



**RICHMOND HILL MONTESSORI PRESCHOOL**

2933 US HWY 17, Richmond Hill, GA 31324

Tel: (912) 756-4554 • Fax: (912) 445-0286

Email: [info@richmondhillmontessoripreschool.com](mailto:info@richmondhillmontessoripreschool.com)

## **Richmond Hill Montessori Enrollment Packet**

Thank you for your interest in Richmond Hill Montessori Preschool and our offered programs. We are glad that you have chosen to allow our program to be an integral part of your child's educational learning. Please fill out this application to its entirety and return to the office.

As part of our enrollment process, you may be require to fill out and bring in additional documentation. Please consider the following checklist:

### **6wks – 12mos:**

- Richmond Hill Montessori Enrollment Packet
- Infant – Preschool Tuition Agreement Form (included in this packet)
- New Infant Enrollment Forms
- Copy of Birth Certificate
- Copy of Social Security Card
- Copy of an Updated Form 3231 (Immunization Record)
- Completed Tuition Express Form (used for billing)

### **12 – 48mos:**

- Richmond Hill Montessori Enrollment Packet
- Infant – Preschool Tuition Agreement Form (included in this packet)
- Copy of Birth Certificate
- Copy of Social Security Card
- Copy of an Updated Form 3231 (Immunization Record)
- Copy of Updated Form 3300 (Ear, Eye, Dental)
- 3 Year-Old AAP Form Well Child – HE0493
- Completed Tuition Express Form (used for billing)

### **Young Learner (before/after school):**

- Richmond Hill Montessori Enrollment Packet
- Young Learner Registration Form
- Copy of Birth Certificate
- Copy of Social Security Card
- Copy of an Updated Form 3231 (Immunization Record)
- Completed Tuition Express Form (used for billing)

**Thank you for choosing Richmond Hill Montessori.**



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**Who can we thank for referring you to Richmond Hill Montessori Preschool?**

\_\_\_\_\_

## **INFANT – PRESCHOOL TUITION AGREEMENT FORM**

At the time of your child's enrollment and every year thereafter, you will be asked to sign a tuition agreement. An annual registration/supply fee of \$125 and \$75 respectfully is due upon your child's enrollment into the center and on August 1<sup>st</sup> of each year thereafter.

Weekly payments are due on Friday prior to the service week. **A \$25 late fee will be assessed to the account on Monday.** RHM will gladly continue to care for your child on Tuesday provided tuition and late fees have been paid. RHM reserves the right to deny child care on delinquent accounts.

*There will be a service charge of \$35.00 for all returned ACH payments and a late fee of \$25. The now late payment must be made by money order, cashier check, or cash.*

All children must be picked-up no later than 6:15 p.m. Anyone arriving after 6:15 will be charged \$20.00 plus an additional \$1.00 every minute. This fee must be paid before the child may return to school.

All tuition amounts are based on the total yearly cost of the program. The weekly and monthly fees are a breakdown of this yearly cost to facilitate parent payments.

**There are three tuition payment methods made available to parents for flexibility. Please select one of the following:**

- Weekly**      \$ \_\_\_\_\_ **due on Friday prior to the service week**
- Semi-Monthly** \$ \_\_\_\_\_ **due on the 1<sup>st</sup> and 15<sup>th</sup> of each month**
- Monthly**      \$ \_\_\_\_\_ **due on the 1<sup>st</sup> of each month**

\_\_\_\_\_  
Child's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Print Name

\_\_\_\_\_  
Parent/Guardian Signature



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## Child Enrollment Information

Child's Name: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### **Primary Parent/Guardian Information** (will be considered primary contact for all incidents/emergencies)

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cellular Provider: \_\_\_\_\_ \*Text notifications (reminders, emergency, etc).  
By not providing a cell phone provider in an event of an emergency, RHMP reserves the right to proceed according to the parent handbook.

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Select all that apply:

- Lives with       Legal Guardian       Authorized Pick Up       Emergency Contact

### **Secondary Parent/Guardian Information**

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Cellular Provider: \_\_\_\_\_ \*Text notifications (reminders, emergency, etc).  
By not providing a cell phone provider in an event of an emergency, RHMP reserves the right to proceed according to the parent handbook.

