

St. Gregory the Great Early Childhood Enrichment Program

Registration Packet

September 2021 – June 2022

To begin your child's enrollment the following is needed to be filled in and completed:

- A \$225.00 Non-Refundable registration fee.
- A copy of your child's Birth Certificate or Passport
- A copy of your child's Baptismal Certificate (if applicable)
- St. Gregory the Great Registration and Tuition Form (attached)
- Proof of Immunization from your child's physician **AND**
- A copy of your child's most recent physical exam
- The New York State Office of Children and Family Services Day Care Registration Form
- Emergency Form, Pick Up Form, & Child Development History
- Napping Agreement & Handbook Photo Permission
- Smart Tuition Enrollment Form
- NYSOCFS Health Screening One Time Attestation Form

Visit Our Website at [**stgregoryearlychildhood.com**](http://stgregoryearlychildhood.com) to see all the fun and exciting events and activities going on at our school! Read the monthly newsletters and hear from the teachers and director about what is going on in the classrooms!

If you have any questions please do not hesitate to contact us at:

Phone: 914-835-1278 / 914-835-1912

Fax Number: 914-835-2070

E-mail Address: stgregoryecep@gmail.com

Thank you for your interest in our program.

Maria Gaudelli, Director

Linda Rinaldi, Administrative Assistant

St. Gregory the Great Early Childhood Enrichment Program is licensed by New York State Office of Children and Family Services (OCFS) and follows the OCFS Regulations for Child Day Cares. The OCFS website give you news and links to update state information, forms and more. You can access the website at <https://ocfs.ny.gov>, then proceed to FIND CHILD CARE then hit the link SEARCH FOR REGULATED CHILD CARE. Only input under school district HARRISON 10528. Scroll down and you will find the school. Child Care Complaint line is 1-800-732-5207

Saint Gregory the Great Early Childhood Enrichment Program
REGISTRATION FORM September 2021- June 2022

Child's Name: _____ Birth Date: _____ Male _____ Female _____

Nick Name _____ E-mail address for school notices _____

PLEASE CHECK ONE: NEW STUDENT _____ ALUMNI FAMILY _____ RE-REGISTERING STUDENT _____

Student's Ethnicity: (please circle-information used for school census):

American Indian Asian Black Hispanic Pacific Islander White Multiracial Other _____

Mother's Name: _____ Home Address _____

Cell Phone Number: _____ Home Phone Number: _____

Mother's Occupation _____ Work Number _____

Church Affiliation _____ School District if other than Harrison _____

Father's Name: _____ Home Address(if different): _____

Cell Phone Number: _____ Home Phone Number: _____

Father's Occupation: _____ Work Number: _____

CHECK APPROPRIATE PROGRAM: ***Please be advised that once you select a specific program option, adjustments cannot be made unless we have an available opening. Students will be randomly placed at the "sole discretion" of the Pre-School Director.*

3 year old options:

				<u>Tuition</u>
-3 half-days a.m.-	T,W,Th	8:45 a.m. to 11:30 a.m.	_____	\$5,113.00
-5 half-days a.m.-	M-F	8:45 a.m. to 11 :30 a.m.	_____	\$7,103.00
-5 half days	M-F	8:45 a.m. to 11:30 a.m.	_____	
+ 3 afternoons	T, W, TH	11:30 a.m. to 2:30 p.m.	_____	\$9,040.00

4 year old options:

-5 half days a.m.	M-F	8:45 a.m. to 11:30 a.m.	_____	\$7,103.00
-5 half-days a.m.	M-F	8:45 a.m. to 11:30 a.m.	_____	
+ 3 afternoons	T,W,TH	11:30 a.m. to 2:30 p.m.	_____	\$9,040.00
-Full day program	M-F	8:45 a.m. to 2:30 p.m.	_____	\$9,794.00

TUITION AGREEMENT A \$225.00 NON-REFUNDABLE application fee MUST accompany ALL applications.
This is a contract, please read carefully before signing.

Between _____ Social Security Number _____
(Name) (please print clearly)

(Address) (City) (State) (Zip Code)

And Saint Gregory the Great Early Childhood Enrichment Program, 94 Broadway, Harrison, New York 10528.

PLEASE CHECK ONE PAYMENT PLAN:

- _____ 1. Annually – Payment due in full August 1st
_____ 2. Semi Annual Payments – payments due August 1st and January 2nd
_____ 3. 10 Equal Payments – payments due August 1st through May 1st.

