



**ST. ALBAN'S PRE-SCHOOL**  
1 Church Lane, Oakland, NJ 07436  
201-337-5928

## **MARK YOUR CALENDARS**

**Registration for the 2022/2023 school year begins on  
Tuesday, March 8<sup>th</sup>, at 9 AM.**

Registration is on a first come, first serve basis.

- ❖ The registration/insurance fee for the 2022/2023 school year will be \$75.00 for currently enrolled students, siblings and alumni. The registration/insurance fee for new students is \$100.00.
- ❖ You will be required to fill out the attached forms, choose your child's schedule and attach a check for the non-refundable registration/insurance fee. This fee will allow us to process your application. Attached are the application form and tuition fees.
- ❖ **Please be sure to tell your friends that Registration will open to the public on Thursday, March 10<sup>th</sup> at 9 am.** We truly appreciate the referrals that you make to our pre-school. The best advertisement is a happy family!

In order to provide the best age appropriate education, children will be admitted to classes according to the following cut-off dates:

1's class -	Must be 1 to start the program
2's class -	Must be 2 to start program
3's class -	Must be 3 by October 31
4's class -	Must be 4 by October 31
TK class -	Must be 5 by December 31

The director and faculty reserve the right to evaluate and recommend placements that deviate from the above policy.

### **SPECIALIST SCHEDULE**

<b>MONDAY</b>	AM	<b><i>Cooking</i></b>
<b>TUESDAY</b>	AM	<b><i>Music &amp; Creative Movement</i></b>
<b>WEDNESDAY</b>	AM	<b><i>Read &amp; Create</i></b>
<b>THURSDAY</b>	AM	<b><i>Physical Education</i></b>
<b>FRIDAY</b>	AM	<b><i>Science/ Social Studies</i></b>

**ST. ALBAN'S PRE-SCHOOL  
APPLICATION FOR ADMISSION**

Child's Name \_\_\_\_\_ Boy [ ] Girl [ ] Birth Date \_\_\_\_\_

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Zip Code \_\_\_\_\_

Preferred E-Mail Contact \_\_\_\_\_

Class:            1's ( )                      2's ( )                      3's ( )                      4's ( )                      TK ( )

<b>CARE CLUB:</b> (circle)	Mon.	<b>FULL DAYS:</b> (circle)	Mon.	<b>HALF DAYS:</b> (circle)	Mon.	AM	PM	
	Tue.		Tue.		Tue.	AM	PM	
	Wed.		Wed.		Wed.	AM	PM	
	Thu.		Thu.		AM: 9-12	Thu.	AM	PM
	Fri.		Fri.		PM: 1-4	Fri.	AM	PM

How did you learn about St. Alban's Pre-School? \_\_\_\_\_

**For Emergency Contact** (If parents/guardians cannot be reached):

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

**FAMILY INFORMATION**

Parent/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Occupation & Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_

Occupation & Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_ Cell  
Phone \_\_\_\_\_

**Other Children in the Family**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent/Guardian's Signature)

Pre-Enrollment Conference Date \_\_\_\_\_

**ST. ALBAN'S PRE-SCHOOL  
STUDENT ENROLLMENT INFORMATION**

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Physician Name & Phone: \_\_\_\_\_

Physician Address: \_\_\_\_\_

**EATING HABITS**

Does the child feed himself? \_\_\_\_\_

Does the child violently dislike any foods? \_\_\_\_\_

Has feeding ever been a problem? \_\_\_\_\_

**SLEEPING HABITS**

Does the child tire easily? \_\_\_\_\_ If so, responding how? \_\_\_\_\_

Does the child nap every day? \_\_\_\_\_ At what time? \_\_\_\_\_

Does the child awaken easily? \_\_\_\_\_

**TOILET HABITS**

Is the child toilet trained? \_\_\_\_\_ Night? Daytime? \_\_\_\_\_ Naptime? \_\_\_\_\_

Does the child ask to go to the toilet? \_\_\_\_\_ If so, how? \_\_\_\_\_

**IN GENERAL**

Has your child been evaluated by Early Intervention or a Developmental Pediatrician? Yes \_\_\_ No \_\_\_

If so, what was the outcome? \_\_\_\_\_

What are your child's principal interests? \_\_\_\_\_

**(OVER)**

Does the child have habits such as thumb-sucking, throwing tantrums? \_\_\_\_\_

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Does your child have any noteworthy fears? Examples (such as noise, the dark) \_\_\_\_\_

When did your child start talking? \_\_\_\_\_ Does your child like to talk? \_\_\_\_\_

Does your child get along well with other children? \_\_\_\_\_

With whom does your child play? \_\_\_\_\_ Playmates' ages \_\_\_\_\_

Does child have any behavior problems? \_\_\_\_\_

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Does child have any special problems when it comes to you? \_\_\_\_\_

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Do you have pets? \_\_\_\_\_ Type? \_\_\_\_\_ Names? \_\_\_\_\_

Does your child have any allergies? \_\_\_\_\_ What are they? \_\_\_\_\_

Symptoms? \_\_\_\_\_ Medication? \_\_\_\_\_

Discuss any special circumstances tending to affect your child's progress at school:

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# ST. ALBAN'S PRE-SCHOOL

## FINANCIAL POLICY

I hereby contract enrollment for my child \_\_\_\_\_ at St. Alban's Preschool for the school year covering September 2022 through June 2023.

