



HUSD Early Childhood Programs



OUR VISION

The Higley Unified School District prides itself on providing quality educational experiences. We feel that enriched early childhood environments not only provide extraordinary opportunities for young children but also form the foundation for a successful educational career. We have designed our *Brilliant Beginnings* Program for three and four year olds and our *Kindergarten Prep* program for four and five year olds who will attend Kindergarten the following school year to provide a loving, safe, and nurturing child-centered educational experience. The goal of our Early Childhood Development Center programs is to bring teachers, parents and community together with a common vision to enhance the lives of children and their families.

Connect Engage Inspire

Master educators will guide your child in learning new skills, help your child develop a sense of belonging and foster a love of learning and celebration of life each and every day. The curriculum will provide a foundation for inquiry and will challenge each individual student. We are committed to providing meaningful and developmentally appropriate educational experiences for your child's intellectual, social, emotional, creative and physical development. Our class size is limited to 20 students per section so that we can maintain a 10:1 student/teacher ratio. We feel that maintaining this ratio is essential in order to enable our early childhood certified teacher to provide students with more individualized and quality instruction on a daily basis.

STAFF QUALIFICATIONS

All *Brilliant Beginnings* and *Kindergarten Prep* teachers are highly qualified, early childhood certified teachers. Instructional aides are selected for their depth of educational training and the quality of prior experiences. Teachers and aides participate in continued formal training each year as well as ongoing professional development opportunities in the areas of classroom management, discipline and child psychology.

ENROLLMENT PROCEDURES

Registration for the 2014-2015 *Brilliant Beginnings* and *Kindergarten Prep* programs begins January 21, 2014 for previously enrolled families and HUSD employees. Open registration begins January 29 at Sossaman ECDC and January 30 at Cooley ECDC. We encourage you to register early. We will accept registrations daily at our preschool campuses.

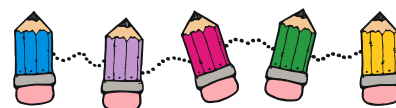
PROGRAM LOCATIONS

North Campus - Elona P. Cooley Early Childhood Development Center located at 1100 S. Recker Road, Gilbert, AZ 85296.

South Campus - Sue Sossaman Early Childhood Development Center located at 18655 East Jacaranda Blvd., Queen Creek, AZ 85142.



Items needed for registration:



***Completed Registration Form** - This form must be filled out entirely for registration to be accepted. Please note that we will not be able to accept partially completed paperwork at registration.

The registration forms are available online and at the Community Education Office located at 3333 E. Vest Ave. Building A, Gilbert AZ 85295. Phone number is (480) 279-7055. Forms are also available at each preschool location.

A non-refundable registration fee of \$50.00 per child is due at registration to finalize your child's placement in the program.

***Emergency Information and Immunization Record** - It is the parent's responsibility to make sure that the information provided on the Emergency Information and Immunization Record is kept current. It is extremely important that all home, business, and emergency contacts are correct and **COMPLETE**. At least 2 local emergency contacts, in addition to the parents/guardians, must be listed on this form. **No one may pick up your child unless they are listed on this card.**

***Proof of Current Immunizations** - Your child's immunization records will be reviewed by the school nurse. The Department of Health Services requires that the immunization record provided by a parent from a health care provider contain all current, age-appropriate immunizations. **If a child's immunizations are not up to date, they will not be allowed to attend either program until the parent/guardian brings an updated immunization record.**





***Copy of Child's Birth Certificate** - Please provide a copy of your child's birth certificate.

We will also need a copy of your driver's license and proof of residency.



PROGRAM OPTIONS AND TUITION

All classes will follow HUSD school calendar year. Before and after school care will be available beginning at 6 a.m. and ending at 6 p.m. There will be no school for preschool students on 11/26/14 and 12/19/14.

*****Brilliant Beginnings ***** - Three and Four year olds. Must be 3 years old and potty trained.

Tuesday/Thursday Classes

Half Day Sessions: A. M. or P.M. \$110 per month
Full day \$210 per month

Monday/Wednesday/Friday Classes

Half Day Sessions: A.M. or P.M. \$165 per month
Full day \$315 per month

Monday - Friday Classes

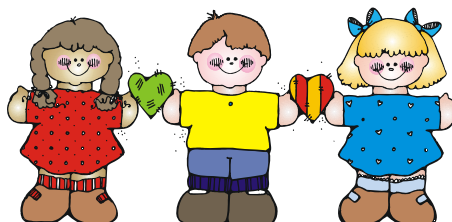
Half Day Sessions: A.M. or P.M. \$275 per month
Full day \$525 per month

*****Kindergarten Prep ***** - Four and Five year olds

Monday - Friday Classes

Half Day Sessions: A.M. or P.M. \$275 per month
Full day \$525 per month

****Parents wishing to enroll their 4 or 5 year old in a 2 or 3 day program, will be placed in an appropriate Brilliant Beginnings class.***



