SECRET GARDEN MONTESSORI

1110 Harrison Street • Frenchtown NJ 08825
**Phone (908) 628-9639 • Fax (908) 996-9801 • www.secretgardenmontessori.org**

Dear families,

Welcome! And thank you for choosing SGM. Enclosed you will find a comprehensive registration packet. Once we receive this packet, your enrollment agreement and all necessary tuition deposits, your child's placement in the program will be secured.

As a licensed childcare center in New Jersey, we are obliged to provide you, as the parent of a child enrolled at our center, with our Parent Handbook that includes the informational statement and our contagious disease, staff discipline & child suspension/expulsion policies.

The informational statement highlights, among other things: your rights to visit and observe our center at any time without having to secure prior permission; the center's obligation to be licensed and to comply with licensing standards; and the obligation of all citizens to report suspected child abuse/neglect/exploitation to the State's Division of Youth and Family Services (DYFS).

Please read the Parent handbook carefully and if you have any questions feel free to contact our office.

We have included a registration checklist below for your convenience:

1. Emergency medical form and immunization records or letter of religious objection.*
   *Please note* Children under 59 months of age are required to receive a flu shot annually between the months of September- December. Record of updated vaccination must be submitted as soon as the flu shot has been received.

2. Universal Child Health record completed and signed by your child's doctor.

3. Receipt of information form

4. Program selection form

Thank you for choosing our school. We are glad to have you in the community!

Sincerely,

Jessikah Humphrey
Head of School

# Consent to Emergency First Aid, Medical Treatment & Transportation

In the event of medical emergency, I hereby grant permission for administration of first aid, transportation to a hospital, if deemed necessary, and treatment by a physician or other medical personnel for the following Secret Garden Montessori student during the 2018-19 summer and school year:

Student's Name _____ Date of Birth: _____

Parent's signature_____ Date: _____

Mailing Address: _____ Home Phone: _____

| | **Custodial Parent #1** | **Custodial Parent #2** |
|---|---|---|
| Name | | |
| Cell Phone | | |
| Work Phone | | |
| Work Address | | |
| Email | | |
| **Is there a non-custodial parent?** | ____ yes ___ no | If yes, has he/she been denied or limited access to child by court order? (Please include copy of court order if so.) |

*Alternate emergency contacts* ***must be able to drive & assume temporary care of child.***

| | #1 Alternate Emergency Contact | #2 Alternate Emergency Contact |
|---|---|---|
| Name | | |
| Phone | | |
| Address | | |
| Relationship to Child | | |

| | |
|---|---|
| Child's Physician: | City, State & Phone #: |
| Child's Dentist: | City, State & Phone #: |
| Insurance company: | Policy #: |
| Child's SSN: | |
| | |
| **Regular medications**:** | |
| **Medicine Allergies**:** | |
| **Food Allergies**** | |
| **Other Allergies**:** | |

**Please explain details and any instructions on other side of paper

# UNIVERSAL
# CHILD HEALTH RECORD

*Endorsed by:* *American Academy of Pediatrics, New Jersey Chapter*
*New Jersey Academy of Family Physicians*
*New Jersey Department of Health and Senior Services*

## SECTION I - TO BE COMPLETED BY PARENT(S)

| Child's Name *(Last)* *(First)* | Gender ☐ Male ☐ Female | Date of Birth / / |
|---|---|---|

| Does Child Have Health Insurance? ☐Yes ☐No | If Yes, Name of Child's Health Insurance Carrier |
|---|---|

| Parent/Guardian Name | Home Telephone Number | Work Telephone/Cell Phone Number |
|---|---|---|
| Parent/Guardian Name | Home Telephone Number | Work Telephone/Cell Phone Number |

***I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.***

| Signature/Date | This form may be released to WIC. ☐Yes ☐No |
|---|---|

## SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

| Date of Physical Examination: | Results of physical examination normal? ☐Yes ☐No |
|---|---|

| Abnormalities Noted: | Weight *(must be taken within 30 days for WIC)* | |
|---|---|---|
| | Height *(must be taken within 30 days for WIC)* | |
| | Head Circumference *(if <2 Years)* | |
| | Blood Pressure *(if ≥3 Years)* | |

| **IMMUNIZATIONS** | ☐ Immunization Record Attached<br>☐ Date Next Immunization Due: |
|---|---|