I enclosed a check for the registration fee with this form. I understand that this amount is not refundable.

Tuition for all students is due by the first (1st) of each month. St. Alban's Pre-School reserves the right of refusal to class if tuition is not received. Should tuition be received after the fifth (5th) of the month, St. Alban's shall charge a \$20.00 late fee. If a check is returned from the bank, St. Alban's shall charge a \$30.00 late fee. Any collection agencies costs incurred due to a delinquent tuition account will be the responsibility of the account holder.

Extended care costs are not included in the regular tuition, and, when needed, will be billed separately at the end of each month.

St. Alban's Pre-School reserves the right to refuse or discontinue enrollment of a child when the association is not conducive to the welfare of the school, its teachers, and the other children, as determined by the school administration. All health forms must be returned by the first day of school. Further, the Director reserves the right to dismiss any child from the school upon non-payment of tuition on time or for any other reason. If such action ever becomes necessary, St. Alban's Pre-School will refund a pro-rated amount of the prepaid tuition. Refer to the Expulsion Policy for more information.

No credit or make-up days will be allowed for absences due to illness, withdrawal, religious or legal holidays, snow days or any other reasons. In this unprecedented time, this includes closure of school by federal, state or local authority due to emergent pandemic status.

I contract for this 10-month school program in ten monthly tuition installments. Withdrawal prior to the completion of the school year will result in a contract termination fee equal to 50% of regular tuition due for the remainder of the contracted year and is due and payable in full within 15 days of withdrawal. This termination fee may be appealed to the Rector, Wardens, and Vestry of St. Alban's Episcopal Church whose decision is final.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent's Signature)

Please circle or list the holiday your family celebrates. We will be learning about all holidays.



Other: \_\_\_\_\_

# ST. ALBAN'S PRE-SCHOOL

## PERMISSION FOR WALKING TRIPS

I hereby give permission for my child \_\_\_\_\_ to participate in walking trips within the neighborhood. I understand these walks: (1) do not involve entrance into any facility; (2) are supervised by a teacher; and (3) involve no known safety hazards along the way. This includes walking to our emergency evacuation site which is Manito School.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent's Signature)

## AUTHORIZATION FOR CHILD PICK-UP

I authorize the following people to pick up my child from St. Alban's Pre-School. All others must present a written request from me for my child to be discharged into their hands, and such in writing absolves St. Alban's Pre-School from responsibility after the child leaves the school. All written request will remain on file at the school. St. Alban's Pre-School has the right to verify identification by asking for proof, such as a driver's license.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent's Signature)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

# ST. ALBAN'S PRE-SCHOOL

## PARENTAL CONSENT TO ADMINISTER MEDICINE

Medication shall only be administered by St. Alban's Pre-School personnel upon my written request and will only be that prescribed by a physician. When I authorize St. Alban's Pre-School personnel to administer medication to my child during school hours, I hereby absolve St. Alban's Pre-School from any responsibility for any ill effects that may occur from the administration of such medication.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent's Signature)

## PARENTAL CONSENT FOR EMERGENCY TREATMENT

I hereby authorize St. Alban's Pre-School to call an emergency ambulance in case of accident or acute illness, and to allow possible emergency care if I am not immediately available. In the case of an emergency, if I and/or my physician cannot be reached, I hereby authorize the staff of St. Alban's Pre-School to provide any necessary medical treatment. It is understood that I will be advised of the nature and extent of such treatment.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Parent's Signature)

# 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth ____ / ____ / ____
Does Child Have Health Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> 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 ( ) -	
<b>I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.</b>			
Signature/Date _____		This form may be released to WIC. <input type="checkbox"/> Yes <input type="checkbox"/> No	

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER			
Date of Physical Examination: _____		Results of physical examination normal? <input type="checkbox"/> Yes <input type="checkbox"/> 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)	_____

<b>IMMUNIZATIONS</b>	<input type="checkbox"/> Immunization Record Attached <input type="checkbox"/> Date Next Immunization Due: _____
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MEDICAL CONDITIONS		
Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	<input type="checkbox"/> None <input type="checkbox"/> Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	<input type="checkbox"/> None <input type="checkbox"/> 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: <input type="checkbox"/> Capillary <input type="checkbox"/> Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

<input type="checkbox"/> <b>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.</b>	
Name of Health Care Provider (Print) _____	Health Care Provider Stamp: _____
Signature/Date _____	



## 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, Vaccine Preventable Diseases Program at 609-826-4860. 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.nj.gov/health/forms/ch-15.dot](http://www.nj.gov/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](http://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.