PAYMENT OPTIONS

You may pay your tuition by mail, phone, online or in person at:



Community Education
Higley Unified School District
3333 E. Vest Ave. Building A
Gilbert, AZ 85295
480-279-7055

***Please note: Payments will not be accepted at either program site**

Payment Schedule: THE FIRST MONTH'S TUITION FOR THE 2014-2015 SCHOOL YEAR IS DUE ON JULY 1, 2014. The remaining tuition is paid monthly beginning on September 1. Payments are due by the first day of each month. A late fee of \$25.00 will be assessed after the fourth day of each month. For example, if your child is attending 5 half days with a tuition payment of \$275, your July payment of \$275 is due by July 1st. Late payment will be assessed on July 5th with the payment and late fee totaling \$300.00. Please note that **NO** monetary credit will be given for unused, sick or vacations days.

Payments must be made before 4:00 p.m. on the due date. Payments collected the following day will be assessed a late fee.

REFUND POLICY

Brilliant Beginnings and *Kindergarten Prep* programs have a **non-refundable monthly tuition policy**. The Program Director and the Community Programs Supervisor may process a refund under extenuating circumstances.

****For additional information please contact either the Elona P. Cooley Early Childhood Development Center at 480-279-8400 or the Sue Sossaman Early Childhood Development Center at 480-279-8600.**



Higley Unified School District
Student Enrollment Form

2935 South Recker Road
Gilbert, Arizona 85295
(480) 279-7000
www.husd.org



H·I·G·L·E·Y
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SCHOOL
DISTRICT

**STUDENT
INFORMATION**

For Office Use Only

COOLEY EARLY CHILDHOOD DEVELOPMENT CENTER
 SOSSAMAN EARLY CHILDHOOD DEVELOPMENT CENTER

 SPED PEER

Student ID # _____ SAIS ID # _____
 Teacher _____ Counselor _____
 Grade _____ Entry Code _____ Entry Date _____
 Date Entered in Genesis _____ Input By _____

Birth Certificate Immunizations Proof of Residency Parent ID PHLOTE
 Custody/Guardian Papers Date Records Requested _____
 Open Enrollment – In District Open Enrollment – Out of District

Please PRINT your child's name as it appears on the legal documentation required for enrollment.

Legal Last Name _____ Legal First Name _____ Legal Middle Name _____ Suffix _____
 Grade _____ Gender Male Female Nick Name _____ Last Name Goes By _____ Birth Date (mm/dd/yyyy) _____
 Birth State _____ Birth Country _____ Student's Email Address _____ Mother's Name on Birth Cert. _____

What is the primary language used in the home regardless of the language spoken by the student? English Spanish Other _____
 What is the language most often spoken by the student? English Spanish Other _____
 What is the language that the student first acquired? English Spanish Other _____

The U.S. Department of Education requires all states to collect race and ethnicity information on students and staff.

Ethnicity (Must select one):

No, not Hispanic/Latino Yes, Hispanic/Latino

Race (Must select one or more)

American Indian or Alaskan Native Asian Black or African American
 Native American or other Pacific Islander White

Student's Home Address

Student's Mailing Address (if different)

 City _____ State _____ Zip Code _____

 City _____ State _____ Zip Code _____

Student's Primary Home Phone

Student's Secondary Home Phone

Subdivision

Dwelling Type Single Family (House) Apartment Mobile Home Trailer

Last school attended (including HUSD schools)

Address of last school attended (including HUSD schools)

Enter & Withdraw Dates

My student is currently on long-term suspension or expulsion from another school district Yes No

REQUIRED DOCUMENTATION: A birth certificate or other reliable proof of the student's identity or age, immunization records and proof of residency are required for enrollment purposes. Failure to comply with ARS 15-821, ARS 15-828, and ARS 15-872 may result in the pupil's suspension from school, and/or the referral to the local law enforcement agency.

Household Information

PARENT/GUARDIAN INFORMATION

Student lives with Both parents Mother Father Guardian Foster Other _____
Custody of student Joint Mother Father State Temporary Other _____
 Custody papers Non-custodial restrictions

NOTE: The school will not honor a request of restrictions unless copies of court orders supporting the request are on file with the school. A power of attorney document cannot replace court-ordered custody papers.

Parent/Legal Guardian #1
Legal Name (First, Middle, Last, Suffix *(Please print clearly)*)

Parent/Legal Guardian #2
Legal Name (First, Middle, Last, Suffix *(Please print clearly)*)

Relationship to Student

Relationship to Student

Home Address

Home Address

City, State, Zip

City, State, Zip

Mailing Address
(if different)

Mailing Address
(if different)

City, State, Zip

City, State, Zip

Home phone Primary number

Home phone Primary number

Cell phone Primary number

Cell phone Primary number

Work phone Primary number

Work phone Primary number

Email address

Email address

Please do not send me District information via email.

Please do not send me District information via email.

