Springfield Township Elementary School
2146 Jacksonville Jobstown Road
Jobstown, NJ 08041
Telephone (609) 723-2479
Facsimile (609) 723-8213
www.springfieldschool.org

CRAIG VAUGHN
Superintendent / Principal

KIMBERLY HANNIGAN
Supervisor of Curriculum

Preschool Program
2020-2021 School Year

This integrated program is comprised of children with special needs as well as typically developing preschool children. A general preschool curriculum is followed for all students. The annual cost, without transportation, has not yet been set and approved by the Board of Education; however, this fee is historically lower than area private preschool programs and is comparable with the tuition rates charged by surrounding districts.

All preschool sessions are two and one-half hour classes, Monday through Friday. The 3 year-old program runs in the morning from 9:00 a.m. through 11:30 a.m. The 4 year-old program runs in the afternoon from 12:30 p.m. through 3:00p.m. Early dismissal days for the 3 year-old program runs from 9:00 a.m. through 10:30 am and for the 4 year-old program from 11:30 a.m. through 1:00 p.m.

Regular education students must submit an application to be eligible for the program. Eligibility is on a first come, first served basis. To start the program in September applicants must be 3 years of age on or before September 30, 2020, and **fully toilet-trained** as of the start of school.

Applications will be available in our main office and on our website at www.springfieldschool.org.

To obtain more detailed information about this exciting program, please call the main office at 609-723-2479 ext.100 or visit our website at www.springfieldschool.org.

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Preschool Program Requirements

Please submit the following with your application:

1. Child's Birth Certificate
2. Completed Preschool Program Application
3. NJ State Demographic and Emergency Information
4. Completed Student Health Questionnaire
5. Universal Child Health Record which should be completed by your child's physician.
6. Records of Immunizations for the following:
    a. 4 doses DTP or DtaP (if a DT is given, a MD note is needed)
    b. 3 doses of Polio
    c. 1 MMR given on or after the first birthday
    d. 1 HIB given after the first birthday
    e. 1 Varicella (chicken pox vaccine) given after the first birthday
    f. Pneumococcal conjugate vaccine (PCV) (at least one dose given on or after the first birthday)
    g. Influenza Vaccine **

For all children 6 months through 59 months of age, at least one dose of influenza vaccine between September 1st and December 31st* ***<u>of each year</u> *is required to prevent exclusion from school in January.*

If you have any questions please call the main office at 609-723-2479 ext.100.

Sincerely,

JoAnn Ricciani, RN, BSN, NJ-CSN

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Preschool Program Application
2020-2021 School Year

Child's Name ______________________________________ Boy ____ Girl ____ DOB ____/____/____
(Students must be 3/4 years old by September 30, 2020)

Street Address ____

City ____ Zip ______________________

Parent/Guardian's Name ____

Parent/Guardian's Name ____

Home Phone ________________________________ Cell Phone _____________________________

Email Address ____

Class signing up for: 3 Year Old Program ________ 4/5 Year Old Program ________

Each program will be held 5 days/week for 2.5 hours. The annual cost, without transportation, has not yet been set and approved by the Board of Education. There is a ***non-refundable*** deposit of $45.00, required to be made payable to Springfield Township School District, to secure enrollment. Enrollment will be based on a first come, first served basis. In the event that there is an oversubscription of this program you will be notified and your name will be placed on a waiting list. At that time your deposit will be returned. The first monthly tuition installment must be received prior to August 1, 2020. If you do not submit the first tuition installment by August 1, 2020, you will lose your spot and we will take the next person on the waiting list.

Before your child can begin the program, you must provide a copy of his/her current physical examination and immunization records and the completed registration.

Parent Signature ___________________________________ Date ___________________________________

Please return this application and $45.00 non-refundable deposit, made payable to Springfield Township School District, ASAP to:
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Springfield Township School District
NJ State Demographic and Emergency Information

Student's Name: ____
Last Name First Name Middle Name

Date of Birth: ____________________ Gender ________ Male ________ Female

City of Birth: ____ State of Birth: ________ Country of Birth: _______________

Ethnicity : ( ) White ( ) American Indian/Alaskan ( ) Multi ______________________
( ) Black ( ) Hawaiian Native/Pacific Islander
( ) Hispanic ( ) Asian

Primary Language: __________________________ Language Spoken at Home: ______________________

Address Where Child Resides: ____
____

Child Lives with: ( ) Both Parents ( ) Mother ( ) Father
( ) Step-Father ( ) Step-Mother ( ) Other ________________________

Mother's Name: ____

Address: ____

Home Phone: _____________________________ Cell. Phone: ___________________________ Work Phone: __________________

