Northern Lights School

A school inspired by the Waldorf curriculum. We engage the mind, ignite the imagination and strengthen the will of our children to help them develop initiative, creativity and life skills. These build the foundation for future academic and life success.

Admissions Procedures

- Submit the enclosed application and all forms.
- We will confirm receipt of your application. An administrator will contact you and your spouse/partner to arrange a classroom visit if you wish so.
- Tuition assistance application must be submitted with enrollment application.

Admissions Policy

Children eligible for nursery and preschool classes must be between ages 18 months and 6 years old. Infant care, starting at 6 months of age is pending approval of NYS Office of Children and Family Services. The teachers will assess each child's readiness for the program. Parents should be in agreement with and supportive of the school's philosophy and understand the basic tenets of Waldorf education from which we receive inspiration for our programming. For your child to gain the most benefit from their education, it is important that you support the work that the teachers have begun at school.

As a small private school without access to all of the services of a public school, we are able to meet the needs of children with a normal range of intellectual, emotional, and physical needs. All evaluations, Individual Education Plans (IEP), and other concerns should be submitted with your application. We are happy to meet with families to assess whether we are able to meet the needs of any children with special requirements and to work with school district to provide any needed services. If it is determined that a child may require services, the child must be enrolled in the public school in order to receive and evaluation even though they are not attending the public school.

The Northern Lights School seeks to develop a culturally and economically diverse faculty, student body, and community. We will take active measures to ensure against discrimination in admissions, employment, recruitment, compensation, termination, promotion, and other conditions of employment against any employee or job applicant on the basis of race, creed, color, national origin, religion, sexual orientation, or gender identity.

Dear Parents:

In order to ensure the health and safety of all children the following forms are required to be completed before a child can be enrolled in school.

- Authorization for the Medical Treatment of Minors (Requires parent signature and a witness.)
- A Child in Care Medical Statement signed by your child's physician (Must have been completed within the past year.)
- A copy of your child's Immunization Record (No religious exemption are accepted at this time, only a Medical Exemption).
- Any Individual Education Plans (IEP's) or other health/social development issues need to be disclosed before admission so that we can make the best plan possible for the success of the child.

If you have further questions, please do not hesitate to contact the school office at 518-891-3206. Thank you!

Authorization for the Medical Treatment of Minors

If your child needs medical, dental, health or hospital services, under the law, you, as a parent, must give permission. Naturally, if you are with your child, you can give permission as the need arises. You can prepare for those unexpected times when you are not with your child by filling out this form. Your signature on this form authorizes other adults to make decisions about medical treatment for your child in your absence.

This is a legal document. If your child needs unexpected medical treatment, the responsible adult should present this document to the appropriate medical personnel.

When a true emergency arises, a child may be treated without parental consent. This happens when a physician determines that immediate medical care is needed and any delay might increase the risk to the child's health or life.

Name of Student:
DOB:
Known Allergies:
Special Conditions:
Date of last tetanus shot:
Current Medications (Please list all):
Medical Insurance ID (Group/Individual):
Student Physician Name:
Physician Phone #:
Physician Address :

I, being the parent of custody or legal guardian of the above named minor, do hereby appoint the following representative to act on my behalf in authorizing unexpected medical, dental, or surgical care, and /or hospitalization for the above named minor in my absence.

Representative/Employee of Northern Lights School: PO Box 228, Saranac Lake, NY 12983 (518) 891-3206

_____	_____
Signature of parent/guardian	Signature of Witness
Date_____	Date_____
Address_____	Address_____
Phone_____	Phone_____

This form is valid from 3/1/20- 8/30/21

EMERGENCY CARD: SY2020–2021

Child's Name:_____

DOB:_____ Weight:_____

Allergies: _____

Parent 1 Name:_____

Daytime Phone:_____

Cell Phone:_____

Parent 2 Name:_____

Daytime Phone:_____

Cell Phone:_____

Who is authorized to pick up child? (Please provide name & relationship):

1._____

2._____

3._____

Emergency contacts listed are required to be available to pick up the child from school at any time during our hours of operation for any reason, including but not limited to health, safety, or behavioral situations. Non-compliance with this policy could result in school dismissal. Emergency name and daytime phone:

1._____

2._____

3._____

Physician name & Contact Information:

Telephone: _____

Address: _____

Dentist name & Contact Information:

Telephone: _____

Address: _____

NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD IN CARE MEDICAL STATEMENT

To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner

Name of Child:	Date of Birth:	Date of Examination:

Immunizations required for entry into day care ☐ Yes ☐ No

Please attach immunization records (up to date within the last 12 months)

Medical Exemption The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

Tests

Tuberculin Test Date: __/__/_____ Mantoux Results: ☐ Positive ☐ Negative _____ mm

TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: __/__/_____

Attach lead level statement

Lead Screening (Include All Dates and Results)

1 year __/__/_____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

2 years __/__/_____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Most recent date of lead screening (if different from above):

__/__/_____ Result: _____ mcg/dL ☐ Venous ☐ Capillary

Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely. If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

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Health Specifics

		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental conditions requiring special attention?	☐ Yes ☐ No	

Summary of Physical Exam

Include special recommendations to child day care providers

On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) Phone

Date

Media Authorization: SY2020-2021

I understand that my child may be photographed/videotaped for educational and publicity purposes.

I understand that these images/recordings may be used:

- as a part of advertising community events, festivals, or
- printed in the newspaper or flyers to be hung at local business and brochures,
- posted on the internet (including, but not limited to, the Northern Lights School website, Instagram, and Facebook.)

Photographs/videos will be used both during the time that the child is an enrolled student at Northern Lights School and after withdrawal from the school, unless specified in writing from the child's parent or guardian. Please indicate if you do not authorize this by writing "No thank you"

_____ _____

Media Authorization Parent Signature Date

Napping Management Form: SY2020-2021

I, (parent name)_____, understand that my child, _____, while under the care of Northern Lights School, will rest in a pack and play in the classroom. Older children often fall asleep in their rest tents on the floor out of foot traffic during rest time.

My napping child will have competent supervision at all times, either through direct supervision by a caregiver who is in the same room and has direct visual contact with him/her, or indirect supervision by a caregiver who uses a functioning electronic monitor that remains on or near the caregiver my child at all times. Please add any additional information we should be aware of below.

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NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES **Non-medication Consent Form**

PARENT TO COMPLETE THIS SECTION (#1 - #14)

1.Child's first and last name:	2. Date of birth:	3.Child's known allergies:
4. Name of product (including strength): School chosen natural sunscreen and bug spray	5. Amount to be administered:	6. Route of administration:

7A. Frequency to be administered, include times of day if appropriate: _____

OR

7B. Identify the conditions that will necessitate administration of the product (signs and symptoms must be observable prior to administration): _____

8A. Possible side effects: ☐ See product label for complete list of possible side effects (parent must supply)

AND/OR

8B: Additional side effects: _____

9. What action should the child care provider take if side effects are noted:

☐ Contact parent _____

Other (describe): _____

10A. Special instructions: ☐ See package insert for complete list of special instructions (parent must supply)

10B. Additional special instructions: _____

11. Reason(s) for use (unless confidential by law): _____

12. Parent name (please print):	13. Date authorized:

14. Parent signature:

X

15. Program name:	16. Facility ID number:	17. Program telephone number:
Northern Lights School	790466	518.891.3206

18. I have verified that #1, -#14 are complete. My signature indicates that all information needed to administer this product has been given to the child day care program.

19. Staff's name (please print): Staff signature:	20. Date received from parent:
Polly Kelting	