

# Erdman Preschool Summer Program 2019



I look forward to fun-filled days at Erdman's Summer Program where your child will explore, create and play with friends. Each session we meet on our shady playground for outdoor play, arts & crafts, stories, games and music. On the occasional rainy day we will be inside at Erdman Preschool. Snack and fresh water are provided.

## Tuesdays - Wednesdays - Thursdays

9:00 AM - 12:00 PM (AM Sessions)

1:00 PM - 4:00 PM (PM Sessions)

Session 1*: June 18-20 (AM) Summertime Fun	Session 4*: June 25-27 (PM) Stars & Stripes	Session 7: July 23-25 (AM) Puppet Pals
Session 2*: June 18-20 (PM) Summertime Fun	Session 5: July 9-11 (AM) By the Sea	Session 8: July 30-Aug 1 (AM) Nature Fun
Session 3*: June 25-27 (AM) Stars & Stripes	Session 6: July 16-18 (AM) Trick or Treat Time	Session 9: August 6-8 (AM) Pirate Week

*\*The June 19-21 and June 26-28 sessions are reserved for children currently attending Erdman Preschool.*

**Each session is \$90 for the first child, the second child in the family attending the same week is \$80.**

The fee is due with your application to confirm your spot.

For Erdman Families tuition payments must be current to register for our summer program.

Checks should be made payable to Erdman Preschool. No cash will be accepted.

Credit will not be given for missed days.

Registration is based on a first come, first serve basis and will be accepted starting 4/1/19.

There is a 10 child minimum per week.

If you must cancel and the spot gets filled, you'll receive full reimbursement. If it does not fill, no credit will be given.

Applications and forms are available at the Erdman Preschool office and online @

<http://www.erdmanpreschool.com/Summer.html> and as of 4/1/19.

### SUMMER Program CHECKLIST:

#### For All Children (due prior to start of the session)

- Application
- Full payment due with registration form; check payable to Erdman Preschool
- Physician's Form listing immunization and lead testing (dated within one year of session date)

#### For Children New to Erdman (due prior to start of the session)

Application, first payment, updated physician's form (see above)

- MA DEEC Authorization and Consent
- Developmental History and Background Information
- First Aid and Emergency Medical Care Consent Form
- Transportation Plan and Authorization

**Location: Erdman Preschool**  
330 First Parish Road (Rear)  
Scituate, MA 02066

**Contact: Patricia Litz**  
Through 6/11/17: 781-545-9309  
[erdmanpreschool@verizon.net](mailto:erdmanpreschool@verizon.net)  
6/11/17 - 8/9/17 : 339-933-8791 home  
[supergrammie3@comcast.net](mailto:supergrammie3@comcast.net)

# Erdman Preschool Summer Program 2019 Application



Child's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Birth date: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Mother's Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Previous school/summer program experience:  
 \_\_\_\_\_  
 \_\_\_\_\_

Schedule: Tuesdays, Wednesdays & Thursdays  
 AM Sessions 9 - 12  
 PM Sessions 1 - 4 (Session 2 & 4 only)  
 Cost: \$90/week due with application  
 \$80/week for 2nd child in family same session  
 Checks payable to **Erdman Preschool**

Check Session(s) Choice

Session 1	June 18-20 AM	Summertime Fun
Session 2	June 18-20 PM	Summertime Fun
Session 3	June 25 - 27 AM	Stars & Stripes
Session 4	June 25 - 27 PM	Stars & Stripes
Session 5	July 9 - 11 AM	By The Sea
Session 6	July 16 - 18 AM	Trick or Treat Time
Session 7	July 23 - 25 AM	Puppet Pals
Session 8	July 30 – Aug 1 AM	Nature Fun
Session 9	August 6 - 8 AM	Pirate Week

ERDMAN PRESCHOOL  
AUTHORIZATION AND CONSENT FORM  
MA DEEC ENROLLMENT

My child \_\_\_\_\_ has been accepted in Erdman Preschool's Summer Program which meets \_\_\_\_\_ 9:00 AM - 12:00 PM Tuesdays, Wednesdays and Thursdays or \_\_\_\_\_ 1:00 – 4:00 PM Tuesdays, Wednesdays and Thursday. The tuition will be \$90/week and is to be paid at the time of sign up. I have read the Summer Program information in the introductory letter.