Saint Gregory the Great is a non- profit organization, therefore, our annual budget is based primarily on tuition income. We are partnered with the Smart Tuition Company to handle tuition collection. There is a yearly family fee of \$45 for this service paid directly to Smart Tuition at the time of your first payment. All payments are due on the 1st of the month of your payment plan. However, if your payment has not been received to Smart Tuition by the 5th of the month it will be considered late and Smart Tuition will automatically charge you a \$40 late fee. Because all of our income is dependent on tuition payments, you must pay on time. Tuition fees are all inclusive. No deductions can be made for absences caused by illness or withdrawal for a portion of the year. All fees are **NON-REFUNDABLE**. I agree to pay my child's tuition as stated above. I understand that tuition payments are due by the above dates. I understand that paying on time is my obligation. I understand the obligation that I have to Saint Gregory the Great and I intend to fulfill this obligation. It is agreed that the Parent/Guardian is responsible for the full tuition.

Parent or Guardian Signature: _____ **Date:** _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
**CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS
HEALTH SCREENING ONE-TIME ATTESTATION**

Before entering a child care program, employees, volunteers, parents, children and essential **visitors must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.** Employees, volunteers, parent, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers “Yes” to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self- Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are “Yes” individuals **cannot** enter the program. If the answers are “No” to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer “No” to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing ANY of the following symptoms?
 - Cough (new or worsening)
 - Shortness of breath (new or worsening)
 - Trouble breathing (new or worsening)
 - Fever
 - Chills
 - Muscle pain (new or worsening)
 - Headache (new or worsening)
 - Sore throat (new or worsening)
 - New loss of taste
 - New loss of smell
4. Have you tested positive for COVID -19 through a diagnostic test in the past 14 days?

If you have answered “NO” to all questions, you have passed and may enter the program.

If you have answered “YES” to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

Type your full name

____/____/____
Date

Type your full name

____/____/____
Date

Note: This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.

EMERGENCY AND PICK UP FORM (please print clearly)

Child's Name: _____ Birth Date: _____

Home Address: _____

Home Phone #: _____ E-mail _____

Mother's Name: _____ Father's Name: _____

Mom's Cell Phone: _____ Father's Cell Phone: _____

Mom's Work : _____ Father's Work : _____

EMERGENCY CONTACT'S: In case of emergency and parent cannot be reached, contact:

Name: _____ Phone : _____ Cell _____ Relation _____

Name: _____ Phone : _____ Cell _____ Relation _____

Name: _____ Phone: _____ Cell _____ Relation _____

Name: _____ Phone : _____ Cell _____ Relation _____

Doctor : _____
Name Address Phone

Dentist : _____
Name Address Phone

Note any medical conditions and explain:

In case of accident or illness, I request that the Early Childhood Program Director contact me. If I am unable to be reached, I hereby authorize this representative to call the physician indicated and to follow physician's instructions. If it is impossible to contact this physician, the representative of the program may make whatever arrangements necessary. I agree to assume financial responsibility for any diagnosis, treatment and/or medication deemed necessary. To the best of my knowledge all the information given is accurate and complete. I hereby consent to and authorize the necessary procedures that have been stated above.

CHILD PICK UP LIST: No child will be allowed to leave with anyone not on this list.

Written permission must be sent to school if there are any other pick up arrangements required.

Name: _____ Phone : _____ Cell _____ Relation _____

Name: _____ Phone : _____ Cell _____ Relation _____

Name: _____ Phone: _____ Cell _____ Relation _____

Name: _____ Phone : _____ Cell _____ Relation _____

Parent/Guardian Signature: _____ Date _____

Saint Gregory the Great Early Childhood Enrichment Program

Child's Name: _____ Date_____

.....

Dear Parents,

During the school year we will be taking pictures of the children as they work and play. These pictures will be used for in class projects and displays, i.e. bulletin boards, art projects and memory books. Please complete this form giving permission for the taking and use of these photos. The PTA would like to distribute a school directory and teachers would like to distribute a class list that includes the children's names, addresses phone numbers and e-mail address. If you do not wish to have your child's name included please indicate below. I received the Parent Handbook and I am aware of the policies and information contained therein.

Photo/Class List/School Directory Release Form

Please check off both sections and return.

____Yes, my child may be photographed for in school use.

____Yes, include my child's information on the class list and school directory

____No, my child may not be photographed

____No, do not include my child on the class list and school directory

Parent/Guardian Signature: _____

ST. GREGORY THE GREAT EARLY CHILDHOOD ENRICHMENT PROGRAM

CHILD'S DEVELOPMENT HISTORY

Child's Full Name: _____ Birth Date _____

Name and ages of siblings _____ Age _____

_____ Age _____

_____ Age _____

EATING HABITS

Please describe your child's appetite _____

Does your child have allergies? _____ If yes, please describe _____

Please tell us your child's favorite foods _____

Does your child eat dinner

() alone

() with family

() with sibling

() with sitter

SLEEPING HABITS

What time does your child go to bed? _____ Wake up? _____

Does your child take a nap? _____ Regularly? _____ For how long? _____

Does your child have his/her own room? _____ Is bed time a regular routine? _____

Does your child () comply () resist at bed time?

