

FUNSHINE

NURSERY SCHOOL

LOCATED AT 208 ROCKEFELLER LANE RED HOOK, NY 12571
MAILING ADDRESS-P.O. BOX 323, RED HOOK NY 12571

ADMISSION APPLICATION

Hours of Operation – 7:00am-5:30pm

TODAYS DATE: _____

I/WE HEREBY APPLY FOR ADMISSION FOR _____ (CHILD'S NAME)

ANTICIPATED START DATE: _____ CHILD'S DATE OF BIRTH: _____

EMERGENCY CONTACT:

NAME & TELEPHONE NUMBER: _____

Toddlers (18 months)

Please indicate the time of drop off and pick up. You may also choose our 9am-12pm program option

1. M _____ to _____ Tu _____ to _____ W _____ to _____ Th _____ to _____ F _____ to _____

Or

2. 9:00am – 12:00pm _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Three Year Old AM Program (2.9 years)

Please indicate the time of drop off and pick up. You may also choose our 9am-12pm program option

1. M _____ to _____ Tu _____ to _____ W _____ to _____ Th _____ to _____ F _____ to _____

Or

2. 9:00am – 12:00pm _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

Four Year Old/Pre K Program (3.9 years) (3 day minimum required)

Please indicate the time of drop off and pick up. You may also choose our 9am-12pm program option

1. M _____ to _____ Tu _____ to _____ W _____ to _____ Th _____ to _____ F _____ to _____

Or

2. 9:00am – 12:00pm _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

PARENT'S NAME: _____

ADDRESS: _____

E-MAIL: _____

TELEPHONE HOME: _____ CELL #: _____

OCCUPATION: _____ WORK # _____

EMPLOYER & BUSINESS ADDRESS: _____

PARENT'S NAME: _____

ADDRESS: _____

E-MAIL: _____

TELEPHONE HOME: _____ CELL #: _____

OCCUPATION: _____ WORK # _____

EMPLOYER & BUSINESS ADDRESS: _____

IN THE CASE OF CHILD CUSTODY,
WHO HAS PRIMARY CUSTODY OF YOUR CHILD?: _____

ARE THERE ANY LEGAL MATTERS THAT WE NEED TO BE MADE AWARE OF? (I.E. ORDER OF PROTECTION, ETC.)



CHILD'S PLACE OF RESIDENCE:

HOW WOULD YOU DESCRIBE YOUR CHILD'S TEMPERAMENT/PERSONALITY? _____

DOES YOUR CHILD HAVE ANY FEARS OR WORRIES YOU WOULD LIKE US TO BE AWARE OF?

WHAT ARE YOUR CHILD'S BATHROOM HABITS? WHAT WORDS DOES YOUR CHILD USE FOR TOILETING?

WOULD YOU LIKE YOUR CHILD TO NAP? YES _____ NO _____ N/A _____

ALSO, DOES YOUR CHILD REQUIRE A DIAPER OR PULL UP DURING NAP TIME? YES _____ NO _____

DESCRIBE YOUR CHILD'S NAPPING HABITS? _____

*WE HAVE A NAPPING AGREEMENT REQUIRED BY THE STATE THAT YOU WILL NEED TO SIGN.

FOOD RESTRICTIONS: _____

ALLERGIES:

PLEASE LET US KNOW IF YOUR CHILD USES AN EPI PEN, INHALER OR HAS ANY SPECIAL MEDICAL NEEDS



MEMBERS OF THE FAMILY THAT RESIDE WITH YOUR CHILD (INCLUDE YOUR PETS):

| NAMES | AGES | SEX |
|-------|------|-----|
| _____ | | |
| _____ | | |
| _____ | | |

WHAT LANGUAGE(S) ARE SPOKEN IN YOUR HOME? _____

ARE THERE ANY SPECIAL FAMILY TRADITIONS OR CULTURAL CUSTOMS YOU WOULD LIKE US TO KNOW ABOUT?

PLEASE DESCRIBE YOUR CHILD'S PREVIOUS EXPERIENCE IN GROUP SETTINGS (CHILD CARE, PLAY GROUPS, ETC.)

SPECIAL INTERESTS (WHAT DOES YOUR CHILD ENJOY DOING?)

WHAT WOULD YOU LIKE YOUR CHILD TO GAIN BY ATTENDING NURSERY SCHOOL?

DO YOU HAVE ANY DEVELOPMENTAL CONCERNS ABOUT YOUR CHILD?

IF SO, HAS YOUR CHILD BEEN EVALUATED YET? YES _____ NO _____

STATE WHEN AND WHERE TESTING HAS OCCURRED. WHAT WERE THE FINDINGS OF THE EVALUATIONS (ATTACH COPIES OF THE EVALUATIONS)? IF SERVICES WERE RENDERED, STATE BY WHOM AND WHERE AND HOW OFTEN SERVICES OCCURRED.

PLEASE KNOW THAT ANY INFORMATION OBTAINED IS HELD IN STRICT CONFIDENCE.
THANK YOU.