Employer: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Select all that apply:

- Lives with       Legal Guardian       Authorized Pick Up       Emergency Contact

### **Additional Authorization List**

#### **I also recognize the following individuals as emergency contacts/authorized pick-ups:**

*\*Please include home addresses for each individual listed. \*Please note any future changes must be done in person or in writing*

Name #1: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_  Authorized Pick-up       Emergency Contact

Name #2: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone #: \_\_\_\_\_  Authorized Pick-up       Emergency Contact

## **Emergency Information**

- Does your child have any unusual health conditions?  No  Yes \_\_\_\_\_
- Does your child have any physical handicap?  No  Yes \_\_\_\_\_
- Does your child have any drug allergies?  No  Yes \_\_\_\_\_
- Does your child have any food allergies/preferences?  No  Yes \_\_\_\_\_

My child has the following special need(s): \_\_\_\_\_

My child is currently on medication(s) prescribed for long-term continuous use and/or has the following pre-existing illness, allergies, or health concerns: \_\_\_\_\_

Child Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

*\*\*\*In the event of an extreme emergency I understand that my child will be transported by the Richmond Hill Ambulance Services to St. Joseph Hospital for care.*

## **Before Coming to RHMP my Child was Cared for:**

- At another child care center: \_\_\_\_\_  By an in-home babysitter
- At home by a parent/guardian or grandparent  Other: \_\_\_\_\_

## **Parental Agreement**

RHMP agrees to provide care for my child, \_\_\_\_\_, on Monday – Friday, from 6:30 a.m. to 6:15 p.m. not to exceed more than 10 hours daily. My child will participate in the following:

**Breakfast (7:30-8:00am) Morning Snack (12 – 36 mts @ 10:00am) Lunch (11:00am) Afternoon Snack (2:00pm)**

*Before any medication is dispensed to my child, I will provide a written authorization, which includes: name of child, date, name of medication, prescription number (if applicable), dosage(s), date and time of day medication is to be given. Medication will be in the original container with my child's name marked on it.*

*My child will not be allowed to enter or leave the facility without being escorted by the parent(s), or person authorized by the parent(s), or facility personnel. Only before/after school (extended care) children will be signed in/out at the front desk by guardian and escorted to proper room. All other Lottery Pre-K are required to use car rider line.*

*I acknowledge it is my responsibility to keep my child's records current to reflect any significant changes as they occur, e.g., telephone numbers, work location, emergency contacts, child's physician, child's health status, infant feeding plans and immunization records, etc.*

*The facility agrees to keep me reasonably informed of any incidents, including illnesses, injuries, adverse reactions to medications, etc., which include my child. The facility also agrees to advise me of my child's progress and issues related to my child's care and special needs.*

*Richmond Hill Montessori Preschool agrees to obtain written authorization from me before my child participates in routine transportation, field trips, special activities away from the facility, and water related activities occurring in water that is more than two feet deep.*

*I am encouraged to participate in special activities at the center. I authorize Richmond Hill Montessori Preschool to obtain emergency medical care for my child when I am not available. I have received a copy and agree to abide by the policies and procedures for Richmond Hill Montessori Preschool.*

\_\_\_\_\_  
Child Name

\_\_\_\_\_  
Guardian Print Name

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date



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## Authorization to Dispense External Preparations 590-1-1-20(1)

Parental Authorization. Except for first aid, personnel shall not dispense prescription or non-prescription medications to a child without specific written authorization from the child's physician or parent. Such authorization will include, when applicable, date; full name of the child; name of the medication; prescription number, if any; dosage; the dates to be given; the time of day to be dispensed; and signature of the parent.

I give Richmond Hill Montessori Preschool permission to apply one or more of the following topical ointments/preparations to my child in accordance with the directions on the label of the container.