### MEDICAL CONDITIONS

| | | |
|---|---|---|
| Chronic Medical Conditions/Related Surgeries<br>• List medical conditions/ongoing surgical concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Medications/Treatments<br>• List medications/treatments: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Limitations to Physical Activity<br>• List limitations/special considerations: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Equipment Needs<br>• List items necessary for daily activities | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Allergies/Sensitivities<br>• List allergies: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Special Diet/Vitamin & Mineral Supplements<br>• List dietary specifications: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Behavioral Issues/Mental Health Diagnosis<br>• List behavioral/mental health issues/concerns: | ☐ None<br>☐ Special Care Plan Attached | Comments |
| Emergency Plans<br>• List emergency plan that might be needed and the sign/symptoms to watch for: | ☐ None<br>☐ Special Care Plan Attached | Comments |

### PREVENTIVE HEALTH SCREENINGS

| Type Screening | Date Performed | Record Value | Type Screening | Date Performed | Note if Abnormal |
|---|---|---|---|---|---|
| Hgb/Hct | | | Hearing | | |
| Lead: ☐ Capillary ☐ Venous | | | Vision | | |
| TB (mm of Induration) | | | Dental | | |
| Other: | | | Developmental | | |
| Other: | | | Scoliosis | | |

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

| Name of Health Care Provider (Print) | Health Care Provider Stamp: |
|---|---|
| Signature/Date | |



Distribution: Original-Child Care Provider Copy-Parent/Guardian Copy-Health Care Provider

# PARENTAL PERMISSIONS 2012-13

## Instructions for Completing the Universal Child Health Record (CH-14)

### Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

### Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.
2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health and Senior Services, Immunization Program at 609-588-7512.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.
3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.
   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.state.nj.us/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.
   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*
   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.
   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.
   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.
   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.
   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.
   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.
5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

## RECEIPT OF INFORMATION TO PARENTS

Name of child: _____

Name of Parent(s): _____

I have received and read the copy of the Information to Parents Statement prepared by the Bureau of Licensing in the Division of Youth and Family Services and included in the Secret Garden Montessori Community Handbook. Additionally I have reviewed Secret Garden Montessori's contagious disease & discipline/suspension/expulsion and release of children policies as required by the Bureau of Licensing.

Signature of Parent: _____ Date _____

## AUTHORIZATION TO USE PHOTOGRAPHS & CHILD WORK

I, _____, hereby authorize Secret Garden Montessori to freely use, reproduce, and/or publish photographs of my child and/or his/her work in press releases, brochures & other promotional materials, and on the Secret Garden Montessori website and in the newsletter, both while they are enrolled at the school and afterwards. This authorization shall remain in place unless specifically rescinded later.

Name of child: _____

Signature of Parent: _____ Date: _____

## BLANKET PERMISSION SLIP FOR WALKS DURING SCHOOL DAY

My child, _____, has permission to be escorted by Secret Garden's faculty/staff and parents on walks in the neighborhood, including but not limited to daily play/lunch at Old Frenchtown Field and visits to our flower garden.

Signature of Parent: _____Date: _____

## PERMISSION TO ADMINISTER SUNBLOCK

Please initial here to signify consent to teacher application of sunblock/lotion (supplied by parents) when deemed necessary during outdoor playtime:

Signature of Parent: _____ Date: _____

# Secret Garden Montessori 2018-19 Program Registration form

Child's name: _____ DOB: _____

Sprouts Infant/Toddler Program

___ Half Day ___ Full Day

Circle all that apply*

M T W TH F

*Subject to availability/ Two day minimum/ Consecutive days **strongly** recommended

Primary Program

___ Half Day ___ Full Day ___ 3 day option*

*Available for 1st semester only/

Before Care ONLY (7:00-8:30am): Circle desired days

M T W TH F

After Care ONLY (3:00-5:30pm): Circle desired days

M T W TH F

Fee schedule options: Please Check One

_____ School year/a la carte

_____ School year/all-inclusive _____ Year-round/all inclusive

Please complete and return to our office with a $50 registration fee. Upon receipt of this registration, SGM will draft an enrollment agreement to be signed by both parties and returned with a one-month deposit. At that time, your child's spot in the program for the 2018-19 school year will be confirmed.

Parent #1 signature: _____ Date: _____

Parent #2 signature: _____ Date: _____

# SECRET GARDEN MONTESSORI

# APPLICATION FOR SPROUTS AND PRIMARY PROGRAMS

## LEVEL

___ SPROUTS (infants-2.5 yr)
*Please circle: M T W TH F*
___ 1st YEAR PRIMARY (Age 3-4)
___ 2ND YEAR PRIMARY (Age 4-5)
___ 3RD YEAR PRIMARY (Age 5-6)

## EXTENDED PROGRAMS

___ BEFORE CARE (7-8:30am)
*Please circle: M T W TH F*
___ AFTER CARE (3-5:30pm)
*Please circle: M T W TH F*
___ VACATION CARE
___ SUMMER PROGRAM

