Fairfield Public Schools
3- and 4- Year Old PRESCHOOL APPLICATION
2016-2017 School Year

3-year old and 4-year old preschool slots are limited and available at Burr Elementary, Dwight Elementary and at the Early Childhood Center.

Please use the following information to identify your preference on the next page.

	Burr Elementary School & Dwight Elementary School	Early Childhood Center (ECC) (located at Fairfield Warde High School)
Tuition	• Tuition determination is based on family income. • Full Tuition = $3,500/year • Reduced Tuition = $1,750/year Free Tuition also available	
Deposit Required	• For students who qualify for full or reduced tuition a one month tuition deposit is required at the time of acceptance ($350 for full tuition and $175 for reduced tuition). • **Deposits are not refundable after April 1, 2016 – no exceptions made.**	
Admission & Placement	• Admission will occur on a rolling basis • Placement will be made as space is available • Placement will be made in order to best balance classrooms • Each class session is made up of a combination of 3- and 4-year old students	
Age of Students	• 3-year olds (must be 3 by December 31, 2016—students cannot start until they are three years old) • 4-year olds (must be 4 by December 31, 2016) • 3-year old students will return as 4-year old students the following year • **Students must be toilet trained to start**	
Curriculum & Assessment	The Fairfield Board of Education Preschool Curriculum identifies what students will learn and be able to do. Developmentally appropriate assessments given throughout the school year measure how students are growing in key curriculum standards.	
Student Enrollment	• 36 student enrollment (18 in the morning and 18 in the afternoon)	• Number of students admitted each year is dependent on current enrollment at the ECC
Siblings	• Siblings of enrolled preschool students can also attend Dwight or Burr Elementary School (please complete separate request form available through the Instructional Office)	• Not Applicable
Days/ Hours of Program	Five days/week (Monday - Friday) • Morning 8:45 a.m. to 11:30 a.m. or • Afternoon 12:30 p.m. to 3:15 p.m.	Four days/week Mornings M-Th • 8:45 a.m. to 11:30 a.m. Afternoons T-F or MTThF • Afternoon 12:30 p.m. to 3:15 p.m.
Transportation	**Transportation will be provided only for students who qualify for Reduced or Free tuition.** Transportation provided to Burr Elementary School from the following schools: McKinley, Holland Hill Burr, Jennings North Stratfield, Stratfield Transportation provided to Dwight Elementary School from the following schools: McKinley, Sherman Dwight, Mill Hill Riverfield, Osborn Hill	• Transportation is **not** provided

Fairfield Public Schools

3 - and 4 -Year Old PRESCHOOL APPLICATION

2016-2017 School Year

Child's Last Name: _____ **First Name:** _____

Child's Home Address: _____

Home Phone Number: _____

Parent/Guardian Information:

Mother/Guardian Name: _____

Home Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____

E-mail_____

Father/ Guardian Name: _____

Home Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Work Phone Number: _____

E-mail_____

Please provide the following information for the child:

Child's Home Elementary School_____

Date of Birth: Month _____ Day_____ Year _____

Child's Age on September 1, 2016: _____

Gender: Male _____ Female _____

Is your child Hispanic/Latino? Yes _____ No _____

Race (check all that apply):

American Indian or Alaskan Native _____
Asian American _____
Black or African American _____
Native Hawaiian or Other Pacific Islander _____
White _____

Siblings:

Name: _____ Age: _____

School sibling attends: _____

Name: _____ Age: _____

School sibling attends: _____

Name: _____ Age: _____

School sibling attends: _____

Please indicate your preferences below.

Preferred location: **(Please check all schools you are interested in applying for)**

Burr Elementary _____ Dwight Elementary _____ Early Childhood Center _____

Preferred session:

Morning session _____ Afternoon session _____ Either session _____

Transportation:

_____ Yes, I need transportation (please see program description for availability of transportation)
_____ No, I do not need transportation

Tuition:

_____ I want to be considered for ***tuition free/reduced*** admission (income verification necessary)
_____ I will pay the ***full tuition*** (no income verification necessary)

(Please note that we will attempt to provide families with their first preference but if that is not possible, we will contact you with other options.
Final determination of preschool session and school location is made by Fairfield Public Schools.)

