the Town of Newington or any other party referred to herein. For the Town of Newington to acquire medical insurance, and/or other data from third parties to be added to this record, and for those third parties to release such information to the Town of Newington.

I authorize certified staff to administer first aid/CPR and authorize that my child be transported by an emergency vehicle for any medical treatment. I authorize duly-licensed physicians, nurses and allied health professionals to provide such necessary medical care and to administer such routine diagnostic tests and procedures as in the judgment of the authorized personnel as deemed necessary or advisable for the care of the individual person herein. If the information contained herein refers to an individual other than myself, I am their authorized legal representative and/or guardian and am hereby authorized to submit this material and execute this release form.

_____ _____

Signature of Parent or Guardian **Date**

Assumption of Liability

Assumption of Liability: Participation in the activity may involve risk or injury. As a parent, guardian, or participant, I am aware of these hazards and my ability to participate. I hereby agree to release, discharge and hold harmless the Town of Newington, its employees, contracted instructors, and volunteers from the liabilities which may occur while participating in the activity. I understand that participation in any recreational or sport activity involves risk. During the COVID-19 pandemic, I also understand that I must adhere to all CDC, state, and local COVID-19 guidelines, including all social distancing, temperature checks, personal protective equipment requirements, and sanitation protocols. I acknowledge that there is a risk of transmission when in a group or class setting, even with personal protective equipment. I further understand that the Town of Newington does not provide accident/medical insurance for the program participants. In addition, I give permission for the participant to be treated by qualified medical personnel in the event that the above named parent/guardian/emergency contact cannot be reached at the phone numbers provided. The Parks and Recreation Department reserves the right to photograph program participants for publicity purposes. Please be aware that these photos are for Parks and Recreation use only and may be used in future catalogs, website, social media, brochures, pamphlets, and/or flyers. No refunds will be given after a participant has registered and paid for a program, except for medical reasons (illness or injury) which prohibit active participation in the program. Refund Requests must be accompanied by a note from the participant's physician. The amount refunded will be pro-rated to reflect the number of classes remaining at time of request.

_____ _____

Signature of Parent or Guardian **Date**

State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	☐Male ☐Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ☐American Indian/Alaska Native ☐Native Hawaiian/Pacific Islander ☐Asian ☐White ☐Black or African American ☐Other ☐Hispanic/Latino of any race	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part 1 — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months?	Y	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place			6. Interaction with others	Y	N	Eating concerns	Y	N
to another	Y	N	7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian _____ Date

C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2); Public Act No. 18-168.

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name_____ Birth Date_____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

☐I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

*HT____in/cm____% *Weight____lbs.____oz /____% BMI____/____% *HC____in/cm____% (Birth–24 months) *Blood Pressure____/____ (Annually at 3–5 years)

Screenings

***Vision Screening**
☐ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
☐ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

☐Unable to assess
☐Referral made to: _____

***Hearing Screening**
☐ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
☐ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	☐ Pass	☐Pass
	☐ Fail	☐Fail

☐Unable to assess
☐Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** | ***Date**

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level
≥ 5µg/dL ☐nNo ☐nYes

***TB:** High-risk group? ☐No ☐Yes
Test done: ☐No ☐Yes Date: _____
Results: _____
Treatment: _____

***Dental Concerns** ☐No ☐Yes
☐Referral made to: _____
Has this child received dental care in the last 6 months? ☐No ☐Yes

***Result/Level:** ***Date**

Other:

***Developmental Assessment:** (Birth–5 years) ☐No ☐Yes **Type:**

Results:

*IMMUNIZATIONS ☐Up to Date or ☐Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

***Chronic Disease Assessment:**

Asthma ☐No ☐Yes: ☐Intermittent ☐Mild Persistent ☐Moderate Persistent ☐Severe Persistent ☐Exercise induced
If yes, please provide a copy of an Asthma Action Plan
☐Rescue medication required in child care setting: ☐No ☐Yes

Allergies ☐No ☐Yes: _____
Epi Pen required: ☐No ☐Yes
History/risk of Anaphylaxis: ☐No ☐Yes: ☐Food ☐Insects ☐Latex ☐Medication ☐Unknown source
If yes, please provide a copy of the Emergency Allergy Plan

Diabetes ☐No ☐Yes: ☐Type I ☐Type II **Other Chronic Disease:** _____
Seizures ☐No ☐Yes: Type: _____

☐ This child has the following problems which may adversely affect his or her educational experience:
☐Vision ☐Auditory ☐Speech/Language ☐Physical ☐Emotional/Social ☐Behavior
☐ This child has a developmental delay/disability that may require intervention at the program.
☐ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