## START DATE

___ IMMEDIATE OPENING
___ SUMMER 20___
___ FALL 20___

## APPLICANT INFORMATION

_____ ___ MALE ___ FEMALE
LAST NAME FIRST NAME MI

_____ _____YRS _____ MTHS
DATE OF BIRTH PLACE OF BIRTH PRESENT AGE

## FAMILY INFORMATION

_____ __ Mr. __ Mrs. __ Dr. __ Ms.
PARENT/GUARDIAN #1 LAST NAME FIRST NAME MI

HOME ADDRESS CITY STATE/ZIP COUNTY

HOME PHONE CELL PHONE EMAIL ADDRESS

EMPLOYER NAME OCCUPATION/TITLE WORK PHONE AND EMAIL

_____ __ Mr. __ Mrs. __ Dr. __ Ms.
PARENT/GUARDIAN #2 LAST NAME FIRST NAME MI

HOME ADDRESS CITY STATE/ZIP COUNTY

HOME PHONE CELL PHONE EMAIL ADDRESS

EMPLOYER NAME OCCUPATION/TITLE WORK PHONE AND EMAIL

PARENTS/GUARDIANS ARE: ___ MARRIED ___ SEPARATED ___ DIVORCED ___ SINGLE ___PARTNERS ___WIDOWED

STEPPARENT NAME (IF APPLICABLE) _____
WITH WHOM DOES THE APPLICANT LIVE? ___ BOTH PARENTS ___ MOTHER ___ FATHER ___ OTHER

PLEASE LIST OTHER CHILDREN IN YOUR FAMILY

NAME _____ DATE OF BIRTH _____ GRADE _____ SCHOOL _____

NAME _____ DATE OF BIRTH _____ GRADE _____ SCHOOL _____

NAME _____ DATE OF BIRTH _____ GRADE _____ SCHOOL _____

NAMES AND RELATIONSHIPS OF ANY FAMILY MEMBERS WHO HAVE ATTENDED SGM

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

## SCHOOL/CHILD HISTORY INFORMATION

PRESENT SCHOOL _____ DATES OF ENROLLMENT _____

ADDRESS _____

PRINCIPAL/DIRECTOR _____ PHONE _____

PREVIOUS SCHOOL _____ DATES OF ENROLLMENT _____

ADDRESS _____

PRINCIPAL/DIRECTOR _____ PHONE _____

REASON FOR CHANGING SCHOOL (IF APPLICABLE) _____

_____

HAS YOUR CHILD EVER HAD ANY EDUCATIONAL OR PSYCHOLOGICAL DIAGNOSTIC EVALUATIONS? ___ Y ___ N

HAS YOUR CHILD RECEIVED/OR IS RECEIVING ANY EARLY INTERVENTION OR SPECIAL SERVICES? ___ Y ___ N

IF YES, PLEASE DESCRIBE THE NATURE OF THESE SERVICES.

_____

_____

_____

DOES YOUR CHILD HAVE ANY PHYSICAL LIMITATIONS OR ALLERGIES? ___ YES ___ NO

DOES YOUR CHILD HAVE ANY SIGNIFICANT MEDICAL HISTORY WE NEED TO BE AWARE OF? ___ YES ___ NO

IS YOUR CHILD CURRENTLY UNDER MEDICAL CARE OR TAKING ANY MEDICATION? ___ YES ___ NO

IS THERE ANY MEDICAL, BEHAVORIAL, BIRTH OR ENVIRONMENTAL HISTORY THAT WILL HELP US UNDERSTAND YOUR CHILD BETTER? PLEASE DESCRIBE.

_____

_____

_____

_____

**IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE ATTACH A SEPARATE SHEET WITH DETAILS AND IF RELEVANT, REQUEST COPIES OF REPORTS TO BE SENT TO US FOR YOUR CHILD'S FILE**

PLEASE ANSWER THE FOLLOWING QUESTIONS. FEEL FREE TO USE A SEPARATE SHEET IF MORE ROOM IS NEEDED. OUR GOAL IS TO LEARN MORE ABOUT YOUR CHILD AND FAMILY TO DETERMINE WHETHER SGM IS A GOOD FIT.

WHAT HAS DRAWN YOU TO SGM? WHY DO YOU FEEL IT WOULD BE A GOOD FIT FOR YOUR CHILD?

_____

_____

_____

WHAT ARE YOUR EXPECTATIONS/GOALS FOR YOUR CHILD AT SGM?