- Baby wipes
- Band-Aids
- Neosporin or similar ointment
- Bactine or similar first aid spray
- Sunscreen (*Rocky Mountain Peak*)
- Insect Repellant (*Parent Provided*)
- Non-Prescription ointment (*Vaseline*)

## Sunscreen and Insect Repellant Authorization

- RHM will apply Rocky Mountain Peak Sunscreen for all of our students in the afternoon. Rocky Mountain Peak is SPF 50, fragrance free, oxybenzone free, water resistant for 80 minutes, hypoallergenic, and greaseless.
- Parent will apply the sunscreen of choice on their student in the morning prior to dropping off.
- Parent will provide insect repellant of choice in the original container with valid expiration date, and labeled with student's name for teacher and classroom use (must be non-aerosol cans & non-lotion/cream).
- Sunscreen will not be applied on students under 6 months.

I give Richmond Hill Montessori Preschool permission to apply the program provided sunscreen Rocky Mountain Peak (SPF 50) and the non-aerosol can insect repellant \_\_\_\_\_ (parent provided) in the afternoon prior to going outside.

*\*I understand that it is my responsibility to apply sunscreen to my child in the morning prior to drop off and the teacher's will reapply in the afternoon prior to going outside when applicable.*

## Audio, Video, and Photo Release Agreement

I / We  **consent**  **do not consent** to my / our child being tape recorded, video recorded, or photographed for educational or publicity purposes while participating in the regular activities of this program.

## Parent Handbook Agreement

Please visit our webpage at [www.richmondhillmontessoripreschool.com](http://www.richmondhillmontessoripreschool.com) for additional parent resources. Classroom lesson plans, program monthly lunch menu, yearly school calendar with building closure dates, and a copy of the most current parent handbook can be found on this webpage.

*\*\*\*Please see an administrator for the password to the password protected pages on the webpage\*\*\**

I have read the RHM Parent Handbook and understand its content.

\_\_\_\_\_  
Child Name

\_\_\_\_\_  
Guardian Print Name

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date



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## Parent Responsibility Agreement

- I agree to communicate with provider regarding the needs of the child.
- I agree to immediately inform the childcare center of any changes in emergency/contact information.
- I agree to keep child's immunizations/physical records current as required by Department of Children & Families.
- I agree to keep a sick child home, including a child that is too ill to participate in the daily indoor and outdoor activities, or pick up a sick child in a timely manner (less than 1 hour) in accordance with the policy.
- I agree to check the daily communication folder and comment/input or initial as necessary.
- I agree to meet with child's teacher to discuss my child's portfolio, progress notes, development, and plan goals together
- I agree to volunteer our time, talent, and/or services to the classroom or school on one or more occasions.
- I understand that my child may participate in unscheduled field trip/activity, such as emergency evacuations

## Center Responsibility Agreement

- We agree to communicate with parent regarding the needs of the child.
- We agree to immediately inform parents through weekly newsletters, text messages, FB postings, bulletin board, etc.
- We agree to keep a current copy of child's records provided by the parent as required by Department of Children & Families.
- We agree to inform parent of a sick child and isolate a sick child in a timely manner in accordance with policy.
- We agree to provide a daily communication folder and comment/input as necessary.
- We agree to meet with child's parent after 6 weeks and near the end of the school year to discuss child's portfolio, progress notes, and development and plan goals together for the current and following year.

## Emergency Medical Agreement

Should my child suffer any injury or illness while in the care of Richmond Hill Montessori Preschool and the facility are unable to contact me/us immediately, it shall be authorized to secure such medical attention and care for the child as necessary. I understand that any and all medical expenses incurred during the treatment of my child are my responsibility. The facility agrees to keep me informed of any incidents requiring professional medical attention involving my child.

## Biting Policy Agreement

Biting is a natural part of a child's development. Children bite for a wide variety of reasons such as teething, lack of verbal skills, over stimulated, hungry, tired, aggression, attention-getting device, etc. Biting is an issue that often surfaces when infants, toddlers and preschoolers are in a child care setting. **Biting, however, is not an acceptable behavior at Richmond Hill Montessori.**

The staff will carefully, thoughtfully, and consistently handle the biting situation by:

- Stopping the action quickly by saying "No" or "Stop"
- Assessing the situation quickly to determine the cause of biting (frustration, hunger, teething, fatigue, separation anxiety, etc.)
- Attending to the child that has been bit with lots of TLC and attention
- Redirecting the biter to another activity or area
- Finishing the interaction on a positive note by reassuring the biter that he/she is still important to you and the rest of the staff.