SPEECH

Does your child speak clearly? _____ Is your child's vocabulary large? _____

Are other languages spoken in the house? _____ If yes, please list _____

DISCIPLINE

Describe your child's response to discipline_____

If your child does not comply after repeated requests, what consequences result from the Non compliance?_____

Do all members of the family agree on methods of discipline?_____

Are there different discipline standard with

() Mother () Father () Grandparents () Sitter () Other_____

Does your child have tantrums? _____I f yes, please describe what occurs_____

What is something your child does not like to do?_____

SOCIAL

Has your child ever been separated from you during the day on a regular basis?_____

What are your child's favorite play item?_____

Can you please tell us your marital status: () married () single () widow/er
() divorced () separated

Are there step-children in your child's life?_____

Does your child watch television?_____ How many hours daily?_____

Which shows?_____

Does your child have any habits? (nail biting, thumb sucking)_____

Describe what you do to comfort your child when he/she is distressed?_____

What are your child's favorite activities?_____

Please describe your child's personality?_____

If your child should unfortunately have difficulties at school, how would you prefer to be approached and informed?_____

Napping/Sleeping Arrangements

Napping and Resting Arrangements are made in writing between the parent and the program in the Pre School Registration Packet. Such arrangements shall include the area of the program where the child may rest or nap, how the child will be supervised, consistent with the requirements of section 418.8 of OCFS Regulations. The resting places are:

- Located in a safe area
- Located in a draft free area
- Will be where children are not stepped on
- Be in an area where egress is not blocked
- Allow a person to move freely and safely within the area to check on or meet the needs of children
- Be at least two feet apart from each other

Children who do not wish to nap are offered a quiet play area, or they may be seated to read a book or select a puzzle to complete, or sit at a table and draw.

Children who attend **extended day classes** are given a rest time daily. This is done immediately following their lunch period. Each family is asked to supply a rest mat for their child as well as individual clean mat coverings (fitted crib sheet or king size pillow case). These will be sent home weekly for laundering. Rest mats are stored separately so they do not come in contact with the sleeping surfaces of another child's rest equipment. Rest mats are cleaned daily. The rest mats are placed on the carpeting portion of the classroom. Students will be supervised by classroom personnel. Soft and soothing music is played during this period and blinds are drawn. The rest period lasts approximately 30 minutes. If a child is asleep at the end of the rest period, we will not disturb them.

During the course of a very busy morning a child in the **half day program** may need to rest or possibly take a short nap. The program has extra mats to accommodate that child. The classroom teachers will disinfect the mats after each use. The primary reason for this policy is to make sure children do not become irritable and it enables teachers to make the rest of the day manageable. Parents will be asked to sign off on this policy. Mats are available as needed and are stored and cleaned daily.

Further reminders:

- Mats located in approved day care space
- Mats located in safe areas of the program
- Mats located in draft-free areas
- Mats are where children will not be stepped on and placed Head to Toe
- Mats are in a location where safe egress is not blocked
- Mats are placed so that a staff member can move freely and safely with the napping area in order to check on or meet the needs of children.

By signing this document, I agree with the policies regarding the Napping/Sleeping Arrangements.

Type Parent Signature: _____ Date _____

Type Child's Name: _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
DAY CARE ENROLLMENT

PHOTO OF CHILD (Optional)	Child's Full Name:		Date of Birth:	Gender:	
	Preferred Name/Nickname:		/ /		
	Child's Home Address:				
	Name of Person Enrolling Child:		Relationship to Child:		
		<input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> Caretaker <input type="checkbox"/> Relative _____ <input type="checkbox"/> Other _____			
Phone Number(s) of Person Enrolling Child: () - <input type="checkbox"/> ok to text			Address of Person Enrolling Child (if different than child):		
Email Address:					
EMERGENCY INFO	EMERGENCY CONTACT NAMES / ADDRESSES		Authorized to Pick Up	PRIMARY PHONE NUMBER	OTHER PHONE NUMBER / EMAIL
	Primary Contact:		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ok to text	<input type="checkbox"/> ok to text
For Program Use Only Date of Enrollment: / /			For Program Use Only Date of Disenrollment: / /		

