SECRET GARDEN MONTESSORI

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

Dear families,

Welcome! We thank you for choosing Secret Garden Montessori. Enclosed you will find a comprehensive registration packet. To secure your child's placement in the program, please submit the packet, new student application (where applicable), and a $75 registration fee. Once these documents are received, an enrollment agreement will be generated for you to sign.

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 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 through the forms carefully and contact the office if you have any questions.

Below is a checklist of included documents **required for enrollment:**

1. Consent to Emergency First Aid, Medical Treatment & Transportation Form

2. 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 Health Record completed and signed by your child's doctor.

3. Receipt of information form (Please note additions for 2021-22 school year)

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

Sincerely,

Rosalie Skakum

Rosalie Skakum
Head of School

Secret Garden Montessori 2021-22 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/ Three day minimum/ Consecutive days **strongly** recommended

Primary Program

___ Half Day ___ Full Day ___ 3 day option*

*Available for 1st Year 1st semester only

Please complete and return to our office with a $75 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 2021-22 school year will be confirmed.

Parent #1 signature: _____ Date: _____

Parent #2 signature: _____ Date: _____

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 2021-22 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*

RECEIPT OF INFORMATION TO PARENTS

Name of child: _____

Name of Parent/Guardians(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. I have reviewed Secret Garden Montessori's 1. Contagious disease policy 2. COVID-19 Travel Policy 3. Release of children policy and 4. Discipline/suspension/expulsion policy as required by the Bureau of Licensing and agree to comply with ALL health and safety protocols outlined for Secret Garden Montessori for the 2021-22 school year.

Signature of Parent: _____ Date _____

AUTHORIZATION TO PHOTOGRAPH/LIVE STREAM

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, newsletter and on social media, 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: _____

I, _____, authorize the use of the application Zoom within the classroom for virtual teacher focused sessions, in the event that a child needs to transition to remote learning due to illness.

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: _____

APPENDIX H **UNIVERSAL CHILD HEALTH RECORD**	*Endorsed by: American Academy of Pediatrics, New Jersey Chapter* *New Jersey Academy of Family Physicians* *New Jersey Department of Health*

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 Date Next Immunization Due:

MEDICAL CONDITIONS

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