Holy Spirit Preparatory School would like to welcome you to enroll your child between the ages of 6 – 23 months in our Mother's Morning Out program at the Preschool. There will be two sessions in which you may enroll your child/ children:

1) The Monday, Wednesday, Friday class: 8:30-12:30 pm

Or

2) The Tuesday and Thursday class: 8:30-12:30 pm

We ask that you walk your child/ children to the Nursery at the assigned start time. The students will experience a morning of social interaction and play. Included in the day will be arts and crafts activities, story time, creative movement, music and playground time. Parents provide the snack for their own child. No peanut products or foods that may be a choking hazard should be sent to Mother's Morning Out.

Parents will provide all wipes, diapers, sippy cups and extra clothing as necessary for their child. All items belonging to children should be clearly labeled.

In order to register for Mother's Morning Out, please complete the attached form and submit payment of the deposit in the amount of $250.00

Regards,

Faith Rummelsburg
Preschool Director

2016-2017 Mother's Morning Out Calendar

	Monday / Wednesday/ Friday	**Tuesday / Thursday**
August	15, 17, 19, 22, 24, 26, 29, 31	16, 18, 23, 25, 30
September	2, 7, 9, 12, 14, 16, 19, 21, 23, 26, 28, 30	1, 6, 8, 13, 15, 20, 22, 27, 29
October	3, 5, 7, 12, 14, 17, 19, 21, 24, 26, 28, 31	4, 6, 11, 13, 18, 20, 25, 27
November	2, 4, 9, 11, 14, 16, 18, 28, 30	1, 3, 8, 10, 15, 17, 29
December	2, 5, 7, 9, 12, 14, 16	1, 6, 8, 13, 15
January	4, 6, 9, 11, 13, 18, 20, 23, 25, 27, 30	5, 10, 12, 17, 19, 24, 26, 31
February	1, 3, 6, 8, 10, 13, 15, 17, 20, 22, 24, 27	2, 7, 9, 14, 16, 21, 23, 28
March	1, 3, 13, 15, 17, 20, 22, 24, 27, 29, 31	2, 14, 16, 21, 23, 28, 30
April	3, 5, 7, 10, 19, 21, 24, 26, 28	4, 6, 11, 18, 20, 25, 27
May	1, 3, 5, 8, 10, 12, 15, 17, 19, 22, 24, 26	2, 4, 9, 11, 16, 18, 23, 25
	103	72

Please register my child for:

_____ Monday / Wednesday/ Friday at a cost of $4055 for the year

_____ Tuesday / Thursday at a cost of $2705 for the year

All checks should be made payable to Holy Spirit Preparatory School and attach to this form.

I am submitting a non-refundable deposit of $250.00 to reserve this space for my child. This deposit will be applied toward the total tuition payment. I will pay the full amount when I am billed for it in July; and it will be fully paid on or before August 1, 2016.
I understand that no refunds will be given in case of withdrawal.

_____ _____

Parent Signature Date

Please initial each statement:

By initiating the statements, I am agreeing to the terms listed below:

_____ *I understand that I must escort my child to the Nursery each morning.*

_____ *I understand that I must bring a diaper bag for my child. The diaper bag must include diapers, wipes, a change of clothes and a snack (drink or food).*

_____ *I understand that I cannot bring in any peanut products.*

_____ *I understand that I must pick up my child from the Nursery.*

Please complete and return pages along with the payment to:

Holy Spirit Preparatory School – Preschool Office
Attn: Faith Rummelsburg
4465 Northside Drive, N.W.
Atlanta, GA 30327

HOLY SPIRIT
PREPARATORY SCHOOL

2016-17 Mother's Morning Out

CONTACT INFORMATION			
CHILD'S NAME			
ADDRESS			
CITY	STATE	ZIP CODE	HOME PHONE
BIRTHDAY		AGE AS OF SEPTEMBER 1, 2015	
MOTHER'S NAME			
WORK PHONE		CELL PHONE	
EMAIL			
FATHER'S NAME			
WORK PHONE		CELL PHONE	
EMAIL			

MEDICAL INFORMATION	
PLEASE LIST ALLERGIES HERE	
NOTE: If you child requires an EpiPen, please be sure to keep it in his/her diaper bag.	
EMERGENCY CONTACT NAME	PHONE NUMBER
WHO WILL BE DROPPING OFF YOUR CHILD?	PHONE NUMBER
WHO WILL BE PICKING UP YOUR CHILD?	PHONE NUMBER

PLEASE REGISTER MY CHILD FOR		
	Monday/ Wednesday/ Friday	$4055
	Tuesday/ Thursday	$2705

Please make all checks payable to Holy Spirit Preparatory School and attach to this form.

