Birth date _____/_____/____

Date enrolled _____

Session assignment:_____

2026-2027
REGISTRATION FORM FOR
LITTLE CHERUBS CHRISTIAN PRESCHOOL

Please complete BOTH sides of form

Please circle class you wish your child enrolled in 3's 9:00-1:00 (Tu/Th) 4/5's 9:00-2:00 (M/W/F)

Child's Full Name _____ Address _____

Birth Date _____/_____/_____ Nickname _____ Sex (circle one) M F (Area Code) Phone _____

Cell Phone _____

Mother's Name _____ Address (if different from child's) _____ e-mail address _____

Mother's Place of Employment/Address _____ Position _____ (Area Code) Phone _____

Father's Name _____ Address (if different from child's) _____ (Area Code) Phone _____

Father's Place of Employment/Address _____ Position _____ (Area Code) Phone _____

Sibling Name/Birth Date _____ Sibling Name/Birth Date _____ Sibling Name/Birth Date _____

Child's Previous School/Daycare Experience _____

How did you hear about us? _____ What is the primary language spoken at home? _____

Church Affiliation _____

EMERGENCY INFORMATION

Name of Child's Physician _____ Address _____ Phone _____

Name of Child's Dentist _____ Address _____ Phone _____

Allergies / Restrictions / Regular Medications _____

Physical / Emotional Needs (Please attach additional pages if more room is needed to explain) _____

REGISTRATION FORM

EMERGENCY INFORMATION, CONTINUED

_____
Child's Name

List below, in order of priority, people to call when neither parent can be reached:

Name/Address	Phone	Relationship to Child
Name/Address	Phone	Relationship to Child
Name/Address	Phone	Relationship to Child
Name/Address	Phone	Relationship to Child

1. The above mentioned people have my permission to pick up my child any time I am unable to do so.
2. I hereby give permission for my child to receive emergency medical or dental treatment, if necessary. I also give permission for staff members of Little Cherubs Christian Preschool to transport my child by state inspected and registered automobile or arrange for transportation by ambulance. Permission is also given for Red Cross trained staff members to administer First Aid.
3. I will furnish certificates satisfactory to the school from a physician certifying as to the health of the child to be enrolled before my child will be admitted to school.
4. My child meets the age requirements and is toilet trained.
5. I understand that if my child is displaying illness he shall be excluded from school at the discretion of the Head Teacher or other staff member in the teacher's absence. I understand that I will be required to pick up my child or have an authorized person pick him up.
6. I agree to pay the annual tuition fee and registration fee. I also agree to the tuition terms as outlined on the "Tuition Fees" sheet.

_____
Parent's Signature Date

_____
Director's Signature Date

TUITION FEES FOR THE 2026 - 2027 SCHOOL YEAR
FOR
LITTLE CHERUBS CHRISTIAN PRESCHOOL

THREE YEAR OLDS: 2 DAYS (Tue, Thurs 9:00 a.m. - 1:00 p.m.) ……...$3,225.00

FOUR/FIVE YEAR OLDS: 3 DAYS (Mon, Wed, Fri 9:00 a.m. - 2:00 p.m.) …….$5,858.75

REGISTRATION FEE: $100.00 (this fee is non-refundable)
*Families with more than one child enrolled get 50% off each child's registration fee.

TUITION TERMS:

1. There is an annual tuition fee that can be paid at the time of registration or divided into ten monthly installments. Tuition installments are due on the first of the month, beginning **August 1** and continuing until **May 1**.
2. No credit is given for time absent due to illness, snow or any other reason. In the event of extended absence due to severe illness or extended hospitalization, please see the Director. Each situation will be given individual consideration and handled according to the discretion of the Director.
3. The **registration fee is to accompany the Registration form** when applying for admission to Little Cherubs Christian Preschool.
4. There will be an automatic late charge in the amount of $25.00 per month if a payment is seven or more days late. This charge is per payment until the bill is up to date. Two or more late payments will result in your being asked to withdraw from the program.
5. If more than one child is enrolled in the program, the tuition rate is reduced by 5% for the younger child.
6. Children are enrolled for the entire year or the balance of the year. Children enrolled after the beginning of the school year will pay a pro-rated tuition fee.
7. Six weeks' written notice is required before withdrawal. There is no withdrawal after March 1.
8. Little Cherubs Christian Preschool reserves the right to terminate this agreement upon thirty day written notice to the parents or the person with whom the child resides.