PLEASE LIST ALL CHILDREN OF SCHOOL AGE AND YOUNGER RESIDING IN THE HOME (OLDEST FIRST)

First, Middle, Last Name, Suffix	Gender	Birth Date	Grade	School Name (if attending)
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			

EMERGENCY CONTACTS (Persons to contact, other than parent, if child becomes ill)

First, Middle, Last Name	Relationship to Student	Home Phone	Work Phone	Cell Phone	Priority

I hereby affirm, by my signature, that I am either the parent or guardian of the above named student (or the student if over 18) and that all information provided is true, accurate and up-to-date. Any false statement subjects the above named student to immediate withdrawal. Also, I hereby grant the Higley Unified School District staff permission, in an emergency, to take my child to the closest emergency center for treatment in the event that I cannot be reached. It is understood that the nurse will try to reach the parent(s) and other persons listed above before arranging for transportation to an emergency facility.

Parent/Guardian (Student if over 18) Signature

Date

Higley Unified School District
Student Enrollment Form

2935 South Recker Road
Gilbert, Arizona 85295
(480) 279-7000
www.husd.org



H-I-G-L-E-Y
UNIFIED
SCHOOL
DISTRICT

**SUPPORT
PROGRAMS**

PLEASE SELECT SCHOOL PROGRAM

- COOLEY PRE-SCHOOL**
- BB T/TH M/W/F M-F KINDER PREP
- SOSSAMAN PRE-SCHOOL**
- BB T/TH M/W/F M-F KINDER PREP

This information will be kept confidential and will be used only to identify students for support services.

Student Name

Student ID

Birth Date

Questions 1. and 1a. are intended to address the McKinney-Vento Assistance Act, U.S.C.A. 42 section 11302(a). Your answers will help us determine residence information necessary for potential services for this student.

1.	Where is the enrolling student presently living? (Check the one box that applies)	
	<input type="checkbox"/> In an emergency shelter. <input type="checkbox"/> In a motel, car, park, camper or campsite. <input type="checkbox"/> With another family in a house or apartment, <input type="checkbox"/> With friends or family members other than parent/guardian. <input type="checkbox"/> Awaiting foster care placement. <input type="checkbox"/> None of the above. You do not need to answer question 1a. Please go to question 2.	
1a.	The student lives with:	
	<input type="checkbox"/> One Parent <input type="checkbox"/> Two Parents <input type="checkbox"/> One Parent and another adult that is not the legal guardian <input type="checkbox"/> A relative, friend(s) or another adult(s) <input type="checkbox"/> Alone with no adults <input type="checkbox"/> An adult that is not the parent or legal guardian	
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or any member of your household moved in the past 3 years for the purpose or working in agriculture-related jobs such as field work, fruit or vegetable packing companies, dairies or ranches?
2a.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the student been previously enrolled in a migrant child education program?
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No	If the child was born outside of the United States, has the student attended U.S. schools for a total of more than 3 academic years?
	If you answered NO , what is the date the student first enrolled in a U.S. School? <input style="width: 150px;" type="text"/>	
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the student Native American?
	If YES , name of Tribe _____ Tribal number _____	
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the student under refugee status?
	If YES , Country _____ I-94 Number _____	

Parent/Guardian Name (please print)

Signature of parent or guardian

Date

2935 South Recker Road
Gilbert, Arizona 85295
(480) 279-7000
www.husd.org



Special Education,
504 and Gifted
Program Services
Information

H·I·G·L·E·Y
UNIFIED
SCHOOL
DISTRICT

PLEASE SELECT SCHOOL PROGRAM

- COOLEY PRE-SCHOOL**
 BB T/TH M/W/F M-F
 KINDER PREP
- SOSSAMAN PRE-SCHOOL**
 BB T/TH M/W/F M-F
 KINDER PREP

Student Name

Student ID

Birth Date

Grade

Welcome to Higley Unified School District. In order to assist us in meeting the educational needs of your child, please read below and supply the requested information to the extent you are able. There are many regulations that govern Special Education, students receiving 504 accommodations and services for gifted students. Services provided by your child's previous school should continue, but HUSD must be provided with proper documentation. (Please understand that not all documentation from the previous school is automatically forwarded in a timely manner.) If you want your child to receive the appropriate services, please submit current reports, evaluations, individualized Education Program (IEP's) and other information you may have regarding your child as soon as possible. Your effort will expedite services. Thank you for taking the time to provide this valuable information.