**Child Information**

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_ Age at Admission: \_\_\_\_\_ Date of Admission: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Identifying Marks: \_\_\_\_\_

Sex: M or F Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Skin Color: \_\_\_\_\_

**Parent/Guardian Information**

1. Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

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

Reachable Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Business Name: \_\_\_\_\_ Business Address: \_\_\_\_\_

Business Phone Number: \_\_\_\_\_ Hours at Work: \_\_\_\_\_

2. Parent/Guardian Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

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

Reachable Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

Business Name: \_\_\_\_\_ Business Address: \_\_\_\_\_

Business Phone Number: \_\_\_\_\_ Hours at Work: \_\_\_\_\_

**Additional Information**

Child's Physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Allergies/Special Diets? \_\_\_\_\_

Individual Health Plan for child with a chronic health condition? Please circle Yes or No If Yes, please attach.

Copies of any custody agreements, court orders, and restraining orders pertaining to the child? If Yes, please attach.

Special limitations or concerns? Use back for more space: \_\_\_\_\_

The school has my permission to take \_\_\_\_\_ on walking trips in the school area, including the Scituate Public Library, in which the group participates during the school year. I understand that I will be notified in advance and must sign a permission slip for trips requiring transportation by car.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Please check desired box(es), sign and date:

The school has my permission to use my e-mail \_\_\_\_\_ on class lists to facilitate communication among parents.

The school has permission to submit pictures of my child involved in school activities to local newspapers.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

The school has permission to use pictures of my child involved in school activities for the website, brochure and social media. (Children will NOT be named or tagged.)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize Erdman Preschool to release my child to the following person (other than parents):

Name \_\_\_\_\_ Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Relationship to child \_\_\_\_\_ Relationship to child \_\_\_\_\_

Telephone # \_\_\_\_\_ Telephone # \_\_\_\_\_

I understand the policy of the school is to release only to the above person/s unless notified in writing.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**ERDMAN PRESCHOOL**  
**DEVELOPMENTAL HISTORY AND BACKGROUND INFORMATION**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Date of admission \_\_\_\_\_ Age at admission \_\_\_\_\_

Personal History

Any speech difficulties? \_\_\_\_\_  
Special words used to describe needs: \_\_\_\_\_  
Language spoken at home: \_\_\_\_\_  
Others in family/household and relationship: \_\_\_\_\_  
Age began sitting: \_\_\_\_\_ crawling: \_\_\_\_\_ walking: \_\_\_\_\_ talking: \_\_\_\_\_

Health

Any complications at birth, serious illnesses or hospitalizations \_\_\_\_\_  
Special physical conditions, chronic health conditions/disabilities, special needs or **allergies** \_\_\_\_\_  
Regular medications/possible side effects \_\_\_\_\_

Eating Habits

Describe favorite foods, foods refused and any special characteristics/difficulties: \_\_\_\_\_  
Please indicate your child's eating habits: \_\_\_\_\_

Toilet Habits

How does child indicate bathroom needs (include special words): \_\_\_\_\_  
Is child ever reluctant to use bathroom? \_\_\_\_\_  
Does child have accidents? \_\_\_\_\_

Sleeping Habits

When does child get up in the morning: \_\_\_\_\_ and go to bed at night \_\_\_\_\_  
Does child become tired or nap during the day? \_\_\_\_\_  
Any special characteristics? \_\_\_\_\_

Social Relationships

How would you describe your child? \_\_\_\_\_  
Reaction to strangers: \_\_\_\_\_ Able to play alone: \_\_\_\_\_  
Favorite toys and activities: \_\_\_\_\_  
Fears (the dark, animals, etc.): \_\_\_\_\_  
How do you comfort your child? \_\_\_\_\_  
What type of behavior management/discipline do you use at home? \_\_\_\_\_  
Please describe your child's schedule on a typical day: \_\_\_\_\_

During the 2018 summer will your child be attending another school program or day care? If yes, please list program(s) and days: \_\_\_\_\_  
What would you like your child to gain from this experience?

Is there anything else you would like us to know about your child, your family, your culture and/or beliefs that will help us plan your child's school experience? You may use the back of this form if necessary. Thank you.

The Department of Early Education and Care  
requires that this information be on file to address  
the needs of your child while in our care.

Parent/Guardian Signature \_\_\_\_\_  
Date \_\_\_\_\_

The Commonwealth of Massachusetts  
Department of Early Education and Care

FIRST AID AND EMERGENCY MEDICAL CARE CONSENT FORM

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I authorize staff in the child care program who are trained in the basics of first aid/CPR to give my child first aid/CPR when appropriate.