WHAT SCHOOL DISTRICT WILL YOUR CHILD ATTEND WHEN HE/SHE STARTS KINDERGARTEN?

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?

A PHYSICIAN SIGNED PHYSICAL AND IMMUNIZATION RECORD DATED WITHIN 12 MONTHS MUST BE SUBMITTED BEFORE YOUR CHILD WILL BE ABLE TO ATTEND SCHOOL. SEE ATTACHED MEDICAL STATEMENT

*******WE REQUEST A \$150 NONREFUNDABLE DEPOSIT WHICH WILL BE APPLIED TO YOUR FIRST TUITION PAYMENT AND A \$50 NONREFUNDABLE REGISTRATION FEE WITH THIS APPLICATION.**

DATE RECEIVED: _____



PARENTAL CONSENT

I HEREBY GIVE PERMISSION FOR MY CHILD TO HAVE THEIR PHOTOGRAPH TAKEN FOR CLASS PICTURES, THE SCHOOL YEARBOOK, THE FUNSHINE WEBSITE, THE FUNSHINE FACEBOOK PAGE, INSTAGRAM OR FOR OTHER SCHOOL RELATED EVENTS OR PURPOSES.

YES _____ NO _____

I GIVE CONSENT FOR MY CHILD TO HAVE THEIR PHOTOGRAPH POSTED ON AN APP THAT WE USE FOR COMMUNICATION BETWEEN STAFF AND FAMILY.

YES _____ NO _____

ANY COMMENTS OR CONCERNS:

*WE HAVE FIELD TRIPS THROUGHOUT THE SCHOOL YEAR. YOU WILL BE NOTIFIED PRIOR TO EACH ONE. IF YOU WOULD LIKE YOUR CHILD TO PARTICPATE, YOU MUST SIGN A PERMISSION SLIP.

THE FOLLOWING PERSON(S) ARE ALLOWED TO PICK UP MY CHILD IF I AM UNABLE TO DO SO:

NAME/RELATIONSHIP TO FAMILY: _____

ADDRESS: _____

NAME/RELATIONSHIP TO FAMILY: _____

ADDRESS: _____

NAME/RELATIONSHIP TO FAMILY: _____

ADDRESS: _____

PARENT'S SIGNATURE

GUARDIAN'S SIGNATURE

PARENT'S SIGNATURE

GUARDIAN'S SIGNATURE

EMERGENCY RELEASE FORM

CHILD'S NAME: _____

PARENT: _____

ADDRESS: _____

TELEPHONE HOME: _____ BUSINESS: _____ CELL: _____

PARENT: _____

ADDRESS: _____

TELEPHONE HOME: _____ BUSINESS: _____ CELL: _____

PERSON TO CALL IN CASE OF EMERGENCY IF PARENTS ARE UNABLE TO BE CONTACTED

NAME/RELATIONSHIP: _____

ADDRESS: _____

TELEPHONE # HOME: _____ BUSINESS: _____ CELL: _____

CHILD'S PHYSICIAN

NAME: _____

ADDRESS: _____

TELEPHONE # _____

CHILD'S DENTIST

NAME: _____

ADDRESS: _____

TELEPHONE # _____

PREFERRED HOSPITAL IN CASE OF EMERGENCY

NAME _____

ADDRESS _____

TELEPHONE # _____

IF THE CHILD'S DOCTOR OR DENTIST IS NOT AVAILABLE, MAY WE CALL ANY LICENSED PHYSICIAN OR DENTIST?

_____ YES _____ NO



AUTHORIZATION FOR MEDICAL CARE

I AUTHORIZE ANY FUNSHINE STAFF WHO ARE CERTIFIED IN CPR/FIRST AID TO PERFORM NEEDED MEDICAL CARE UNTIL PROFESSIONAL MEDICAL CARE IS OBTAINED AND/OR PARENTS ARE NOTIFIED.

_____ YES _____ NO

I AUTHORIZE FUNSHINE NURSERY SCHOOL TO ARRANGE FOR POSSIBLE EMERGENCY MEDICAL CARE AT (1) THE CLOSEST HOSPITAL AVAILABLE IN DIRE EMERGENCY, OR (2) THE HOSPITAL DESIGNATED. IT IS UNDERSTOOD THAT A CONSCIENTIOUS EFFORT MUST BE MADE TO NOTIFY ME/US

_____ YES _____ NO

IF IT IS IMPOSSIBLE TO LOCATE ME/US AND ARRANGEMENTS ARE MADE FOR EMERGENCY MEDICAL CARE, I/WE WILL ACCEPT THE EXPENSES OF SUCH CARE.

PARENT'S SIGNATURE: _____

PARENT'S SIGNATURE: _____

GUARDIAN'S SIGNATURE: _____

INSURANCE CARRIER: _____

INSURANCE NUMBER: _____

RESPONSIBLE PARTY FOR INSURANCE: _____