_____

_____

_____

PLEASE CIRCLE ALL THAT APPLY:

IS YOUR CHILD; ADOPTED IN FOSTER CARE UNDER LEGAL GUARDIANSHIP

ARE THERE PERTINENT CUSTODY ARRANGEMENTS? YES NO

IF YES, PLEASE DESCRIBE: _____

HAS YOUR CHILD EXPERIENCED SEPARATION FROM THE PRIMARY CAREGIVER BEFORE? YES NO

ARE THERE OTHER CAREGIVERS WITH WHOM YOUR CHILD SPENDS A LOT OF TIME? YES NO

IF YES, PLEASE DESCRIBE (I.E. FREQUENCY, NATURE OF RELATIONSHIP,ETC)

_____

_____

IS YOUR CHILD POTTY TRAINED? NOT AT ALL PARTIALLY COMPLETELY

HOW OFTEN DOES YOUR CHILD NAP? DAILY OFTEN RARELY

DESCRIBE YOUR CHILD'S APPETITE. EATS WELL EATS POORLY LIKES/DISLIKES VARIETY

IS YOUR CHILD; RIGHT-HANDED LEFT-HANDED NOT DISPLAYING A PREFENCE

_____

_____

_____

PLEASE TELL US A BIT ABOUT YOUR CHILD'S PERSONALITY, DISPOSITION AND SOCIAL INTERACTIONS.

_____

_____

_____

_____

_____

IF THERE ARE ANY ADDITIONAL THINGS YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD, PLEASE SHARE THEM WITH US ON A SEPARATE SHEET.

SECRET GARDEN MONTESSORI

# AUTHORIZATION FOR THE RELEASE OF RECORDS

NAME OF APPLICANT _____

PRESENT SCHOOL _____

ADDRESS

_____

_____

TELEPHONE _____ FAX _____

ON BEHALF OF MY CHILD, _____, WHO IS PRESENTLY ENROLLED AS A STUDENT AT YOUR SCHOOL, I HAVE APPLIED FOR ADMISSION TO SECRET GARDEN MONTESSORI BEGINNING WITH THE TERM STARTING _____, 20 _____.

I HEREBY AUTHORIZE YOU TO RELEASE THE FOLLOWING:

- A COMPLETED COPY OF HIS/HER FILE
- A TRANSCRIPT OF HIS/HER ACADEMIC RECORD
- HEALTH FORMS
- RELEVANT TEST SCORES
- TEACHERS' COMMENTS AND OBSERVATIONS OF HIS/HER OVERALL DEVELOPMENTAL PROGRESS

SIGNATURE OF PARENT/GUARDIAN _____

DATE _____

PLEASE FORWARD ALL RECORDS TO:
SECRET GARDEN MONTESSORI
ATTN: HEAD OF SCHOOL
1110 HARRISON STREET
FRENCHTOWN, NJ 08825
PH 908-628-9639
FAX 908-996-9801

THIS APPLICATION IS REGARDED AS A FORMAL REQUEST FOR CONSIDERATION OF YOUR CHILD AS A POTENTIAL STUDENT AT SECRET GARDEN MONTESSORI AND AS AUTHORIZATION FOR OUR OFFICE TO OBTAIN TRANSCRIPTS AND RECOMMENDATIONS FROM PREVIOUS SCHOOLS.

UPON RECEIPT OF THIS APPLICATION AND FEE, YOUR CHILD WILL BE PLACED IN OUR ACTIVE APPLICANT POOL. OUR HEAD OF SCHOOL WORKS WITH OUR ADMISSIONS COMMITTEE TO REVIEW ALL APPLICATIONS AND MAKE OUR FINAL ENROLLMENT DETERMINATIONS. YOU WILL BE NOTIFIED OF OUR DECISION WITHIN 30 DAYS OR LESS FROM THE DATE OF YOUR APPLICATION SUBMISSION. IF ACCEPTED, YOU WILL ALSO RECEIVE AN ENROLLMENT AGREEMENT TO BE SIGNED AND SUBMITTED PROMPTLY.

SECRET GARDEN MONTESSORI DOES NOT DISCRIMINATE ON THE BASIS OF AND ADMITS STUDENTS OF ANY RACE,COLOR, NATIONAL AND ETHNIC ORIGIN, FAITH, GENDER, GENDER IDENTITY, SEXUAL ORIENTATION, PHYSICAL DISABILITY OR ANY OTHER CHARACTERISTIC PROTECTED BY LAW, TO ALL THE RIGHTS, PRIVILEGES, PROGRAMS AND ACTIVITIES GENERALLY ACCORDED OR MADE AVAILABLE TO STUDENTS AT THE SCHOOL.

