Stafford Primary School

"world-class education...small school setting"

S.P.A.R.T.A. Academy

(**S**partan **P**re-Schoolers **A**re **R**eady **T**o **A**chieve **A**cademy)

2019-2020
APPLICATION

Providing Child Care Services for District Employees in an Inclusion Setting

Updated 05/2018

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S.P.A.R.T.A. Academy
Application 2019-2020

APPLICATION DEADLINE: August 1, 2019

S.P.A.R.T.A. Academy is a collaborative pre-school/inclusion program for children of Stafford MSD and City of Stafford employees in the Pre-school Program for Children with Disabilities (PPCD).
Children of Stafford MSD staff who are ages 3 or 4 are eligible for application to S.P.A.R.T.A. Academy. Students must be 3 years old, on or before September 1st in the current school year, and have no special Education disability, including speech.

Registration Documents:

- ✓ Birth Certificate
- ✓ Social Security Card
- ✓ Current Immunization Card

S.P.A.R.T.A. Academy Campus: Stafford Elementary School DATE: _____

Child's Home District: _____

Child's Home Campus: _____

Child's Name: _____ Child's DOB: _____

Parent(s) or Guardian's Name(s): _____

Parent's District Employment Assignment: _____
(Position and location)

Home Address: _____

Contact phone numbers:

_____	_____	_____
Parent/Guardian Work	**Home**	**Pediatrician**
_____	_____	_____
Parent/Guardian Work	**Cell (Parent/Guardian)**	**Emergency Contact**

For enrollment in the S.P.A.R.T.A. Academy students are required to be FULLY potty trained.

Is your child FULLY potty trained? Yes No

Does your child currently receive any special education services? Yes No

Office use only.
Date application received by office: _____ Application received by: _____
(Initials)

*05/2018

REQUEST FOR FOOD ALLERGY INFORMATION

This form allows you to disclose whether your child has a food allergy or severe food allergy that you believe should be disclosed to the District in order to enable the district to take necessary precautions for your child's safety.

"Severe food allergy" means a dangerous or life-threatening reaction of the human body to a food-borne allergen introduced by inhalation, ingestion, or skin contact that requires medical attention.

Please list any foods to which your child is allergic or severely allergic, as well as the nature of your child's allergic reaction to the food.

Food:	Nature of allergic reaction to the food:

The District will maintain the confidentiality of the information provided above and may disclose the information to teachers, school counselors, school nurses, and other appropriate school personnel only within the limitations of the Family Educational Rights and Privacy Act and District policy.

_____ _____ _____

Student Name Date of Birth Grade

_____ _____ _____

Parent/Guardian Name Work Phone # Cell Phone #

_____ _____

Parent/Guardian Signature Date

Office use only.

Date form was received by the school: _____.

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STUDENT HEALTH HISTORY

Student Name_____ Grade_____ Date of Birth_____

Please circle the appropriate number if any of the following conditions apply to the student and give a brief explanation in the space provided below. **This information may be shared with the appropriate personnel on a need to know basis.**

1 Allergy-Bee Sting (requiring Epi-Pen)
2 Allergy-Medication (list below)
3 Allergy-Seasonal or Environmental
4 Anemia
5 Arthritis
6 Asthma
7 Birth Defect/Chromosome Disorder
8 Blood Disorder
9 Refusal of Blood/Blood Products
10 Cancer/Leukemia
11 Cerebral Palsy
12 Color Blindness
13 Cystic Fibrosis
14 Diabetic
15 Eating Disorder (explain)
16 Endocrine Disorder
17 Epilepsy/Seizures
18 Growth Disorder (explain)
19 Hearing Loss (which ear? _____)
20 Hearing Aid Used
21 Heart Disease/Defect
22 Hemophilia
23 Hyperactive: ADD or ADHD (requires medication)
24 Kidney Disorder (explain below)
25 Medication Prescribed (list below)
26 Medication needed at school (list below)
27 Menstrual cramps (severe)
28 Migraine Headaches
29 Muscular Dystrophy
30 Nose Bleeds (frequent)
31 Osgood-Schletter Disease
32 Physical Activity Limitations (requires doctor's note)
33 Rheumatic Fever History
34 Scoliosis
35 Sickle Cell Anemia
36 Speech Problem
37 Tuberculosis
38 Ulcer
39 Vision Impairment (wears glasses/contacts)
40 Vision Impairment (blind)
41 Other (explain below)
42 **No Health Problems**

Explain:

_____

_____

_____

Complete if applicable:

This to verify that _____ had varicella disease (chicken pox) on or about _____and does not need varicella vaccine.

_____ _____ _____

Signature **Relationship to Student** **Date**

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Payroll Deduction
2019-2020

I, _____, authorize Stafford MSD payroll department to deduct $200.00 from my bi-monthly paycheck for the 20 pay periods between September 2019 and June 2020. (Ten month-deduction schedule from September 2019 to June 2020).

This is payment for tuition for the S.P.A.R.T.A. Academy Program.

Child enrolled in S.P.A.R.T.A. Academy: _____

Program start date: August 3, 2019 (date returning Staff report)

Employee Social Security Number: _____

Parent/Guardian's District Employment Assignment: _____
(job title, location)

Employee Signature: _____ Date _____

S.P.A.R.T.A. Academy Principal Signature: _____ Date _____

*05/2018

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S.P.A.R.T.A. Academy Program Agreement

2019-2020

I understand that enrollment in S.P.A.R.T.A. Academy is considered a district benefit, and agree to work collaboratively and positively with the S.P.A.R.T.A. Academy campus and S.P.A.R.T.A. Academy team. I agree to the terms of this Agreement.

_____ _____

Child's Name Parent/Guardian Signature

_____ _____

Principal Signature Date

For Office Use: _____ New Student _____Returning student

*05/2018

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Registration Checklist
2019-2020

Name of Child _____

Date of Birth _____

1. **____ Parent's employment assignment _____**
2. **____ Birth Certificate (verify birth date)**
3. **____ Social Security Card of the child**
4. **____ Current immunization records**

Attach all forms listed below to the cumulative folder and place this form on top.

****

1. **____ Locator Card (Make sure both sides must be complete and signed by parent). Write "S.P.A.R.T.A. Academy" in the top corner. Transportation to and from school should be noted on the back of the card.**
2. **____ Health History**
3. **____ Cumulative Folder (Make sure name and grade are on folder)**
4. **____ Parents and Principal sign the S.P.A.R.T.A. Academy Program Agreement**
5. **____ Parents complete Payroll Authorization Form.**
6. **____ Send Payroll Authorization form to the Payroll Specialist, in the SMSD Business Office, to institute payroll deduction. Keep a copy on campus.**
7. **____ Place cumulative folder in PPCD grade level box**

*05/2018