SERVICES/PROGRAMS

Please check all programs that student has been enrolled in:

- | | |
|---|--|
| <input type="checkbox"/> Special Education with IEP | <input type="checkbox"/> Title I Reading |
| <input type="checkbox"/> Speech Therapy | <input type="checkbox"/> Title I Math |
| <input type="checkbox"/> OT/PT | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> ELL Program | |

504 SERVICES

<input type="checkbox"/> Yes <input type="checkbox"/> No	Did your child receive accommodations under a 504 plan?
	If YES , please indicate the disability for which the child had a 504 plan: _____
	Name of diagnosing physician: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a copy of the physician's statement or report?
	If YES , please provide a copy _____

GIFTED PROGRAM SERVICES

<input type="checkbox"/> Yes <input type="checkbox"/> No	Did your child receive Gifted and Talented Services (GATE) at the previous school?
	Please describe the services provided to your child: _____

Parent/Guardian Name (please print)

Signature of parent or guardian

Date



State of Arizona
Department of Education
Office of English Language Acquisition Services

**Primary Home Language Other Than English (PHLOTE)
Home Language Survey**
(Effective April 4, 2011)

These questions are in compliance with Arizona Administrative Code, R7-2-306(B)(1), (2)(a-c).

Responses to these statements will be used to determine whether the student will be assessed for English Language Proficiency.

1. What is the primary language used in the home regardless of the language spoken by the student? _____
2. What is the language most often spoken by the student? _____
3. What is the language that the student first acquired? _____

Student Name _____ Student ID _____

Date of Birth _____ SAIS ID _____

Parent/Guardian Signature _____ Date _____

District or Charter _____

School _____

Please provide a copy of the Home Language Survey to the ELL Coordinator/Main Contact on site.

In SAIS, please indicate the student's home or primary language.



Estado de Arizona
Departamento de Educación
Servicios de Aprendizaje del Inglés

Idioma Principal en el Hogar excluyendo el inglés (PHLOTE)
Encuesta sobre el Idioma en el Hogar
(Efectivo el 4 de abril de 2011)

Preguntas en conformidad con R7-2-306(B)(1), (2)(a-c) del Reglamento de la Junta Directiva.

Las respuestas que proporcione a las preguntas siguientes serán usadas para determinar si se evaluará la competencia en el idioma inglés de su hijo(a).

1. **¿Cuál idioma se habla principalmente en su hogar sin considerar el idioma que habla el estudiante?** _____
2. **¿Cuál idioma habla el estudiante con mayor frecuencia?** _____
3. **¿Cuál fue el primer idioma que aprendió el estudiante?** _____

Nombre del estudiante _____ Núm. de identificación _____

Fecha de nacimiento _____ Núm. de SAIS _____

Firma del padre o tutor _____ Fecha _____

Distrito o Charter _____

Escuela _____

Please provide a copy of the Home Language Survey to the ELL Coordinator/Main Contact on site.

In SAIS, please indicate the student's home or primary language.



MEDICAL HISTORY

(480) 279-7000
www.husd.org

Student Name (<i>Legal Last, First, and Middle Names</i>)		Birth Date
<input type="text"/>		<input type="text"/>
Does your child take any medications on a routine basis? <input type="checkbox"/> Yes <input type="checkbox"/> No During school hours? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of medication _____	Purpose of medication _____	
Name of medication _____	Purpose of medication _____	
Please contact the school health office regarding the policies for medication(s) taken during school hours.		

HEALTH CONDITIONS (check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> CYSTIC FIBROSIS | <input type="checkbox"/> HEARING AIDS |
| <input type="checkbox"/> ALLERGIES (LIFE THREATENING) | <input type="checkbox"/> DEVELOPMENTAL DELAY | <input type="checkbox"/> HEARING IMPAIRED |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> BEHAVIORAL/EMOTIONAL | <input type="checkbox"/> EATING DISORDER | <input type="checkbox"/> PSYCHOLOGICAL |
| <input type="checkbox"/> BLOOD DISORDERS | <input type="checkbox"/> ENDOCRINE DISEASE | <input type="checkbox"/> SEIZURE DISORDER |
| <input type="checkbox"/> BRAIN/CNS DISORDER | <input type="checkbox"/> ENVIRONMENTAL/ALLERGIES | <input type="checkbox"/> TRACH/G-TUBE/O2 |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> GENETIC DISORDER | <input type="checkbox"/> URINARY/KIDNEY |
| <input type="checkbox"/> CARDIOVASCULAR | <input type="checkbox"/> G.I. DISORDER | <input type="checkbox"/> VISUALLY IMPAIRED |
| <input type="checkbox"/> CEREBRAL PALSY | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> OTHER _____ |

PLEASE FULLY EXPLAIN ANY ANSWERS CHECKED ABOVE:

FOOD ALLERGIES

- Yes No WHAT FOODS? _____
- Yes No EPI PEN NEEDED* Yes No BENADRYL NEEDED*

***PLEASE BRING THESE ITEMS TO THE HEALTH OFFICE TO SIGN IN**

Please list any other concerns, surgeries, illnesses or accidents in the past year:

CHICKENPOX (VARICELLA) STATUS

Beginning with the 2011 school year, students entering preschool, kindergarten and all other grades will be required to have proof of receiving the chickenpox vaccination (Varicella) or a history of having the chickenpox disease.