I am submitting a non-refundable deposit of $250.00 to reserve this space for my child. This deposit will be applied toward the total tuition payment. I will pay the full amount when I am billed for it in July; and it will be fully paid on or before August 1, 2015. I understand that no refunds will be given in case of withdrawal.

PARENT SIGNATURE	DATE

PLEASE INITIAL EACH STATEMENT	
By initialing the statement, I am agreeing to each of the terms.	
	I understand that I must escort my child to the Nursery each morning.
	I understand that I must bring a diaper bag for my child. The diaper bag must include diapers, wipes, a change of clothes, and a snack (drink and food).
	I understand that I cannot bring in any peanut products.
	I understand that I must pick up my child from the Nursery.

Please complete and return along with the payment to:

Holy Spirit Preparatory School – Preschool Office

Attn: Faith Rummelsburg

4465 Northside Drive, NW

Atlanta, GA 30327

HOLY SPIRIT PREPARATORY SCHOOL

PRESCHOOL & LOWER SCHOOL STUDENT HEALTH RECORD 2016-2017

This record is to be completed by Parent/Guardian and signed by student's physician. The record must be returned to the school clinic no later than July 31, 2016. For students in any grade entering HSPS for the first time, a Georgia Certificate of Immunization, Form 3231, MUST be completed for school attendance. For returning students Pre-K and entering grades K, 3 & 6, and updated Form 3231 MUST be provided for school attendance. A sample Form 3231 is included with this form. An original must be obtained, stamped and signed by your physician. Please fill out this record completely. Mark N/A if not applicable.

Entering Grade _____ in August 2016 Status: (check one) _____New Student _____Returning Student

Student's Name _____ Date of Birth _____-_____-_____

PARENT OR GUARDIAN INFORMATION – RESIDING WITH STUDENT

Parent/Guardian Name(s) _____ Relationship _____

Student's Home Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____

Fax (_____) _____

Email Address _____@ _____

Mother's Business Phone (_____) _____ Father's Business Phone (_____) _____

Mother's Cellular Phone (_____) _____ Father's Cellular Phone (_____) _____

Additional Contact Numbers _____

PARENT OR GUARDIAN INFORMATION – NOT RESIDING WITH STUDENT

Parent/Guardian Name(s) _____ Relationship _____

Student's Home Address _____

City _____ State _____ Zip Code _____

Home Phone (_____) _____

Fax (_____) _____

Email Address _____@ _____

Business Phone (_____) _____ Cellular Phone (_____) _____

EMERGENCY CONTACTS – IF WE ARE UNABLE TO REACH PARENT/GUARDIAN

Name _____ Relationship _____

Home Phone _____Cellular/Other Phone (_____) _____

Name _____ Relationship _____

Home Phone _____Cellular/Other Phone (_____) _____

HEALTH PROVIDER & INSURANCE INFORMATION

Health Insurance Company _____ Policy / Group # _____

ALLERGIES

Does student have any allergies to? Check Yes or No. If yes is checked, please explain. **Yes** **No**

☐ ◇ Medications: _____

☐ ◇ Foods/Beverages: _____

☐ ◇ Insects: _____ ◇

◇ Insects/Other: _____ ◇

◇ Requires EpiPen (parent to provide: _____

MEDICAL HISTORY OF STUDENT

MUST be completed by Parent / Guardian

Student's Name _____ **Date of Birth** _____/_____/_____

Physician's Name _____ **Phone # (_____)** _____

Dentist's / Orthodontist's Name _____ **Phone # (_____)** _____

Does student have any current problem or history of: (if yes, please explain?)

