



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

Preschool Program 2023-2024 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, 2023, 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 **of each year** 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 2023-2024 School Year

Child's Name _____ Boy ____ Girl ____ DOB ____/____/____
(Students must be 3/4 years old by September 30, 2023)

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 31, 2023. If you do not submit the first tuition installment by August 31, 2023, 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:
Springfield Township School District
2146 Jacksonville Jobstown Road
Jobstown, NJ 08041

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