- YES**, my child has had the chickenpox disease. Month and year of disease _____
- YES**, my child has had the chickenpox vaccine. Date of vaccine _____
- NO**, my child has never had the illness or vaccine for chickenpox.

Children must have proof of all required immunizations, or valid exemption, in order to attend school. If your child's immunizations are not current, please contact the school health office for a list of free vaccination clinics.



CDC/SGH# or name: _____

**Arizona Department of Health Services
Bureau of Child Care Licensing
Emergency, Information and Immunization Record Card**

Child's Name:	Date Enrolled:	Updated:
Home Address (#, Street, City, State, Zip Code):		Date Disenrolled:
Home Phone:	Date of Birth:	Sex: <input type="checkbox"/> male <input type="checkbox"/> female

Mother or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

Father or Guardian Name:	Home Address (#, Street, City, State, Zip Code):
Cell Phone (optional):	Contact Telephone Number:

I authorize the following individuals to collect my child from the facility in case of emergency or if I cannot be contacted:

Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:
Name:	Contact Telephone Number:

If Medical care is necessary, call:

Health Care Provider*	Name:	Contact Telephone Number:
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*A Health Care Provider is a physician, physician assistant or registered nurse practitioner.

I hereby give authority to any hospital or doctor to render immediate aid as might be required at the time for his/her health and safety. It is understood by me that the expense of this service will be accepted by me.

In case of injury or sudden illness, I request that this individual be called first:

Does your child have insurance coverage? No Yes Name of Insurance Company:

The following individual(s) may NOT remove my child from the facility:

Name(s):

Custody papers have been provided and are on file at the facility. yes no

Telephone Authorization Code (optional): _____

Immunization Information

(A licensee shall attach an enrolled child's written immunization record or exemption affidavit to the enrolled child's Emergency, Information and Immunization Record card.)

For information regarding current immunization requirements go to:

www.azdhs.gov/phs/immun/index.htm or contact the Arizona Immunization Program Office at (602)364-3630.

One of these items must accompany the EIIR card at all times:

<input type="checkbox"/>	Copy of current official documented immunization record attached
<input type="checkbox"/>	Religious Beliefs exemption form signed by parent/guardian attached
<input type="checkbox"/>	Medical Exemption form signed by physician and parent/guardian attached
<input type="checkbox"/>	Signed Laboratory Proof of Immunity form attached

Notification of immunizations needed sent to Parent(s) or Guardian(s):	mo /day/ yr	mo /day/ yr	mo /day /yr
Updated immunizations received and attached:	mo /day/ yr	mo /day/ yr	mo /day /yr

Medical Information

<p>Is child allergic to food or other substances? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, describe symptoms, name foods or substances to be avoided, and the procedure to follow if reaction occurs:</p>
<p>Is child usually susceptible to infections and if so, what precautions need to be taken? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Is child subject to convulsions and what should be our procedure if one occurs? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, specify procedure:</p>
<p>Is there any physical condition that we should be aware of and what precautions should be taken (heart trouble, foot problem, hearing impairment, hernia, etc.)? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>If yes, list precautions:</p>
<p>Additional comments:</p>
<p>Other special instructions:</p>

This **Emergency Information and Immunization Record Card** is accurate and complete, front and back, and was provided by:

Parent/Guardian PRINTED Name:	SIGNED Name:	DATE:
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District Offices

480.279.7000
480.279.7005 Fax

2935 S. Recker Road
Gilbert, AZ 85297

www.husd.org

Dear Parent(s)/Guardian(s),

We would like to provide you with important information regarding our school health offices. This information allows us to provide consistency in the care of your children.

- **Fever/Temperature:** Please keep your child home if they have a temperature of 100 degrees or higher. They may return to school after being fever-free for at least 24 hours without the use of medication.
- **Vomiting and/or Diarrhea:** Please keep your child home until symptom free for at least 24 hours. The child must be able to consume his/her regular diet without any problem.
- **Pink eye:** Your child may return to school after a full 24 hours of antibiotic treatment.
- **Strep throat:** Your child may return to school after a full 24 hours of antibiotic treatment and fever-free.
- **Medications:** Do not send your child to school with medication of any type. All medications must be checked in through the health office. Prescription medications must have a pharmacy label and the medicine cannot be past the expiration date. Over-the-counter medications must be in the original container. A consent form must be completed for ALL medications not listed on the HUSD emergency card.
- **Flip-flops:** Please inspect your child's flip-flops on a regular basis for wear and tear. We cannot repair them. Children must call their parent/guardian from the classroom and hope that they are available to bring another pair of shoes to school.
- **HUSD Lice Policy:** We have a nit-free policy. If your child contracts lice please do not send them to school until they have been treated and all lice and nits are removed from the hair. Please report this condition to the health office. Your child will be examined for lice and/or nits privately in the health office prior to returning to class.
- **Immunizations:** All students must be up to date on their immunizations to attend school per state laws A.R.S. 15-871-874. If you have questions regarding requirements for your child's age and grade level, please contact your school's health office. You can access information regarding FREE immunization clinics at AZ Department of Health Services Website or call the health office and we will send a schedule home with your child. Please make sure to take your child's immunizations records with you to the clinic and then bring proof to the health office so we can update the school record.
- **Water Bottle Donations:** We appreciate any water bottle donations to our school health offices. We also appreciate new packages of boys and/or girls underwear and used pants for the inevitable accidents that occur at school.
- **Passes:** Our goal and highest priority is to take care of your child's health needs and help ensure their safety. With this in mind, school policy is that all students must come to the health office with a pass from their instructor. If a student is sent without a pass they will be sent back to class to get one. The only exception is in the event of an emergency situation. This policy allows staff to know where your child is at all times and provides for your child's safety.