Yes **No**

◇ ◇ Asthma (if yes, check type) Exercise – induced: _____ Seasonal: _____ Other: _____

◇ ◇ Uses inhaler at school (if yes, how often & what type) _____

◇ **If using inhaler at school, an extra inhaler must be provided to the clinic.**

◇ ◇ Arthritis/Bone or Joint Disease _____

◇ ◇ ◇ Blood Disorders/Anemia _____

◇ ◇ ◇ Cancer _____

◇ ◇ ◇ Diabetes (if yes, type of insulin) _____

◇ ◇ ◇ Insulin _____

◇ ◇ ◇ Epilepsy / Seizures (if yes, medication used) _____

◇ ◇ ◇ Medications Used _____

◇ ◇ ◇ Heart Murmur / Cardiac Disease _____

◇ ◇ ◇ History of Head Injury / Headaches _____

◇ ◇ ◇ History of Migraines (if yes, medication used) _____

◇ ◇ ◇ Kidney Disease _____

◇ ◇ ◇ Lung Disease _____

◇ ◇ ◇ History of Broken Bone(s) _____

◇ ◇ ◇ History of Orthopedic Problems or Surgery _____

◇ ◇ ◇ Skin Conditions/Problems _____

◇ ◇ ◇ Chronic Illness (explain) _____

◇ ◇ ◇ Other _____

◇ ◇ ◇ Visual Problems / Contacts or Eyeglasses (circle one or both) _____

◇ ◇ ◇ Additional Details History: _____

Does the student take any medications regularly? _____ (if yes please list type and dosage of medication)

Name of Medication(s) _____

Will these medications be taken at school? _____

Reason for Medication(s) _____

Please Note: For medications that will be administered by the nurse or a designated school staff member at school, the parent and physician must complete the "Authorization to Administer Medications" form, including an EpiPen, inhalers, diabetic supplies and medications.

OVER-THE-COUNTER MEDICATIONS

Indicate below which over-the-counter medications we may give your child.

Yes **No**

◇ ◇ Tylenol (brand or generic)

◇ ◇ Antacids

◇ ◇ Hydrocortisone Cream

◇ ◇ Triple Antibiotic (ointment / cream)

Yes **No**

◇ ◇ Ibuprofen (Motrin or Advil)

◇ ◇ Benadryl (oral or topical for allergic reactions)

◇ ◇ Benadryl (spray / cream)

AUTHORIZATION AND CONSENT TO ADMINISTER MEDICATIONS AND MEDICAL TREATMENT

Understanding that my child may need emergency treatment during school hours or while at school activities, I authorize the school through its nurse or other qualified person, to administer such first aid and/or other minor medical treatment as shall be deemed best under the circumstances, **including but not limited to the use of an EpiPen for severe allergic reactions**, and I consent for my child to receive such treatment. I understand that certain emergencies may require such prompt and immediate attention to my child that nursing or other qualified assistance may not readily be available and I therefore understand that any school employee may provide emergency assistance to my child. I understand that in the event of an emergency requiring immediate medical care, the school will attempt to notify me or any other legal guardian of my child and if the school is unable to notify me, I understand that the school may seek emergency services for my child without notification to me and I consent to have my child treated by a duly qualified physician at the nearest hospital or other emergency facility. In addition, I hereby request that Holy Spirit Preparatory School, through its designated authority, assist, supervise and/or administer the over-thecounter medications indicated in this document as well as any prescription or nonprescription medications I have requested be given to my child by submitting an *Authorization to Administer Medications* form. I release the Board of Trustees, school, and any school employee from liability for administering medications and first aid to my child and I agree to hold harmless, indemnify the school, its employees and agents either jointly or severally, from and against any and all claims, damages, causes of action or injuries arising from the medication of my child while at school or at school-sponsored events. I acknowledge that it is my responsibility to keep my child's records current to reflect any allergies, medical/physical conditions, and communicable diseases. I also understand that the obligation to provide medical insurance for my child rests with me as a parent or guardian.

_____

Parent/Guardian Signature *Date*

STUDENT'S ANNUAL PHYSICAL EXAM

This exam must be completed by a physician and dated between May 1, 2016 and July 31, 2016.
ALL STUDENT ATHLETES MUST HAVE A PHYSICAL ON FILE BEFORE BEGINNING PRACTICE.