**If a bite breaks the skin and or draws blood the child will be sent home for the day.** A staff member will notify the parents of the biter and the bitten child stressing the severity or mildness of the incidents. If a child bites twice in one day, staff will contact the guardians to pick up the child. It is mandatory for you to pick up your child from the center within one hour. No exceptions. Staff will continue working with the family to stop the biting behavior.

The staff will assess the room and modify any necessary changes to better help the child to stop the biting. If nothing works and the child continues to bite and injure other children, it will be necessary for the parent to make other child care arrangements. At which time the child will be asked to withdraw from the program, the parents will be given one (1) week to find other suitable child care arrangements.

**It is the responsibility of the childcare center staff to ensure the safety of all children under our care.**

\_\_\_\_\_  
Child Name

\_\_\_\_\_  
Guardian Print Name

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

# Food Allergy Action Plan

- No, my child does not require a food allergy action plan** (*Do not fill this form*)
- Yes, my child requires a food allergy action plan** (*please fill out below form*)

Student's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Teacher: \_\_\_\_\_

**ALLERGY TO:** \_\_\_\_\_

Asthmatic       Yes\*    No      \*Higher risk for severe reaction

## STEP 1: TREATMENT

### Give Checked Medication\*\*:

\*\*(To be determined by physician authorizing treatment)

### Symptoms:

If a food allergen has been ingested, but *no symptoms*:

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>○ Mouth:      Itching, tingling, or swelling of lips, tongue, mouth</li> <li>○ Skin:        Hives, itchy rash, swelling of the face or extremities</li> <li>○ Gut:         Nausea, abdominal cramps, vomiting, diarrhea</li> <li>○ Throat†:    Tightening of throat, hoarseness, hacking cough</li> <li>○ Lung†:      Shortness of breath, repetitive coughing, wheezing</li> <li>○ Heart†:     Thready pulse, low blood pressure, fainting, pale, blueness</li> <li>○ Other†:     _____</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Epinephrine</li> <li><input type="checkbox"/> Epinephrine</li> <li><input type="checkbox"/> Epinephrine</li> <li><input type="checkbox"/> Epinephrine</li> <li><input type="checkbox"/> Epinephrine</li> <li><input type="checkbox"/> Epinephrine</li> <li><input type="checkbox"/> Epinephrine</li> <li><input type="checkbox"/> Epinephrine</li> </ul> | <ul style="list-style-type: none"> <li><input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> Antihistamine</li> <li><input type="checkbox"/> Antihistamine</li> </ul> |
|--|--|--|

If reaction is progressing (several of the above areas affected), give  Epinephrine       Antihistamine

The severity of symptoms can quickly change. †Potentially life-threatening.

### DOSAGE

**Epinephrine:** inject intramuscularly (**circle one**) EpiPen® EpiPen® Jr. Twinject™ 0.3 mg Twinject™ 0.15 mg

**Antihistamine:** give \_\_\_\_\_  
medication/dose/route

**Other:** give \_\_\_\_\_  
medication/dose/route

**IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.**

## STEP 2: EMERGENCY CALLS

1. Call 911 (or Rescue Squad: \_\_\_\_\_) . State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. \_\_\_\_\_ at \_\_\_\_\_

3. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.) _____	2.) _____
b. _____	1.) _____	2.) _____
c. _____	1.) _____	2.) _____

**EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!**

## FAMILY INFORMATION FORM – Students 12 months or older

<b>CHILD GENERAL INFORMATION</b>			
Child's Name:	DOB:	Sex:	Place of Birth:
If your child is adopted, list age at adoption:		Is child aware of adoption?	
<b>PARENT/GUARDIAN INFORMATION</b>			
Name of Father/Guardian:	Age:	Occupation:	
Name of Mother/Guardian:	Age:	Occupation:	
Marital Status of Parents:			
Custody/Visiting Arrangements:			
Please describe your guidance/discipline styles and strategies:			
When your child is upset, how do you comfort them?			
<b>HOUSEHOLD INFORMATION</b>			
Other members of the household (List name, age, and relation):			
Siblings not residing in the household (name and age):			
Other than yourself, who has cared for your child?			
Is there any other language other than English that is spoken in the home? If yes, what language?			
Family Nationality:			
Religious preference:			
Are there any holidays that you do not wish your child to celebrate? If yes, which ones?			