_____

Parent's Signature Date

_____

Director's Signature Date

EMERGENCY DENTAL PERMISSION FORM

I hereby give permission for my child to receive emergency dental treatment, if necessary. I also give permission for staff members of Little Cherubs Christian Preschool to transport my child by state inspected and registered automobile or arrange for transportation by ambulance. Permission is also given for Red Cross trained staff members to administer First Aid.

_____

Parent's signature Date

_____

Director's Signature Date

EMERGENCY MEDICAL PERMISSION FORM

I hereby give permission for my child to receive emergency medical treatment, if necessary. I also give permission for staff members of Little Cherubs Christian Preschool to transport my child by state inspected and registered automobile or arrange for transportation by ambulance. Permission is also given for Red Cross trained staff members to administer First Aid and CPR.

_____

Parent's signature Date

_____

Director's Signature Date

DISCIPLINE POLICY

Little Cherubs practices a positive behavioral modification approach to dealing with behavior issues. We will expect a child to behave according to the rules set forth by the teachers. The teachers are in agreement with setting clear limits for the children. We expect the children to treat each other with respect, obey the teacher when asked to do something or to stop doing something when asked, using words to solve confrontations instead of using physical violence, and treating the toys and equipment gently.

1. Positive Guidance:
   When disputes arise among children, or between a child and staff, the staff will encourage a "Talking Out" process where the goal is to review with the child why the behavior was unacceptable and help the child to acknowledge feelings and find solutions using the children's ideas wherever possible to find an acceptable answer to the conflict.
2. Redirection:
   If the incident happens again the teacher will redirect the child to another area of the classroom away from the child or situation that was the problem. If redirecting does not help, the child will be asked to sit in a time out chair (1 Minute per age). He/she will be losing their time of playing. Staff will continuously supervise the child during the disciplinary actions.
3. The child will be removed from the class if he/she is endangering the other children or himself with his/her behavior, is willfully destroying preschool property or has completely lost self-control. The Director will speak to the child away from the other children but close enough for other staff to hear conversation. The parent will be called and asked to pick the child up. The child will then be brought back into the classroom until the parent arrives to pick up the child. Once again, the child will be supervised by the staff giving him/her a quiet activity to do until the parent arrives. The staff will work closely with the parents to help the child learn appropriate self-control. At no time will a teacher be abusive, neglectful or use corporal, humiliating or frightening punishment under any circumstances. No child will be physically restrained unless it is necessary to protect the safety or health of the child or others, using least restrictive methods, as appropriate.
4. Teachers will use verbal positive reinforcement in all situations to encourage the growth in self-esteem.
5. If a child purposely hits/punches/injures a teacher out of anger, he/she will be sent home. This type of behavior is not tolerated at Little Cherubs.
6. If a child is consistently behaving in an inappropriate way and every attempt has been made to work with parents and child over a course of time, the child will be disenrolled from our school. The Director reserves the right to send any child home for harmful, aggressive, or disobedient behavior at any time or to disenroll any child for repeated poor behavior.

Parent's signature_____Date_____

Director's Signature_____Date_____

PESTICIDE ACKNOWLEDGMENT

I acknowledge the fact that CLC may periodically need to treat the church building and grounds with pesticides to extinguish any pest issues that may arise. I understand that all attempts will be made to have any required treatment done while school is not in session.