ALL NEW Students MUST have a Current 3231 Immunization Form Completed.
Current Students, please complete an updated form if a New Booster Immunization is received.

STUDENT'S NAME: _____ AGE: _____ DOB: _____

VITAL SIGN/STATISTICS _____ Height _____ Resting Pulse
_____ Weight _____ Pulse (immediately post exercise)
_____ B/P (resting) _____ Pulse (after brief rest period)

REVIEW OF SYSTEMS Head/Neck: _____ Spine: _____ Lungs: _____
Extremities: _____ Heart/Murmurs: _____
Other: _____
Abdomen/Hernia: _____

The physical examination was completed and the student was found to be free of communicable diseases.	**YES or NO**
The student was checked for scoliosis, scapula prominence and shoulder tilt.	**YES or NO**
The student's vision and hearing are normal.	**YES or NO**
The student may fully participate in physical education and in all athletic activities.	**YES or NO**

Student's General Condition: (check one) _____Excellent _____Good _____ Fair _____ Poor

PHYSICAL EDUCATION & EXTRACURRICULAR ATHLETICS

_____ Student is cleared for **full participation** in physical education and all athletics.
_____ Student is **not cleared** for full participation in physical education and all athletics. Explain limitation / exemption: _____
_____
_____ Student is cleared to participate in physical education and all athletics **after completing evaluation / rehabilitation** for: _____
_____

Date of Exam: ____/____/____ Physician's Signature: _____ Physician's Stamp:
Phone #: (_____)_____

Fax #: (_____)_____

CERTIFICATE OF IMMUNIZATION

Lastname, Firstname I.
Child's Name (Last name first)

10 | 01 | 2001
Birthdate

Lastname, Mother I.
(Optional) Parent/Guardian Name (Last name first)

Date of Expiration
(Next required immunization or review of medical exemption due.)

OR

X (Fill in X) **Complete For**
School Attendance
Child must be ≥ 4 years and have met all requirements for school attendance. The vaccine history section must be filled in.

Unless specifically exempted by law, Georgia law (O.C.G.A. § 20-2-771) requires a certificate on file for each child in attendance in any school or child care facility in Georgia with penalties for failure to comply. Detailed instructions for this form and immunization requirements by age are spelled out in policy guides 3231INS and 3231REQ distributed by the Georgia Immunization Program.

VACCINE	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	DATE MM DD YY	Total Doses	Diagnosed	Serology +	History	Med. Exemption
Required Vaccines for School or Child Care Attendance											
DTP, DTaP, DT											
Td or Tdap											
Hepatitis B											
OPV											
IPV											
HIB (Under Age 5)											
PCV (Under Age 5)											
Measles											
Mumps											
Rubella											
Hepatitis A (Born on/after 1/1/06)											
Varicella											
Recommended Vaccines (For Information Only)											
MCV/MPSV											
Rotavirus											
HPV											
Influenza											
Td or Tdap (Booster Dose)											

SAMPLE

Notes:
A licensed physician or qualified employee of a local Board of Health or the State Immunization Program is responsible for the content of this certificate. All dates must include month, day and year. In cases of natural immunity or Medical Exemption, the 4 digit year of infection, test or exemption must be filled in in the appropriate box(es). ***The certificate is NOT valid without name and birthdate of the child, date of expiration OR "X" in Complete for School Attendance box, legible name and address of the physician or health department, certified by signature and a date of issue.*** A school or facility official is responsible for keeping a current valid certificate on file for each child in attendance. A certificate must be replaced within 30 days after expiration. ***When a child leaves or transfers to another facility, the Certificate of Immunization should be given to a parent/guardian or sent to the new facility.***

Printed, Typed or Stamped Name, Address and Telephone # of Licensed Physician or Health Dept.