☐No ☐Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
☐No ☐Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
☐No ☐Yes This child may fully participate in the program.
☐No ☐Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

☐No ☐Yes Is this the child's medical home? ☐ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):
State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑Male ❑Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	Normal	**Referral Made:**
Completed by: ❑Dentist	Completed by: ❑MD/DO ❑APRN ❑PA ❑Dental Hygienist	❑Yes ❑Abnormal (Describe) _____ _____ _____ _____ _____	❑Yes ❑No

Risk Assessment	**Describe Risk Factors**	
❑Low	❑Dental or orthodontic appliance	❑Carious lesions
❑Moderate	❑Saliva	❑Restorations
❑High	❑Gingival condition	❑Pain
	❑Visible plaque	❑Swelling
	❑Tooth demineralization	❑Trauma
	❑Other_____	❑Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA/RDH	Date Signed	Printed/Stamped ***Provider*** Name and Phone Number

Child's Name:_____ Birth Date:_____ REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____(date); _____(confirmed by)

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

TOWN OF NEWINGTON

200 Garfield Street Newington, Connecticut 06111

Parks & Recreation Department

Creative Playtime Preschool Program Parent's Agreement

Child's Name: _____ Parent's Name: _____

Verification of Receipt of Parent Handbook

By signing this document, I verify that I have read the Creative Playtime Preschool Program's Parent Handbook. I am aware of the discipline and behavior policies that will be implemented in the classroom.

Parent's Signature: _____ Date: _____

Discussion of Behavior Management Techniques

The techniques used to manage child behaviors in the facility have been discussed with me prior to enrollment and will be reviewed, as needed, during the period of my child's enrollment.

Parent's Signature: _____ Date: _____

Non-Refundable Deposit

I understand that the 25% deposit paid at the time of registration to reserve my child's spot in the Creative Playtime Preschool Program is **non-refundable**.

Parent's Signature: _____ Date: _____

Payment Agreement (please check one)

- ☐ **Pay in Full Option**: I have chosen to pay my child's registration fees in full at the time of registration.
- ☐ **Payment Plan Option**: I have chosen the payment plan option and understand and agree that payments will be my responsibility and will be due on or before **8/14/2025, 11/13/2025, 1/22/2025 and 3/12/2026.** I understand that I will not receive reminder notices when these bills are due and that it is my sole responsibility to make the payments on time. I understand that a $100 late fee will be assessed for *each* payment more than one week overdue and that if any payment is more than two weeks overdue, I will forfeit my child's space in the program, my deposit, and any other fees or payments made to the program. I also understand that I may choose to pay in full at any time.

Parent's Signature: _____ Date: _____

Join the Lillio App!

This app was formerly HiMama.

What is Lillio program?

Lillio will be used by our educators to record activities and to document updates throughout the day.

What will Lillio do for me?

HiMama will keep you in the loop- all day long! Whether it be at work, home, or on the go through Lillio mobile app, you'll never miss a moment!

Amazing! What should I do next?

You can download "Lillio - The Childcare App". Check your email inbox - we'll be sending your invitation shortly!

Want to learn more? Visit www.lillio.com!

Lillio
formerly himama

Photo Release Form

I, _____ , the parent or legal guardian of _____
PARENT/GUARDIAN NAME — CHILD'S NAME

grant _____ permission to use photos of my child,
CENTER NAME

and agree to the following:

I understand that my child, whose name is listed above, may be photographed at the center during normal daycare hours, field trips or activities. I understand that these photographs may be used in promoting child care services in either print or on the Internet.

With my signature below I grant permission for my child to be photographed, or their images recorded for print or electronic use in promoting the Center's services. I understand that it is my responsibility to update this form in the event that I no longer wish to authorize the above uses. I agree that this form will remain in effect during the term of my child's enrollment. I understand that there will be no payment for me or my child's participation in this release.

_____
PARENT/GUARDIAN SIGNATURE

_____
PARENT/GUARDIAN NAME

_____
CHILD'S NAME

_____
PHONE NUMBER

_____
DATE

Creative Playtime Preschool Program

PERMISSION SLIP

I, _____ give the staff of the Creative Playtime Preschool Program permission to apply sun block lotion to my child_____. I understand I am responsible for bringing in a labeled bottle that does not contain an antibiotic or prescription lotion.