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize the program to call my pediatrician, the school's consulting pediatrician, Dr. Margaret Carolan at Cohasset Pediatrics and/or the Scituate Fire Department to transport my child to the nearest medical facility and/or to \_\_\_\_\_ and to secure necessary medical treatment for my child.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Today's Date (valid for one year)

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

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

Phone Number: \_\_\_\_\_

Child's Allergies: \_\_\_\_\_

Chronic Health Conditions: \_\_\_\_\_

**EMERGENCY CONTACTS (in order to be contacted)**

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

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

Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Do you give permission for child to be released to this person?

Please circle: Yes No

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

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

Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Do you give permission for child to be released to this person?

Please circle: Yes No

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

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

Relationship to child: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Do you give permission for child to be released to this person?

Please circle: Yes No

Health Insurance Coverage	_____	Policy #	_____
Parent/Guardian name	_____	Phone	_____
Parent/Guardian name	_____	Cell	_____
Parent/Guardian name	_____	Phone	_____
Parent/Guardian name	_____	Cell	_____

ERDMAN PRESCHOOL

PHYSICIAN'S EXAMINATION

Complete this form or provide a CURRENT (not older than one year from date of issue) physician's form which lists immunizations. The State requires that health forms be on file when your child starts school or summer camp.

**CHILD'S NAME** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

**NAME OF PHYSICIAN** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

**PHONE** \_\_\_\_\_

**DATE OF EXAM** \_\_\_\_\_

**PHYSICAL EXAM**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Nutrition \_\_\_\_\_

Posture \_\_\_\_\_

Skin \_\_\_\_\_

Pilonidal Sinus? \_\_\_\_\_

Eyes \_\_\_\_\_

Ears \_\_\_\_\_

Nose \_\_\_\_\_

Mouth \_\_\_\_\_

Teeth \_\_\_\_\_

Pharynx \_\_\_\_\_

Thyroid \_\_\_\_\_

Lymph Glands \_\_\_\_\_

Lungs \_\_\_\_\_

Heart \_\_\_\_\_

Blood Pressure \_\_\_\_\_

Pulse \_\_\_\_\_

Abdomen \_\_\_\_\_

Hernia \_\_\_\_\_

Genitals \_\_\_\_\_

Skeleton \_\_\_\_\_

Feet \_\_\_\_\_

Reflexes \_\_\_\_\_

**Childhood Diseases and Operations:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IMMUNIZATIONS	DATES
D.P.T. _____	_____
O.P.V. _____	_____
M.M.R. _____	_____
T.B. _____	_____
H.I.B. _____	_____
Hep B. _____	_____
Blood Lead (mandatory) _____	_____

LABORATORY TESTS		
TEST	DATE	RESULT
Tuberculin	_____	_____
Chest X-Ray	_____	_____
Hemoglobin	_____	_____

URINALYSIS	DATE
Specific Gravity _____	_____
Albumin _____	_____
Sugar _____	_____
Microscopic _____	_____

**ALLERGIES:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**REMARKS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SIGNATURE OF PHYSICIAN:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

THE COMMONWEALTH OF MASSACHUSETTS  
Department of Early Education and Care

TRANSPORTATION PLAN AND AUTHORIZATION

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

My child will arrive at the program:

- \_\_\_\_\_ Supervised walk
- \_\_\_\_\_ Unsupervised walk
- \_\_\_\_\_ Public/private/van
- \_\_\_\_\_ Program bus/van
- \_\_\_\_\_ Contract/van
- \_\_\_\_\_ Private trans. Arranged by parent
- \_\_\_\_\_ Other

My child will depart from the program:

- \_\_\_\_\_ Supervised walk
- \_\_\_\_\_ Unsupervised walk
- \_\_\_\_\_ Public/private/van
- \_\_\_\_\_ Program bus/van
- \_\_\_\_\_ Contract/van
- \_\_\_\_\_ Private trans. Arranged by parent
- \_\_\_\_\_ Other

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I give permission for my child to be released from the program at the end of the program day as stated above and/or give permission to the following people to receive my child at the end of the day. (If no one is authorized other than the parent/legal guardian please indicate below "No One".)

**\*If a child is protected by a restraining order please submit order to the provider.**

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

Relationship: \_\_\_\_\_

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

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

Cell: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

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

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

Cell: \_\_\_\_\_

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

Relationship: \_\_\_\_\_

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

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

Cell: \_\_\_\_\_