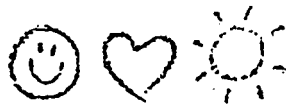
4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public health personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place 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.



## **St. Alban's Pre-School**

1 Church Lane  
Oakland, New Jersey 07436  
(201) 337-5928  
Teresa M. Ercan, *Director*

### **PARENT RECEIPT OF INFORMATION:**

- ❖ **General Information Letter**
- ❖ **Information to Parents Document**
- ❖ **Policy on the Release of Children**
- ❖ **Positive Guidance and Discipline Policy**
- ❖ **Policy on Communicable Disease Management**
- ❖ **Expulsion Policy**
- ❖ **Policy on the Use of Technology, Social Media and Methods of Parental Notification**
- ❖ **Health Screening Policy**

***I have read and received a copy of the information/policies listed above.***

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***Child(ren)'s Name:***

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***Parent/Guardian's Name***

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***Signature***

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***Date***



## St. Alban's Pre-School

1 Church Lane  
Oakland, New Jersey 07436  
(201) 337-5928  
Teresa M. Ercan, *Director*

### School Calendar 2022 - 2023

<b>2022</b>	Sept. 6	Tuesday	School Opens
	Sept 26	Monday	Rosh Hashanah
	Oct. 5	Wednesday	Yom Kippur-Closed
	Nov. 8	Tuesday	Election Day - Closed/Staff Development
	Nov. 10 & 11	Thursday & Friday	NJEA Convention - Closed
	Nov. 23	Wednesday	Minimum Day, 1 PM closing
	Nov. 24 & 25	Thursday & Friday	Thanksgiving Recess - Closed
	Dec. 23	Thursday	Minimum Day, 1 PM closing
	Dec. 26 - Jan. 2	Monday - Monday	Holiday Recess - Closed
<b>2023</b>	Jan. 3	Tuesday	School Reopens
	Jan. 16	Monday	Martin Luther King, Jr. Day - Closed
	Feb. 20-24	Monday-Friday	Winter Break - Closed
	April 7-14	Monday-Friday	Spring Recess / Good Friday-
	May 29	Monday	Memorial Day - Closed
	June 23	Friday	Anticipated Last Day of School Minimum Day, 1PM closing

*St. Alban's Pre-School reserves the right to  
change this calendar, if necessary.*

In the event of inclement weather we will follow the emergency school closing procedure of the Franklin Lakes/Oakland Schools. It is important that you do *not* call the police---the police will not and cannot give you information about school closing. On Delayed Opening days, school will begin at 10 AM.

To assist you the following methods will be available:

1. Tune in to Local Cable Channel 12
2. Facebook : St. Albans Pre-School

**ST. ALBAN'S PRE-SCHOOL  
SPECIALIST SCHEDULE**

**MONDAY**

*Cooking*

**TUESDAY\***

*Music & Creative Movement*

**WEDNESDAY**

*Read & Create*

**THURSDAY\***

*Physical Education*

**FRIDAY**

*Science / Social Studies*

*Specials are offered in the AM Sessions for the 2's, 3's, 4's & TK classes.*

**\*IN ORDER FOR YOUR CHILD TO SAFELY PARTICIPATE THEY MUST BE DRESSED  
IN COMFORTABLE CLOTHES AND SNEAKERS ON TUESDAY & THURSDAY.**

# ST. ALBANS PRESCHOOL ENTRY HEALTH SCREENING

Full Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Questions:

*Please circle your response as well as any symptoms*

- |  |    |     |
|--|----|-----|
| 1. Have you any household member been tested and /<br>or awaiting test results for COVID -19 in the past 14 days?  | No | Yes |
| 2. Have you or any household member had close contact with<br>anyone diagnosed with COVID-19 in the past 14 days?  | No | Yes |
| 3. Have you or any household member had a fever or been<br>administered any fever reducing medication in the past 24 hours?  | No | Yes |
| 4. Have you or anyone in your household had any cough, shortness of<br>breath, new loss of taste or smell, trouble breathing?  | No | Yes |
| 5. Have you or any household member had headache, fever, muscle aches<br>chills, shivers, sore throat, nausea/vomiting, diarrhea, fatigue,<br>congestion/runny nose? | No | Yes |

*Last updated March 7, 2022*

## Preschool Directory Information

We hope that you will find the school directory to be helpful when planning play dates or mailing party invitations.

We would like to remind you that this directory is issued to you as a personal service. This directory is not for commercial use and is not to be released to any other individual, organization or promotional enterprise.

Thank you for your cooperation.

Please fill out the information that you would like included in the directory and return it to the school immediately.

### **PLEASE PRINT**

Child's Name: \_\_\_\_\_

Parent(s) Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Please check the box if you do not want to be included in the St. Alban's Directory.