PRESCHOOL REGISTRATION

WELCOME TO CBRSD PRESCHOOL!

Dear Incoming Preschool Families:

We are excited to welcome you to Preschool at Central Berkshire Regional School District! Please find important information below for registering your child in one of our preschool programs. At Central Berkshire, our vision for your preschooler is to provide a stimulating environment that nurtures and embraces the whole child; allowing each child to reach their fullest potential.

SCREENING, REGISTRATION, AND A VIRTUAL WELCOME

Preschool registration is available online this year. As you scroll down, you will see a list of documents that need to be completed remotely and those that must either be attached in an email, mailed, or delivered to your child's preschool location in August. The CBRSD Preschool Registration Form and the Home Language Survey can be completed remotely on this site. The health record, immunization form, and birth certificate must either be attached in an email and addressed directly to the school's administrative assistant, mailed, or brought to the school office in August. Please see below for a checklist of required forms and ways that you can get these to us.

We will send you a date and time for a "Preschool Welcome" for each school in late spring.

Please contact the building principal if you have any questions about enrolling your child in CBRSD Preschool. We are looking forward to welcoming you and your preschooler in September!

ORIENTATION AND THE FIRST DAY OF SCHOOL

Preschool orientation is scheduled for August 31, 2021. This will be a drop-in session that is designed for you and your child to get to know the teacher and become familiar with the classroom setting.

Again, we are looking forward to welcoming your incoming preschooler!

Sincerely,

Leslie Blake-Davis
CBRSD Superintendent

Central Berkshire Regional School District, in accordance with its non-discrimination and zero tolerance policy, does not discriminate in its programs, activities, facilities, employment, or educational opportunities on the basis of race, color, age, disability, sex, religion, national origin, sexual orientation, homelessness, veteran status, or gender identity and does not tolerate any form of discrimination, intimidation, threat, coercion and/or harassment that insults the dignity of others by interfering with their freedom to learn and work. [M.G.L. c.76, s5]

SCHOOL INFORMATION

Becket Washington School
12 Maple St., Becket MA 01223
Website: *http://cbrsdbecket.ss10.sharpschool.com/*
Principal: MaryKay McCloskey/mmccloskey@cbrsd.org
Administrative Assistant: Ronda Bilodeau/rbilodeau@cbrsd.org

Kittredge School
80 Maple St.,Hinsdale, MA 01235
Website: *http://cbrsdkittredge.ss10.sharpschool.com/*
Principal: Kathy Buckley/kbuckley@cbrsd.org
Administrative Assistant: Leslee Brennan/lbrennan@cbrsd.org

REGISTRATION CHECKLIST

- ☐ CBRSD Preschool Registration Form/**Online**
- ☐ CBRSD Home Language Survey/**Online**
- ☐ Birth Certificate/**Attach document, mail or bring to school in August**
- ☐ Massachusetts School Health Records

(a) Your doctor will fill out this form when you arrange a physical for your child. The Massachusetts Health Record, when completed, should be returned to the preschool where your child is registering.

(b) At the time of registration, if your child has not yet had his/her physical exam, please inform us of the date of your appointment and the name of the doctor. *The immunization, month and year of each immunization must be recorded on the form by your physician.* /**Attach document, mail, or bring to school in August**

ORIENTATION AND THE FIRST DAY OF SCHOOL

Preschool orientation is scheduled for August 30th. This scheduled session is designed for both families and incoming preschoolers to get to know their teachers and classroom environment.

TUITION

Preschool Payment Information and Rates for 2022-2023

IMMUNIZATION REQUIREMENTS

Childcare/Preschool[¶†]

Attendees <2 years should be immunized for their age according to the ACIP Recommended Immunization Schedule.
Requirements listed in the table below apply to all attendees ≥2 years. These requirements also apply to children in preschool classes called K0 or K1.

Hib	**1-4 doses;** the number of doses is determined by vaccine product and age the series begins
DTaP	**4 doses**
Polio	**3 doses**
Hepatitis B	**3 doses;** laboratory evidence of immunity acceptable
MMR	**1 dose;** must be given on or after the 1st birthday; laboratory evidence of immunity acceptable
Varicella	**1 dose;** must be given on or after the 1st birthday; a reliable history of chickenpox* or laboratory evidence of immunity acceptable

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REQUEST FORM

Parent's Name: ____

Child's Name: ____

DOB: _____________

I would like my child to attend:

- ☐ Becket Washington Preschool
- ☐ Kittredge Preschool

For the 2021-2022 school year I would like my child to attend:

- ☐ **1/2 day AM**
- ☐ **1/2 day PM**
- ☐ **Full day**

I would like my child to attend the preschool program on the following days:

- ☐ **Monday**
- ☐ **Tuesday**
- ☐ **Wednesday**
- ☐ **Thursday**
- ☐ **Friday**

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CERTIFICATE OF IMMUNIZATION

Name: **Date of Birth:** / / **Sex:** M F

Please indicate vaccine type (e.g., DTaP-Hib, etc.)