Child's Full Name:		Date of Birth:
		/ /
Check boxes below to indicate if your child has any special needs/services: <input type="checkbox"/> None <input type="checkbox"/> Early Intervention/Special Education <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Speech/Language <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Allergies (list) _____ <input type="checkbox"/> Other _____		
Please provide information here AND discuss with your child care provider:		
Child's Primary Care Physician's Name/ Group:		Phone Number:
		() -
Preferred Hospital:		Phone Number:
		() -
Child's Dental Care:		Phone Number:
		() -
Child health Insurance information is available by calling toll-free 1-800-698-4543 or the NYS Health Marketplace website: https://nystateofhealth.ny.gov/		
AGREEMENTS		
• I consent to emergency medical treatment for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I consent for my child to take part in neighborhood trips (i.e., library, park and playground) away from the program under proper supervision.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program may need additional permissions for situations such as transportation, medication, release of information, and field trips.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I provided information on my child's special needs to the program to assist in caring for my child.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I understand the program must give parents, at the time of enrollment of a child, a written policy statement as required by regulation.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
• I agree to review and update this information whenever a change occurs and at least once every year.....		<input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE – PARENT OR PERSON(S) LEGALLY RESPONSIBLE:		DATE:
		/ /



St. Gregory the Great Early Childhood Enrichment Program – #76587
94 Broadway Harrison New York 10528

PLEASE ENTER FAMILY INFORMATION

FIRST NAME OF PARENT/GUARDIAN/BILL PAYER

LAST NAME OF PARENT/GUARDIAN/BILL PAYER

FIRST NAME OF ADDITIONAL AUTHORIZED PARTY

LAST NAME OF ADDITIONAL AUTHORIZED PARTY

STREET ADDRESS OR P.O. BOX

APT #

CITY

STATE

ZIP CODE

HOME TELEPHONE NUMBER

MOBILE TELEPHONE NUMBER

EMAIL ADDRESS

(Smart emails reminders for your upcoming payments)

SELECT A PAYMENT METHOD

The school has chosen the following due dates:

☐ I agree to make payment by mail, we or telephone. I agree to the following due date

5th

☐ I authorize SMART to automatically debit my payments from the below provided account. I agree to the following automatic payment date:

5th

PLEASE DEBIT MY:

☐

CHECKING (PLEASE ATTACH A VOIDED CHECK) OR

☐

SAVINGS

9 DIGIT ROUTING NUMBER:

BANK ACCOUNT NUMBER

SELECT A PAYMENT

PLAN A 1 PAYMENT

AUGUST 1st

ENTER PLAN
LETTER HERE

PLAN B 2 EQUAL PAYMENTS

AUGUST 1st and JANUARY 2nd

PLAN C 10 EQUAL PAYMENTS PAYMENTS

AUGUST 1st - MAY 1st

ENTER STUDENT INFORMATION

FIRST NAME OF STUDENT

LAST NAME OF STUDENT

1

2

FOR SCHOOL OFFICE USE ONLY

STUDENT 1 TUITION

STUDENT 2 TUITION

FAMILY SUBTOTAL

SMART

ADMINISTRATIVE FEE

\$45

ANNUAL TOTAL DUE

DUE \$

PLEASE READ AND SIGN: I have read and agree to the terms and conditions of this document.

I agree that the school may re-enroll me in the Smart Tuition programs for each subsequent school year. I agree to pay the amount established by my school for the student(s) above by my specified due date. I realize that if I fail to have a payment posted or if there is an outstanding balance on my account by the specified due date, Smart Tuition may contact me via email and telephone and a late fee of \$40.00 will be assessed to my account. A \$30 fee will apply for any electronic transaction of dishonored check.

Primary Bill Payer

DATE

Saint Gregory the Great
Early Childhood Enrichment Program
94 Broadway
Harrison, New York 10528
914-835-1278

Tuberculin Skin Test / Waiver Form

Patient's Name: _____ Date: _____

I. Tuberculin Skin Test:

The above named patient has been assessed for his/her need for formal tuberculin skin testing according to the guidelines as published by the New York State Department of Health, Center for Disease Control, and the American Academy of Pediatrics.

PPD Test: Date Given ____/____/____ Date Read: ____/____/____

Result: Positive _____ Negative: _____

CXR: _____ Date: ____/____/____ Neg. ____ Pos. ____

I. Waiver:

According to the guidelines the patient does not require formal skin testing ☐

Physician Name (print): _____

Physician Signature: _____ Date: _____

St. Gregory the Great Early Childhood Enrichment Program
94 Broadway
Harrison, New York 10528
914-835-1278 fax 914-835-2070

DENTIST CERTIFICATE

Student Name: _____
(last) first) (M.I)

Address: _____
(street address)

(town) (state) (zip code)

PLEASE CHECK WORK THAT WAS COMPLETED:

Inspection: _____ Cleaning: _____

Repair: _____ No Treatment Needed: _____

This is to certify that all dental work has been completed on the following date:

Name of Dentist: _____

Address: _____

THIS SLIP IS TO BE RETURNED TO THE SCHOOL THE CHILD ATTENDS, ATTENTION OF
SCHOOL NURSE.