<b>DOES YOUR CHILD...</b>	<b>Yes</b>	<b>No</b>	<b>Comments</b>
Prefer to play alone?			
Prefer to play in groups?			
Have pets?			
Hear well? If no, please explain			
Have good vision? If no, please explain			
Talk like other children?			
Walk, run and climb like other children?			
Have any diagnosed physical conditions or disabilities? If yes, please list in comments.			
Have a special needs diagnosis? If yes, please specify in comments.			
Have any special fears? What are they?			
Take correction easily?			
Have a history of hospitalization? When/why?			
Have any recent medical problems? Please list.			
Take any special medications? List what and why			
Receive any special services? If yes, what services?			



DOES YOUR CHILD...	Yes	No	Comments
Have frequent colds?			
Have frequent ear aches?			
Have frequent sore throat?			
Have frequent stomach aches?			
Have frequent fevers?			
Have food allergies? If yes, please specify			
Follow a specialized diet?			
Have any food dislikes or eating problems? List			
Feed them self?			
Use utensils successfully?			
Use the toilet independently? Include words used			
Have regular bowel movements?			
Have any problems with constipation?			
Have any problems with diarrhea?			
Exhibit Separation Anxiety? Describe in comments			
Have a security object or favorite toy?			
Use a pacifier?			
Sleep well?			
Sleep in his/her bed?			

What time does your child go to bed?	Wake up?	Nap?
Describe your child's go-to-sleep routines		
Describe your child's wake-up routines		

What goals do you have for your child upon entering Richmond Hill Montessori?	
What are your expectations of Richmond Hill Montessori? What do you hope will be included in your child's pre-school program?	
Has your child gone to pre-school or daycare before? Please describe your previous experience.	

My Child Is... (Check All That Apply)	
<input type="checkbox"/> Happy	<input type="checkbox"/> Aggressive
<input type="checkbox"/> Dependent	<input type="checkbox"/> Stubborn
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Friendly
<input type="checkbox"/> Moody	<input type="checkbox"/> Clumsy
<input type="checkbox"/> Fearful	<input type="checkbox"/> Quiet
<input type="checkbox"/> Good-natured	<input type="checkbox"/> Even-tempered
<input type="checkbox"/> Attentive	<input type="checkbox"/> Sympathetic
<input type="checkbox"/> Shy	<input type="checkbox"/> Sleepy
<input type="checkbox"/> Other:	

My Child Can... (Check All That Apply)		
<input type="checkbox"/> Say Nursery Rhyme	<input type="checkbox"/> Sing Songs	<input type="checkbox"/> Listen to Stories
<input type="checkbox"/> Say his or her name	<input type="checkbox"/> State age & sex	<input type="checkbox"/> Draw a person
<input type="checkbox"/> Follow simple directions	<input type="checkbox"/> Count How far? _____	<input type="checkbox"/> Recognize and name common objects
<input type="checkbox"/> Dress independently	<input type="checkbox"/> Ride a tricycle	<input type="checkbox"/> Throw & catch a ball
<input type="checkbox"/> Name basic colors	<input type="checkbox"/> Hop on 1 foot	<input type="checkbox"/> Balance on one foot
<input type="checkbox"/> Write name		
Other (Note significant accomplishments):		

# 3 YEAR WELL CHILD FORM - OPTIONAL

<u>Accompanied by/Informant</u>		<u>Preferred Language</u>	<u>Date/Time</u>	<u>Name</u>		
<u>Drug Allergies</u>		<u>Current Medications</u>		<u>ID Number</u>		
<u>Weight (%)</u>	<u>Height (%)</u>	<u>BMI (%)</u>	<u>Blood Pressure</u>	<u>Temperature</u>	<u>Birth Date</u>	<u>Age</u> M   F