I _____ give my child, _____, permission to walk from Creative Playtime Preschool Program facility to play on the Mortensen Community Center gymnasium, on the Mill Pond Park playgrounds, and to the Lucy Robbins Welles Library. I understand that my child will be under the supervision of the Creative Playtime Preschool Program staff.

I, _____ give my child _____ permission to be taken on a walk by the Creative Playtime Preschool Program. The walks will include the area around the Mill Pond Park and Garfield Street. I understand my child will be under the supervision of the Creative Playtime Preschool Program staff.

_____ _____

Parent Signature Date

Parent/Caregiver Information Form

I. Information

Parent Name: _____ Child's Name: _____

Child's Date of Birth: _____ Child's age in months: _____ Gender of Child: ☐ Male ☐ Female

Home Address: _____ Zip Code: _____

Home Phone Number: _____ Work Phone Number: _____

Primary language in the home: ☐ English ☐ Spanish ☐ Other: _____

Adults in the home: ☐ Two biological parents ☐ Shared custody ☐ Mother alone ☐ Father alone ☐ Adopted

☐ Foster parent(s) ☐ Mother with partner ☐ Father with partner ☐ Other ____

No.of siblings & Ages: _____

Child's age at entry into Child Care: ____ years ____ months

Has the child been in other Child Care Center(s) or Family Child Care Home(s)? ☐ Yes ☐ No

Child Care Provider/Center Name:

_____

Facility Type: ☐ Home Provider ☐ Center ☐ Informal ☐ Pre K-12 ☐ Early/Head Start

II. Concerns

What is the (1) primary, (2) secondary, (3) tertiary concern? ☐ Aggression ☐ Attention ☐ Anxiety ☐ Disruption

☐ Hyperactivity ☐ Pica (eating non-edible items) ☐ Seems Depressed ☐ Self Injury ☐ Withdrawn

☐ Somatic (excessive complaints of physical ailments) ☐ Other

_____

When did behavioral difficulties begin?

_____

Are there any significant changes in the child's life?

_____ When: _____

Does the child have a diagnosis or diagnoses? ☐ Yes ☐ No

☐ Attention-Deficit Hyperactivity Disorder ☐ Bi-Polar Disorder ☐ Autism Spectrum Disorder

☐ Speech and Language Delay ☐ Cognitive Delay ☐ Developmental Delay

☐ Sensory Impairment ☐ Physical Disability ☐ Other: _____

Does child understand simple directions? (e.g. "Put that down;" "Get your coat.") ☐ Yes ☐ No

III. Other Participation in Programs

Is the child receiving services from any other program? ☐ Yes ☐ No

If yes, please specify: _____

IV. General Developmental:

Medical Needs

Does your child have any medical needs or concerns that we need to know? ☐ Yes ☐ No

If Yes please explain: _____

_____

Is there any special care or medications needed to service and meet the needs of your child?

☐ Yes ☐ No

If Yes, please explain: _____

How does your child let you know that it's time "to go"? _____

Does your child need regular reminders to use the bathroom? ☐ Yes ☐ No

Social and Emotional development

Is your child comfortable in group situations? ☐ Yes ☐ No

What is your child's regular routine when at home?

Is there anything we should know about your child's play with other children, by themselves, any concerns?

What kinds of activities does your child enjoy? Are there activities your child avoids?

How would you describe your child's temperament and personality?

What soothes your child?

What frightens your child?

Does your child have any favorite songs or games that comforts them?

What are your expectations or hopes for your child at our child care center?

What are your expectations for the Creative Playtime Preschool Program Center and staff members?

How do you feel about celebrating religious holidays in school?

Would you like to share with us what your religious celebrations are?

Is there anything regarding your family, extended family or child that you would like to share with us?

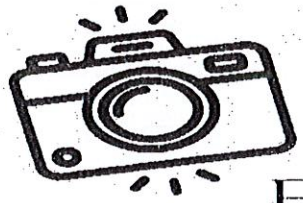
Any other comments or information you would like to share:

V. Consent Agreement

I give permission to use the information provided on this form to assist in identifying my child's needs. I understand this also includes any preliminary evaluations/screens used to assess my child. I understand that this information will be kept completely confidential. I am aware that I may request this information to be removed from my child's file if it is inaccurate, misleading or otherwise in violation of the privacy or other rights of my child. I am also aware that I may request a copy of this completed form for my own records.

Name of Parent/Guardian Date:

Signature of Parent/Guardian Date:



Friendly Reminder

A recent 4 x 6 or
5 x 7 picture of
your child must be
submitted with
your paperwork
for our records.
Thank you.