Email Address: ____ Mother's Date of Birth: ___________________________

Father's Name: ____

Address: ____

Home Phone: ____________________________ Cell. Phone:_________________________ Work Phone: ______________________

Email Address: ____ Father's Date of Birth: ___________________________

Please list two neighbors or nearby relatives who are at home during the day and would be willing to pick up your child at school and/or assume temporary care of your child if you cannot be reached during an emergency. *PLEASE LIST TWO.*

Name: ____ Name: ____

Address: ____ Address: ______________________________________

Relationship: ____ Relationship: __________________________________

Phone: ____ Phone: ____

Signature of Parent/Guardian: ____ Date: __________________

Springfield Township Elementary School Student Health Questionnaire

School Year: _______________

Name: ____ Date: ___________________________

This questionnaire will help the doctor and school nurse to find out if your child is in the best of health for school. The questionnaire will become part of your child's personal health record and is confidential. Take the questionnaire to your family doctor when he examines your child, as your answers will help him too.
Please write down any special questions you have regarding your child's health. The doctor or school nurse will help you with any questions you might have with parts of this questionnaire.

Please circle the correct answer. Explain if answer is YES.

1.	Has your child had Headaches or Dizzy Spells?	**No**	**Yes**
2.	Convulsions or other seizures?	**No**	**Yes**
3.	Trouble with eyes or with seeing?	**No**	**Yes**
4.	Trouble with ears or with hearing?	**No**	**Yes**
5.	Nose bleeds, constant colds, sore throats, or sinus?	**No**	**Yes**
6.	Frequent swollen glands?	**No**	**Yes**
7.	Asthma, wheezing, cough, bronchitis, pneumonia? If YES – medication for the above	**No**	**Yes**
8.	Heart trouble?	**No**	**Yes**
9.	Frequent upset stomach or bowel trouble?	**No**	**Yes**
10.	Trouble with urination or making water?	**No**	**Yes**
11.	Kidney or bladder infection?	**No**	**Yes**
12.	Any exposure to Tuberculosis?	**No**	**Yes**
13.	Any previous illness at any age?	**No**	**Yes**
14.	Special doctoring at any age?	**No**	**Yes**
15.	Diabetes?	**No**	**Yes**
16.	Mumps, Measles, Chicken Pox, Whooping Cough or German Measles? (**Circle**)	**No**	**Yes**
17.	Any stays in a hospital? (If YES, explain) Why: ____ When:	**No**	**Yes**
18.	Any operations? Date: What Kind:	**No**	**Yes**
19.	Any bad accidents or broken bones?	**No**	**Yes**
20.	Hay Fever, Hives or Eczema?	**No**	**Yes**
21.	Allergies? ____ Medication for above:	**No**	**Yes**
22.	Tires easily, loss of vigor, or trouble fighting-off infections?	**No**	**Yes**
23.	Any trouble sleeping or nightmares?	**No**	**Yes**
24.	Bed wetting or day wetting?	**No**	**Yes**
25.	Thumb sucking, nail biting, stammering, stuttering?	**No**	**Yes**
26.	Other speech problems?	**No**	**Yes**
27.	Nervous habits, high-strung, easily upset, temper tantrums?	**No**	**Yes**
28.	Shy, glum, sulky or feelings easily hurt?	**No**	**Yes**
29.	Wanting too much attention – disobedient?	**No**	**Yes**

Springfield Township Elementary School Student Health Questionnaire

School Year: _______________

Name: _______________________________________ Date: __________________________

Please answer these questions about the history of pregnancy, birth and early life:

1.	Was there a sickness or complication during pregnancy? **(Optional)**	**No**	**Yes**
2.	Did you have any infections or viruses during pregnancy? **(Optional)**	**No**	**Yes**
3.	Did you have high blood pressure or extra water retention during pregnancy**? (Optional)**	**No**	**Yes**
4.	Did you take medication during pregnancy? **(Optional)**	**No**	**Yes**
5.	Was there trouble with the labor and/or delivery? **(Optional)**	**No**	**Yes**
6.	Was the baby abnormal at birth or was there a birth defect?	**No**	**Yes**
7.	Did the baby do well for the first few months?	**No**	**Yes**
8.	Was there any problem with colic, crying, vomiting, sleeping, or settling the baby?	**No**	**Yes**
9.	At what hospital was the baby born? Birth weight: Address:	**No**	**Yes**
10.	Who is your child's family physician? Address:	**No**	**Yes**
11.	How many times has your child seen a doctor in the last year?	**No**	**Yes**
12.	When was your child's last check-up?	**No**	**Yes**