Additional Information:

Has the child attended preschool before? Yes _____ No _____

If yes, please provide name of school and at what age the child attended: _____

_____

Does the child have any special medical condition or needs? Yes _____ No _____

If yes, please describe: _____

_____

Does the child have any identified special educational needs? Yes _____ No_____

If yes, please describe: _____

What language did the child learn to speak first? _____

What is the primary language spoken in the child's home? _____

_____

Is there anything else you think we should know about the child? _____

_____

****

Please Note: Please send a copy of the following items with your application:

- Child's official birth certificate
- Parent/Guardian photo identification (driver's license or passport)
- Proof of residency: **(all three documents listed below)**
    - Mortgage statement/deed to property or lease agreement
    - one current utility bill
    - Automobile registration certificate
- Verification of income from both parents/guardians free/reduced tuition consideration (e.g., 1040 tax form for 2014 or 2015)
- State of Connecticut Early Childhood Health Assessment Record

Please send completed application to:

Michael Cummings
Director of Elementary Education
Fairfield Public Schools
501 Kings Highway East
Fairfield, CT 06825

Phone Number: (203) 255-8372
Fax Number: (203) 255-8273

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 I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). 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/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
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 I — 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

ED 191 REV. 8/2011

Part II — 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

Lead poisoning (≥ 10ug/dL)

❑ No ❑ Yes

***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

Child's Name: _____ **Birth Date:** _____ REV. 8/2011

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						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

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	1 or 2 doses	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

REQUIREMENT FOR REGISTRATION IN THE FAIRFIELD PUBLIC SCHOOLS

Dear Parent or Guardian,

The following are health requirements for students entering preschool, kindergarten, or transferring into other grades. These requirements conform to state law and Fairfield Board of Education policy. Please contact your child's school nurse if you have questions or if you need further information.

Immunizations

A complete immunization record must be presented before a child enters school. For all students, this record must show date of adequate immunization against diphtheria, pertussis, tetanus, poliomyelitis (initial series plus booster given on or after the fourth birthday), Varicella, Hepatitis B vaccine, and against Measles, Mumps and Rubella. Additionally, adequate immunization must be shown for the following:

Hib	1 dose given on or after the first birthday for students under five years of age.
Pneumococcal	1 dose given on or after the first birthday for students under five years of age who were born on or after January 1, 2007 and are enrolled in Pre Kindergarten or Kindergarten on or after August 1, 2011.
Hepatitis A	2 doses for all students born on or after January 1, 2007 who are enrolled in Pre Kindergarten or Kindergarten on or after August 1, 2011. First dose given on or after the first birthday.
Influenza	1 dose for students under five years of age enrolled in pre school. Vaccine administered annually between August 1 and December 31st. Individuals receiving the vaccine for the first time require two doses.
Measles, Mumps, Rubella	2 doses for all students enrolled in Kindergarten through 12 on or after August 1, 2011. First dose given on or after the first birthday.
Varicella	2 doses for those enrolled in Kindergarten or 7th grade on or after August 1, 2011. First dose given on or after the first birthday.
Tdap	1 dose for those enrolled in 7th grade on or after August 1, 2011.
Meningococcal	1 dose for those enrolled in 7th grade on or after August 1, 2011.

Under certain circumstances, proof of immunity based upon specific blood testing or disease certification is acceptable in lieu of immunization. For further information, contact the school nurse.

Connecticut state statutes permit exemptions from receiving immunizations if vaccination is medically contraindicated and such contraindication is certified by a physician and is in accordance with the provisions of state law, ***or*** if such immunization is contrary to the religious beliefs of the child and there is parent/guardian statement to that effect. A written statement is needed. For further information, contact the school nurse.

Health Assessments (Physical Examinations)

A complete health assessment done by a physician or osteopath licensed to practice in the United States, or by an advanced practice registered nurse, registered nurse, or Physician's Assistant licensed to practice in Connecticut, must be presented to the school before a child enters school. A State of Connecticut Health Assessment form is provided by the school to be completed when your child receives the required health assessment. All required information must be completed before the health assessment may be accepted.

For students entering preschool and kindergarten, the health assessment must have been done on or after August 15 of the school year preceding entry into these grades. For older students, the health assessment must have been done as recently as the last required health assessment for the student's grade level. The school nurse will inform you of the acceptable time frame for your child's health assessment.

Tuberculin Tests

Health assessments required prior to initial entrance into a Fairfield school shall include evidence of a Mantoux tuberculin skin test performed after most recent entry into the United States for students entering school in Fairfield from a country with a high prevalence of tuberculosis. In addition, health assessments done on or after August 15th, 2005 shall include documentation of the student's risk of exposure to tuberculosis. Any student determined to be at high risk shall receive a Mantoux tuberculin skin test performed in the United States as part of the required health assessment. For further information, contact the school nurse.

ACKNOWLEDGEMENT

I have received and read the above requirements. I understand that my child shall not be permitted to register for or attend school until such time as the requirements are fulfilled.

Parent Signature	Date	Home Phone

Student's Name	Grade	School