## History

## Physical Examination

<input type="checkbox"/> Previsit Questionnaire Reviewed	<input type="checkbox"/> Child has special health care needs
<input type="checkbox"/> Child has a dental home	

Concerns and questions:  None  Addressed (see other side)

\_\_\_\_\_

\_\_\_\_\_

Follow-up on previous concerns:  None  Addressed (see other side)

\_\_\_\_\_

\_\_\_\_\_

Interval history  None  Addressed (see other side)

\_\_\_\_\_

\_\_\_\_\_

NL

### Bright Futures Priority

- Eyes (red reflex, cover/uncover test)
- Teeth (canines, white spots, staining)
- Neurologic (language, speech, social interaction)

### Additional Systems

- General Appearance
- Head
- Ears
- Nose
- Mouth and Throat
- Neck
- Lungs
- Heart
- Abdomen
- Genitalia
- Extremities
- Back
- Skin

Abnormal findings and comments \_\_\_\_\_

\_\_\_\_\_

## Assessment

Well Child

\_\_\_\_\_

\_\_\_\_\_

## Social/Family History

See initial History Questionnaire  No interval change

### Family situation

Parents working outside home  Mother  Father

Child care:  Yes  No Type: \_\_\_\_\_

Preschool:  Yes  No Type: \_\_\_\_\_

Changes since last visit: \_\_\_\_\_

\_\_\_\_\_

## Review of Systems

See Initial History Questionnaire and Problem List.

No interval change

Changes since last visit: \_\_\_\_\_

\_\_\_\_\_

Nutrition: \_\_\_\_\_

Elimination:  NL \_\_\_\_\_

Toilet training:  Yes  In process \_\_\_\_\_

Sleep:  NL \_\_\_\_\_

Behavior/Temperament:  NL \_\_\_\_\_

Physical activity

Play time (60 min/d)  Yes  No

Screen time (<2 h/d)  Yes  No

Parent-child interaction

Communication:  NL \_\_\_\_\_

Choices:  NL \_\_\_\_\_

Cooperation:  NL \_\_\_\_\_

Appropriate responses to behavior:  NL \_\_\_\_\_

Development (if not reviewed in the Pre-visit Questionnaire)

Social-Emotional	Communications	Physical Development
<ul style="list-style-type: none"> <li>• Self-care skills</li> <li>• Imaginative play</li> </ul>	<ul style="list-style-type: none"> <li>• 2-3 sentences</li> <li>• Usually understandable</li> <li>• Names a friend</li> <li>• Names objects</li> <li>• Knows if boy or girl</li> </ul>	<ul style="list-style-type: none"> <li>• Builds tower (6-8 blocks)</li> <li>• Stands on foot</li> <li>• Throws ball overhand</li> <li>• Walks upstairs alternating feet</li> <li>• Copies circle</li> <li>• Draws person (2 body parts)</li> <li>• Toilet trained during day</li> </ul>

## Anticipatory Guidance

Discussed and/or handout given

### Family support

- Show affection
- Manage anger
- Reinforce appropriate behavior
- Reinforce limits
- Find time for yourself

### Encourage literacy activities

- Read, sing, play
- Talk about pictures in books
- Encourage child to talk

### Playing with Peers

- Encourage appropriate play
- Encourage fantasy play
- Encourage play with peers

### Promoting physical activity

- Family exercise activities
- Limit screen time (max 2 hr/day)
- No TV in bedroom

### Safety

- Car safety seat
- Supervise play near cars and street
- Safety near windows
- Guns

## Plan

Immunization (See Vaccine Administration Record)

Laboratory/Screening results:  Vision \_\_\_\_\_

\_\_\_\_\_

Referral to \_\_\_\_\_

\_\_\_\_\_

Follow-up/Next visit \_\_\_\_\_

\_\_\_\_\_

See other side \_\_\_\_\_

Print Name	Signature
Resident	
Provider	

WELL CHILD/3 years



# Program Survey Form: **Military Families (Optional)**

The survey date is \_\_\_\_\_

## STUDENT INFORMATION

Student's Last Name	First Name	M.I.	Date of Birth	Grade	School Name Richmond Hill Montessori Preschool	
Address		City		State	Zip Code	
If the above property is a federal property, enter the name of the property.		Name of federal property				

## PARENT/GUARDIAN EMPLOYMENT INFORMATION: CIVILIAN

Enter information in this section regarding the parent/guardian if 1) neither parent/guardian with whom the student resided was on active duty in the Uniformed Services of the United States *and* 2) either parent/guardian with whom the student resided was employed on federal property, *or* 3) either the parent/guardian reported to work on federal property *on the survey date*. Enter the parent/guardian's name as it appears on the employer's payroll record.