SECRET GARDEN MONTESSORI RESERVES THE RIGHT TO AMEND OR WITHDRAW ANY PROGRAM FOR WHICH THERE IS NOT SUFFICIENT ENROLLMENT.

PLEASE SHARE WITH US THE NAME AND ADDRESS OF THE INDIVIDUAL(S) WHO WILL ASSUME FINANCIAL RESPONSIBILITY FOR TUITION (IF OTHER THAN YOURSELF):

NAME _____

ADDRESS _____

_____

PHONE _____

SIGNATURE OF PARENT/GUARDIAN #1 _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN #2 _____ DATE _____

PLEASE SUBMIT THIS APPLICATION ALONG WITH A $50 NON-REFUNDABLE APPLICATION FEE TO:

SECRET GARDEN MONTESSORI
1110 HARRISON STREET
FRENCHTOWN, NJ 08825

PH (908) 628-9639
FAX (908) 996-9801
EMAIL: INFO@SECRETGARDENMONTESSORI.ORG

THANK YOU FOR YOUR INTEREST IN OUR SCHOOL!

# SECRET GARDEN MONTESSORI | 2018-2019 CALENDAR

**2-6** Vacation Care
**4** Independence Day
No school/ No VC
**9** 1st Day of Summer Program

**JULY 2018**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 8 | 9 | 10 | 11 | 12 | 13 | 14 |
| 15 | 16 | 17 | 18 | 19 | 20 | 21 |
| 22 | 23 | 24 | 25 | 26 | 27 | 28 |
| 29 | 30 | 31 | | | | |

**15 Board meeting 7pm**
**17** Last day of Summer Program
**20-24** Full Shut Down
**27-31** Full Shut Down

**AUGUST 2018**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | |

**3** Labor Day
No school/No VC
**4** First Day for Return Students
**10** First Day for New Students
**17** Back to School Night 6pm
**19 Board meeting 7pm**

**SEPTEMBER 2018**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | | | | | | |

**1** No AC/Staff In-service
**8 Indigineous Peoples Day**
No School/VC Offered
**17 Board meeting 7pm**
**26** Fall Festival

**OCTOBER 2018**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | 31 | | | |

**12** Veterans Day
No School/VC Offered
**14 Board meeting 7pm**
**13-14** Primary Conferences
**15-16** Sprouts Conferences
**19-21** No School/VC Offered
**22-23** Thanksgiving Day
No School/ No VC

**NOVEMBER 2018**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | 1 | 2 | 3 |
| 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11 | 12 | 13 | 14 | 15 | 16 | 17 |
| 18 | 19 | 20 | 21 | 22 | 23 | 24 |
| 25 | 26 | 27 | 28 | 29 | 30 | |

**14** Winter Sing Along
**18** No School/Kid Care Freebie
**19-21** No School/VC Offered
**24-26** Winter Holiday
No School/No VC
**27-28** VC Offered
**31** New Year's Eve
No School/No VC

**DECEMBER 2018**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | 31 | | | | | |

**JANUARY 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
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| 6 | 7 | 8 | 9 | 10 | 11 | 12 |
| 13 | 14 | 15 | 16 | 17 | 18 | 19 |
| 20 | 21 | 22 | 23 | 24 | 25 | 26 |
| 27 | 28 | 29 | 30 | 31 | | |

**1** New Year's Day
No School/No VC
**16 Board meeting 7pm**
**18** Peace Gathering 6pm
**21** M.L. King Day
No School/No VC

**FEBRUARY 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
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| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | | |

**4** No AC/ Staff In-Service
**18 No school**/VC Offered
**20 Board meeting 7pm**

**MARCH 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | 1 | 2 |
| 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| 10 | 11 | 12 | 13 | 14 | 15 | 16 |
| 17 | 18 | 19 | 20 | 21 | 22 | 23 |
| 24 | 25 | 26 | 27 | 28 | 29 | 30 |
| 31 | | | | | | |

**1** No School/No VC
Staff In-service
**15** Grandparent's Visit
**20 Board meeting 7pm**

**APRIL 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | | | | |

**17 Board meeting 7pm**
22-26 Spring break/VC available

**MAY 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | |

**6** No AC/Staff In-Service
**15 Board meeting 7pm**
**27** Memorial's Day
No School/No VC

**JUNE 2019**

| S | M | T | W | Th | F | S |
|---|---|---|---|---|---|---|
| | | | | | | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 30 | | | | | | |

**7** Year End Show
**12 Board meeting 7pm**
**14** Last Day of School
**17** Full Shut Down
**24-28** VC Offered

Green= No Scool/VC Offered Red= No School/NO VC Yellow= Start/End of program Purple= Family event Grey= Modified Schedule