Sample Q. Physician, M.D. P.C.
1234 Some Street
Fictitious Town GA 99999-9999

(555) 123-4567

Sample Q. Physician, M.D.
Certified by (Signature)

12 | 01 | 2006
Date of Issue

HOLY SPIRIT
PREPARATORY SCHOOL

2016 - 2017 AUTHORIZATION TO GIVE MEDICATION AT SCHOOL

If medications can be given at home or after school hours, please do so. However, if medication must be given during school hours, this form must be completed.

STUDENT NAME	
TEACHER	GRADE

I hereby request that Holy Spirit Preparatory School, through its designated authority, supervise/assist in the administering of medication to my child, according to the instructions contained on the statement below. I understand that:

- Medications must be in the original labeled container (no baggies, foil, etc.)
- Parent /guardian must provide specific instructions, as well as the medication and related equipment to the principal, or clinic personnel.
- It will be the responsibility of the parent / guardian to inform the school of any changes. New medication or new doses will not be given unless a new form is completed.
- All medication will be taken directly to the office / clinic by the parent. ▯ Medications must be picked up at the end of the year, or will be disposed of by the school.

NAME OF MEDICINE	DOSAGE AND TIME OF ADMINISTRATION
STOP MEDICATION ON (ENTER DATE)	CHILD'S MEDICATION ALLERGIES
PHYSICIAN'S NAME	PHYSICIAN'S PHONE

I release the school board, the school, and any school employee from any liability for administering this medication.

PARENT/GUARDIAN SIGNATURE	DATE

HOME PHONE	CELL PHONE	WORK PHONE

To be completed by Health Care Provider for long term medications (more than two weeks):

CONDITION REQUIRING MEDICATION	POSSIBLE SIDE EFFECTS, IF ANY
SIGNATURE OF HEALTH CARE PROVIDER	DATE

HOLY SPIRIT
PREPARATORY SCHOOL

2016 - 2017 Preschool Pick-Up Authorization

CHILD'S NAME		HOME PHONE NUMBER
MOTHER'S NAME	CELL NUMBER	BUSINESS NUMBER
FATHER'S NAME	CELL NUMBER	BUSINESS NUMBER

My child will be picked up on a regular basis by the following people (This should be a parent, nanny, or a regular carpool, etc.). Anytime that there is any deviation from this normal pick up, I understand that I must send a note.

Name	Phone Number	Relationship

In an absolute emergency, in addition to the above names, the people listed below have my permission to pick up my child from the preschool. I will inform my child's teacher/director each time a special pick up is necessary.

Name	Phone Number	Relationship

The following people DO NOT have permission to pick up my child. Please note: a copy of the court decision must be on file at the preschool office in order for the preschool NOT to release your child to his or her non-custodial parent.

NAME	RELATIONSHIP
ADDRESS	PHONE NUMBER

Should there be a change in this information, please notify the school immediately.

PARENT SIGNATURE	DATE

HOLY SPIRIT
PREPARATORY SCHOOL

2016 - 2017 Activity and Transportation Waiver

A transportation waiver is required to move students from one building to another on the same campus, and is also needed in case of an emergency where we would need to move the students off premises.

STUDENT LAST NAME		STUDENT FIRST NAME		
STREET ADDRESS		CITY	STATE	ZIP CODE
AGE				
PARENTS/GUARDIANS' NAMES				
CELL PHONE	HOME PHONE		WORK PHONE	
E-MAIL ADDRESS				

PLEASE READ CAREFULLY AND SIGN THE FOLLOWING STATEMENT:

I hereby give permission for my child, _____, to attend on or off campus school organized or sponsored activities on their scheduled (or any rescheduled) day and to be transported by school bus, private bus, public transportation, van or private vehicle(s) as determined by the school. For myself and the named child; I hereby waive and release any claim against Holy Spirit Preparatory School and its members, board, employees, servants, volunteers and agents for any injury or loss incurred by my child during such activities (save for any personal injury directly resulting from gross negligence on the part of the school) and agree to indemnify the school and its members, board, employees, servants and agents against any expenses, loss or damages incurred as a consequence of any action or inappropriate inaction on the part of my child. I confirm that there are no medical or other circumstances that should be known to the chaperone(s) that are not appropriately detailed on the reverse of this permission slip.

☐ Check here if there are any notes on the reverse.

SIGNATURE OF PARENT/GUARDIAN	DATE