Parent/Guardian's Last Name	First Name and M.I.	Name of Parent/Guardian's Employer			
Address of Parent/Guardian's Employer		City	State	Zip Code	
Name of federal property					
Address of federal property		City	State	Zip Code	

## PARENT/GUARDIAN EMPLOYMENT INFORMATION: UNIFORMED SERVICES

Enter information in this section regarding the parent/guardian if either person was on active duty in the Uniformed Services of the United States *on the survey date*.

Parent/Guardian's Last Name	First Name and M.I.	Branch of Service	Rank
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## PARENT/GUARDIAN EMPLOYMENT INFORMATION: FOREIGN MILITARY

Enter information in this section regarding the parent/guardian if either person was both an accredited foreign government official and a foreign military officer *on the survey date*.

Parent/Guardian's Last Name	First Name and M.I.	Branch of Service	Rank
Name of Foreign Government			

## PARENT/GUARDIAN EMPLOYMENT INFORMATION: FARMING, GRAZING, LUMBERING AND MINING

Enter information in this section if either the parent or guardian spent more than 50 percent of his or her working time on federal property (whether as an employee or self-employed) engaged in farming, grazing, lumbering or mining.

Parent/Guardian's Last Name	First Name and M.I.	Name of Parent's/Guardian's Employer			
Address of Parent/Guardian's Employer		City	State	Zip Code	
Name of federal property		Address of federal property			
Permit Number	Township	Range	Section		

→ Signature of Parent/Guardian \_\_\_\_\_ → Date \_\_\_\_\_



# Automated Payment Processing Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express® – an automatic payment processing system that allows on-time tuition and fee payments to be made from your bank account.

## AUTHORIZATION FOR **BANK ACCOUNT**

I (we) hereby authorize \_\_\_\_\_ to initiate debit entries to my (our) Checking or Savings Account indicated below. To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice.

**Credit Union Members:** Please contact your Credit Union to verify account and routing numbers for automatic payments.

\_\_\_\_\_  
Your Name Phone #

\_\_\_\_\_  
Address City State Zip

\_\_\_\_\_  
Bank or Credit Union Name Bank or Credit Union Address City State Zip  
XXXXX \_\_\_\_-\_\_\_\_-\_\_\_\_ XXXXXXXX \_\_\_\_-\_\_\_\_-\_\_\_\_  Checking  Savings

\_\_\_\_\_  
Routing Number (Last 4 Digits ONLY) Account Number (Last 4 Digits ONLY)

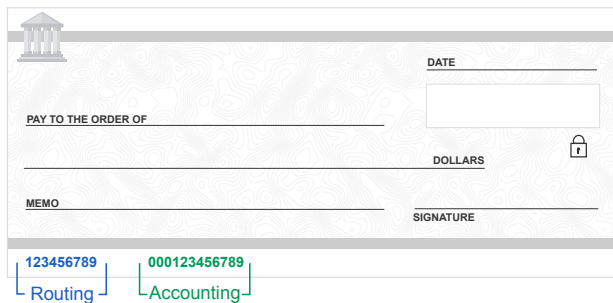
\_\_\_\_\_  
Signature Today's Date

Check if you wish to make online payments

*For Official Use Only...*

\_\_\_\_\_  
*Date Received*

\_\_\_\_\_  
*Employee Signature*



A service of



- - - - - < Cut Here > - - - - -

\_\_\_\_\_  
Routing Transit Number Account Number  Checking  Savings

For Security, please...

\_\_\_\_\_  
Today's Date

return this Section of the Authorization Form.

Shred this Section of the Authorization Form.