Thank you for your cooperation!

HUSD School Health Offices

Arizona Immunization Requirements for Birth to 5 Years Childcare, Preschool and Kindergarten in 2012

Because children who attend child care are at greater risk of exposure to illness, Arizona state law requires that some immunizations be completed at the beginning of the age range listed on the recommended immunization schedule found at <http://www.cdc.gov/vaccines/recs/schedules>. Exceptions, minimum intervals and a "catch up" schedule are on the back of this handout. Updates to these requirements will be posted at <http://www.azdhs.gov/phs/immun/back2school.htm>.

At birth	Hep B #1 Note: Hep B #1 is the only shot babies under 2 months must have for childcare.			
Required at 2 months	DTaP #1	Polio #1	Hib #1	
Required at 4 months	DTaP #2	Polio #2	Hib #2	Hep B #2
Required at 6 months	DTaP #3	Hib #3 If Pedvax Hib or Comvax is used, the 3rd dose of Hib is not due until 12-15 months of age.		
Required at 12 months	Polio #3	Hep B #3 If Hep B #3 was given before 24 weeks of age, a 4th dose is needed.	MMR #1 Note: MMR and Varicella must be given on the same day or at least 28 days apart.	Varicella¹ #1 (Chicken Pox Vaccine) Note: MMR and Varicella must be given on the same day or at least 28 days apart.
Required at 15 months	DTaP #4	Hib #4 (Booster) Hib #4 is not needed if Hib #3 is given at/after 12 months of age. A Hib dose at/after 12 months is required for all children under 5 years. One Hib dose given at/after 15 months of age meets the Hib requirement regardless of the total number of Hib doses received.		
Summary of vaccines required for all children 15 -24 months of age	<u>All</u> of these doses are required as of 15 months of age: 4 DTaP, 3 Polio, 1 MMR, 1 Varicella ¹ , 3 Hep B and 3-4 Hib (with 3 rd or 4 th dose on/after 1st birthday) or 1 Hib dose given at/after 15 months. (Hepatitis A is required for 1 through 5 year olds in Maricopa County only.)			
Summary of vaccines required for all children 2 - 5 years of age	Must have 4 DTaP, 3 Polio, 1 MMR, 1 Varicella ¹ , 3 Hep B and 3-4 Hib (with 3 rd or 4 th dose on/after 1st birthday) or 1 Hib dose given at/after 15 months. (+2 doses of Hepatitis A in Maricopa County only.)			
5+ years in kindergarten	At <u>kindergarten entry</u> must have 5 DTaP*, 4 Polio*, 2 MMR, 1 Varicella ¹ & 3 Hep B. (Hepatitis A is not required for kindergarten.) *Children who received DTaP #4 and/or Polio #3 on/after the 4th birthday do not need additional doses to enter kindergarten.			

¹ Parental recall of chicken pox disease is accepted only for children who enrolled in childcare before 9/1/2011.

Exceptions and Additions To The Rules

Parents whose religious beliefs do not allow immunization must sign a **religious exemption** form. A **medical exemption** form must be signed by the child's doctor if there is lab evidence of immunity or a medical reason why the child cannot receive shots. A copy of the lab results must be kept on file to prove the child's immunity.

- A child who is missing shots required for his age can start childcare but must get a dose of each shot due within 15 days of enrollment *and* bring a copy of the shot record completed by the clinic to the child care setting. **After 15 days, the child may not attend without documentation of these shots.**

- **CATCH UP SCHEDULE** for children missing immunizations:

DTaP: The 2nd dose is due 1-2 months after the 1st dose; the 3rd dose is due 1-2 months after the 2nd dose; the 4th dose is due 6 months after the 3rd dose.

Polio: The 2nd dose is due 1-2 months after the 1st dose; the 3rd dose is due 1-2 months after the 2nd dose. (If the child is 4+ years of age, the 3rd Polio may qualify as the child's final dose and a 6-month space is recommended between the last two Polio doses.)

Hep B: The 2nd dose is due 1-2 months after the 1st dose; the 3rd dose is due 3-4 months after the 2nd dose. If Hep B #3 was given before 24 weeks of age, a 4th dose is needed.