_____

Parent's signature Date

_____

Director's Signature Date

Permission To Use Pictures

I give Little Cherubs Christian Preschool, of Cheshire Lutheran Church permission to use my child's picture:

___ displayed in school/church

___ in local newspapers, (no last names will be used)

___ on our website/Facebook/Instagram (no names used)

___ public events (no names used)

Parent signature: _____

Child's name: _____

Date: _____

Director's signature: _____

State of Connecticut Department of Education

Health Assessment Record

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, physician assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity ❑ American Indian/ Alaskan Native ❑ Hispanic/Latino	❑ Black, not of Hispanic origin ❑ White, not of Hispanic origin ❑ Asian/Pacific Islander ❑ Other
Primary Care Provider		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N

If your child does not have health insurance, call 1-877-CT-HUSKY

*If applicable

Part 1 — To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle Y if "yes" or N if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)	Y	N
Any relative ever have a sudden unexplained death (less than 50 years old)				Y	N	Diabetes	Y	N
Any immediate family members have high cholesterol				Y	N	ADHD/ADD	Y	N

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take in school:

*All medications taken in school require a separate **Medication Authorization Form** signed by a health care provider and parent/guardian.*

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian _____ Date _____

To be maintained in the student's Cumulative School Health Record

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

❑ I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height ____ in. /____% *Weight ____ lbs. /____% BMI ____ /____% Pulse ____ *Blood Pressure ____/____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen					
Genitalia/ hernia					
Skin					

*Postural ❑ No spinal abnormality ❑ Spine abnormality: ❑ Mild ❑ Moderate ❑ Marked ❑ Referral made

Screenings * According to Bright Future's Periodicity Schedule

*Vision Screening

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Referral made

*Auditory Screening

Type:	Right	Left
	❑ Pass ❑ Fail	❑ Pass ❑ Fail

❑ Referral made

*History of Lead Level ≥3.5 µg/dL ❑ No ❑ Yes — Date

Results:

*Speech (school entry only)

*HCT/HGB:

TB: High-risk group? ❑ No ❑ Yes PPD date read: Results: Treatment:

*IMMUNIZATIONS

❑ Up to Date or ❑ Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

*Chronic Disease Assessment:

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
If yes, please provide a copy of the Asthma Action Plan to School

Anaphylaxis ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Unknown source

Allergies *If yes, please provide a copy of the Emergency Allergy Plan to School*
History of Anaphylaxis ❑ No ❑ Yes Epi Pen required ❑ No ❑ Yes

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II Other Chronic Disease:

Seizures ❑ No ❑ Yes, type:

❑ This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medications (*specify*): _____
This student may: ❑ **participate fully in the school program**
❑ participate in the school program with the following restriction/adaptation: _____

This student may: ❑ **participate fully in athletic activities and competitive sports**
❑ participate in athletic activities and competitive sports with the following restriction/adaptation: _____

❑ Yes ❑ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
Is this the student's medical home? ❑ Yes ❑ No ❑ I would like to discuss information in this report with the school nurse.

_____
Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑ Male ❑ Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	Visual Screening	Normal	Referral Made:
Completed by: ❑ Dentist	Completed by: ❑ MD/DO ❑ APRN ❑ PA ❑ Dental Hygienist	❑ Yes ❑ Abnormal (Describe) _____ _____ _____ _____ _____	❑ Yes ❑ No

Risk Assessment	Describe Risk Factors	
❑ Low ❑ Moderate ❑ High	❑ Dental or orthodontic appliance ❑ Saliva ❑ Gingival condition ❑ Visible plaque ❑ Tooth demineralization ❑ Other _____	❑ Carious lesions ❑ Restorations ❑ Pain ❑ Swelling ❑ Trauma ❑ Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian — Date

_____

Signature of health care provider — DMD / DDS / MD / DO / APRN / PA / RDH — Date Signed — Printed/Stamped *Provider* Name and Phone Number

Student Name: _____ Birth Date: _____ HAR-3 REV. 3/2024

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx of above _____ (Specify) _____ (Date) _____ (Confirmed by)

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://portal.ct.gov/-/media/SDE/Digest/2020-21/CSDE-Guidance---Immunizations.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached.
https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through11th grade
- August 1, 2024: Pre-K through 12th grade

** **Verification of disease**: Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

_____

Initial/Signature of health care provider – MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number