Hib: If child is less than 1 year, doses are given 2 months apart. If child is at least 15 months old and less than 5 years, a single dose is needed to catch up.

MMR*: The 1st dose is required at 12 months of age. A 2nd dose is required for kindergarten entry.

Varicella*: The 1st dose is required at 12 months of age. **Parental recall of chicken pox disease is accepted only for children who enrolled before 9/1/2011. All other children must have proof of immunization, or a valid exemption for lab evidence of immunity, medical reasons or religious beliefs.**

Hep A: Children 1 through 5 years of age in Maricopa County only are required to obtain dose #1 within 15 days of enrollment in child care, preschool or Head Start. Dose #2 is due 6 months after dose #1.

- Children who are missing required shots must stay on the above "catch up" schedule to attend childcare. A 15-day notice must be given to parents whose children fall behind. If they do not provide proof of shots after 15 days, the child must be excluded from care until proof is given.
- What **proof of immunization** is needed? Copies of shot records signed or stamped by the health care provider, and/or records from the Arizona State Immunization Information System (ASIIS) must be kept on file at the childcare facility.

***Important note:** MMR and Varicella may be given on the same day. If they are not given on the same day, they must be separated by at least 28 days.

Higley Unified School District
Early Childhood Program Registration
2014-2015



Enrollment Date _____

Start Date _____

Choose one:

North Campus _____

South Campus _____

Elona P. Cooley Early Childhood Development Center

Sue Sossaman Early Childhood Development Center

Child Information:

Last Name _____ First _____ Middle _____

Address _____ City _____ Zip _____

Birth Date _____ (Must be 3 years-old and potty trained)

Does Child Have an IEP? (Documents must be provided to Community Education prior to admission to program) Yes _____ No _____

Parent/Guardian:

Name _____ Relationship to Child _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Employer Address _____

Email Address _____

Spousal Information (if applicable):

Name _____ Relationship to Child _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Employer Address _____

Email Address _____

Program Options and Tuition: (All prices monthly)

*****Brilliant Beginnings (3 years old and early 4's)***
Students must be potty trained.**

Half Day Programs:

2 days (T/Th) \$110_____ 3 days (M/W/F) \$165_____ 5 days (Monday to Friday) \$275_____

AM section _____ PM section _____



Full Day Programs p.m.:

2 days (T/Th) \$210_____ 3 days (M/W/F) \$315_____ 5 days (Monday to Friday) \$525_____



*****Kindergarten Prep (4 and 5 years old)***
Students must be potty trained.**

Half Day Program:

5 days (Monday to Friday) \$275_____

AM section _____ PM section _____



Full Day Program:

5 days (Monday to Friday) \$525_____



Non-refundable Registration Fee: \$50.00 per child

HUSD Employee Discount: 20% per child

Sibling Discount: 10% per Sibling

Discounts may not be combined

Enrollment Agreement:

I, _____, certify that I am the legal guardian of _____
_____. I understand that only the legal guardian may make changes to this agreement and that **all change requests require a Program Change Request form that must be submitted by the 15th day of the month prior to the effective date and will incur a Program Change Fee (if applicable). I understand that I will be assessed one month tuition if not submitted in the required time frame.** I further certify that a Financial Agreement has been completed regarding the payment of this account and that my child may be removed from the program if the terms of the financial agreement are violated.

I agree that my child will be asked to comply with all program rules and expectations. Violations of such rules may result in my child not being allowed to continue attending should the program determine the behavior(s) poses a safety risk to my child, peers, or program staff, or if it is determined that the child's behavior cannot be safely managed within the program.

Signature: _____ **Date:** _____

Optional:

I hereby grant my permission for my child's photograph to be taken at Brilliant Beginnings, STARS or Kindergarten Prep for purposes of brochures, newspaper articles and/or news releases. Use of these images will be at the discretion of Community Education administration.

Signature: _____ **Date:** _____

Sibling(s) Name _____

Other Program(s) _____

Discount Schedule	
<u>Only one discount applies</u>	
<u>(whichever is greater)</u>	
<input type="checkbox"/>	20% Employee Discount (Legal Guardian Only)
<input type="checkbox"/>	10% Sibling Discount
_____	Total Tuition
_____	% Discount
_____	Total Due

Any family removing a child from the program or making a change for the upcoming month must complete and submit a PROGRAM CHANGE REQUEST FORM by the 15th of THE CURRENT MONTH to avoid paying further monthly charges.

*****REMEMBER: Payments are due by the 4th of EACH MONTH to avoid late payment fees.***

Financial Agreement

Legal Guardian name: _____

Child enrolling: _____

Program(s) enrolling: _____ Total Fee: _____

Child enrolling: _____

Program(s) enrolling: _____ Total Fee: _____



Please read and initial beside each item:

Tuition and Monthly Fees:

- ___1. I understand that the tuition is due the 1st of each month beginning July 1st. The second payment is due September 1st and then the first of each month throughout the school year.
- ___2. I understand that the tuition is delinquent if not paid by 4:00 PM on the 4th day of each month, a fee of \$25 per child will be assessed.
- ___3. I understand that there is no refund or credit for unused program days.
- ___4. I understand that if, at any time the account becomes delinquent, the contract will be terminated and the child removed from the program without regard to multiple financially responsible parties.
- ___5. I understand that if the bank returns my check to Community Education for any reason, I will be assessed a returned check fee as listed below and that I will be required to provide cashier's check or money order for all future financial transactions with Community Education. **Additional collections will be processed through the District agreement with CCM Enterprises**

Additional Fees:

- ___1. I understand that the following fees will be assessed to my account based upon the criteria listed in relation to said fees and that I will be held financially responsible for the payment of these fees. I understand that all fees are non-refundable and non-transferable.
 - \$25.00 per child Late Payment fee - assessed if tuition is not paid to the Community Education Office by 4:00 PM on the 4th day of each month.
 - \$25.00 Reinstatement fee - assessed to each child previously terminated and requesting to re-enter the program, space permitting. (Payable upon registration)
 - \$2.00/minute Late Pick-Up fee - assessed to the account for any child picked up after contracted program end time. (This is a per child fee as stipulated in the handbook)
 - \$25.00 Returned Check fee - assessed to checks returned to Community Education for any reason.

Procedure Agreements:

- ___1. I will read the HUSD Early Childhood Program Parent Handbook and abide by the terms and conditions.
- ___2. I understand that if I wish to make changes to my child's program, I must do so by the 15th of the month prior to the changes taking effect. A change request form is required. Changes become effective on the first business day of the following month.

I, _____, certify that I have read, understand, and received
(please print legal name)

a copy of the conditions, regulations, and stipulations contained herein. I agree to the Financial Terms and Conditions as listed above.

(Signature of Financially Responsible Party)

(Date)



Early Childhood Program AUTO-PAY Authorization



This form will enable HUSD Community Education to charge your Visa or MasterCard for your monthly HUSD Early Childhood Program tuition payment. **PLEASE PRINT**

Name of Child/Children _____

Cardholder name _____
(as it appears on card)

Cardholder billing address _____

Cardholder daytime telephone number _____

Please circle appropriate card: Visa MasterCard

Card number _____ Security # _____

Exp. Date _____

PROGRAM ENROLLMENT

Brilliant Beginnings (3 years old and early 4's)

Half Day Programs: 2 days (T/Th) \$110 _____ 3 days (M/W/F) \$165 _____ 5 days (Monday - Friday) \$275 _____

Full Day Programs: 2 days (T/Th) \$210 _____ 3 days (M/W/F) \$315 _____ 5 days (Monday to Friday) \$525 _____



Kindergarten Prep (4 and 5 years old)

Half Day Program: 5 days (Monday to Friday) \$275 _____

Full Day Program: 5 days (Monday to Friday) \$525 _____

Month starting is _____

If your card is declined two times for any reason, you will no longer be eligible for our auto-pay program.

I hereby authorize Higley Unified School District #60/Community Education to automatically charge the above card for stated monthly tuition payment amount the first week of each month. This recurring charge authorization is limited to the tuition payment for each month during the period of July 1, 2014 and September 1, 2014 to May 1, 2015. **Cardholder is responsible for updating the credit information used for this service.** The cardholder may terminate this service at any time upon written notice to HUSD Community Education.

Cardholder signature _____

Should you have any questions, please call (480)-279-7055 or (480) 279-7034.

Please mail or deliver to:

Community Education
Higley Unified School District
3333 E. Vest Avenue, Building A,
Gilbert, AZ 85295

Higley Unified School District Early Childhood Extended Care Registration

Enrollment Date _____ School _____ Start Date _____

Child Information:

Last Name _____ First _____ Middle _____

Address _____ City _____ Zip _____

Birth Date _____

Does Child Have an Individual Educational Plan? (Document must be provided to Community Education prior to admission to program) Yes _____ No _____

Parent/Guardian:

Name _____ Relationship to Child _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Employer Address _____

Email Address _____

Spousal Information (if applicable):

Name _____ Relationship to Child _____

Address (if different than child) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Employer Address _____

Program Registration Information: (All prices monthly)

Program Options	<u>2 days</u>		<u>3 days</u>		<u>5 days</u>	
Available for AM or Full day	___AM	\$70	___AM	\$95	___AM	\$150
Available for PM or Full day	___PM	\$120	___PM	\$140	___PM	\$230
Available for Full day only	___AM/PM	\$180	___AM/PM	\$210	___AM/PM	\$340

Daily Drop In Rate: \$30

Registration Fee: \$25.00 (annual fee)

H.U.S.D. Employee Discount: 20% per Child

Sibling Discount: 10% per Sibling