Vaccine		Date	Vaccine Type	Vaccine		Date	Vaccine Type
Hepatitis B (e.g., HepB, HepB-Hib, DTaP-HepB-IPV, HepA-HepB)	1			**Measles, Mumps, Rubella** (e.g., MMR, MMRV)	1		
	2				2		
	3			**Varicella** (Var, MMRV)	1		
	4				2		
Diphtheria, Tetanus, Pertussis (e.g., DTP, DTaP, DT, DTaP-Hib, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV, Td, Tdap)	1			**Meningococcal Quadrivalent** MenACWY-Conjugate (MCV4) or Polysaccharide (MPSV4)	1		
	2				2		
	3			**Meningococcal Serogroup B (Men B)** MenB-FHbp MenB-4C	1		
	4				2		
	5				3		
	6			**Seasonal Influenza** Inactivated IIV4, IIV4-ID, IIV3, IIV3-ID, IIV3-HD, RIV3-IM, ccIIV3-IM Live Attenuated LAIV, LAIV4 (quadrivalent)	1		
	7				2		
	8				3		
***Haemophilus influenzae* type b** (e.g., Hib, HepB-Hib, DTaP-Hib, DTaP-IPV/Hib, Hib-MenCY)	1				4		
	2				5		
	3				6		
	4				7		
Polio (e.g., IPV, DTaP-HepB-IPV, DTaP-IPV/Hib, DTaP-IPV)	1			**2009 H1N1 Influenza** Inactivated or Live	1		
	2				2		
	3			**Pneumococcal Polysaccharide** (PPSV23)	1		
	4				2		
	5			**Hepatitis A** (HepA, HepA-HepB)	1		
Pneumococcal Conjugate (PCV13, PCV7)	1				2		
	2			**Human Papillomavirus** (9vHPV, 4vHPV, 2vHPV)	1		
	3				2		
	4				3		
Rotavirus (e.g., RV5: 3-dose series, RV1: 2-dose series)	1			**Zoster** (shingles)	1		
	2			**Other:**	1		
	3				2		

Please see next page ➡

CERTIFICATE OF IMMUNIZATION (continued)

Serologic Proof of Immunity		Check One	
Test (if done)	Date of Test	Positive	Negative
Measles	/ /		
Mumps	/ /		
Rubella	/ /		
Varicella*	/ /		
Hepatitis B	/ /		
* Must also check Chickenpox History box.			

Chickenpox History
☐ Check the box if this person has a physician-certified reliable history of chickenpox. Reliable history may be based on: • physician interpretation of parent/guardian description of chickenpox • physical diagnosis of chickenpox, or • serologic proof of immunity

I certify that this immunization information was transferred from the above-named individual's medical records.

Doctor or nurse's name *(please print)*: ______________________ **Date:** / /

Signature: ______________________

Facility name: ______________________

MASSACHUSETTS SCHOOL HEALTH RECORD
Health Care Provider's Examination

Name ______________________ ☐ Male ☐ Female Date of Birth: ______________

Medical History ______________________

Pertinent Family History

Current Health Issues

Y N

☐ ☐ Allergies: Please list: Medications ______________ Food ______________ Other ______________
History of Anaphylaxis to ______________ Epi -Pen®: ☐ Yes ☐ No

☐ ☐ Asthma: Asthma Action Plan ☐ Yes ☐ No (*Please attach*)

☐ ☐ Diabetes: ☐ Type I ☐ Type II

☐ ☐ Seizure disorder: ______________

☐ ☐ Other (*Please specify*) ______________

Current Medications (if relevant to the student's health and safety) *Please circle those administered in school; a separate medication order form is needed for each medication administered in school.*

Physical Examination **Date of Examination:** ______________

Hgt: ________(____%) Wgt: ________(____%) BMI: ________(____%) BP: ________

(Check = Normal / If abnormal, please describe.)

☐ General ______________ ☐ Lungs ______________ ☐ Extremities ______________

☐ Skin ______________ ☐ Heart ______________ ☐ Neurologic ______________

☐ HEENT ______________ ☐ Abdomen ______________ ☐ Other ______________

☐ Dental/Oral ______________ ☐ Genitalia ______________

Screening:

	(Pass)	(Fail)
Vision: Right Eye	☐	☐
Left Eye	☐	☐
Stereopsis	☐	☐

	(Pass)	(Fail)
Hearing: Right Ear	☐	☐
Left Ear	☐	☐

	(Pass)	(Fail)
Postural Screening: (Scoliosis/Kyphosis/Lordosis)	☐	☐

Laboratory Results: ☐ Lead ______ Date ______________ ☐ Other ______________

The entire examination was normal: ☐

Targeted TB Skin Testing: ☐ Med-to-High risk (exposure to TB; born, lived, travel to TB endemic countries; medical risk factors):
TB Test Type: ☐ TST ☐ IGRA Date: __________ Result: ☐Positive ☐Negative ☐Indeterminate/Borderline
Referred for evaluation to: ______________ Date:______ ☐ Low risk (no TB test done)

This student has the following problems that may impact his/her educational experience:

☐ Vision ☐ Hearing ☐ Speech/Language ☐ Fine/Gross Motor Deficit

☐ Emotional/Social ☐ Behavior ☐ Other

Comments/Recommendations: ______________

☐Y ☐ N **This student may participate fully in the school program, including physical education and competitive sports. If no, please list restrictions:** ______________

☐ Y ☐ N **Immunizations are complete: If no, give reason: Please attach Massachusetts Immunization Information System Certificate or other complete immunization record.**

______________________ ______________________

Signature of Examiner *Circle:* MD, DO, NP, PA Date *Please print name of Examiner.*

____

Group Practice Telephone

____

Address City State Zip Code

Please attach additional information as needed for the health and safety of the student. *MDPH 08/15/13*

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH
DIVISION OF COMMUNICABLE AND VENEREAL DISEASES
600 Washington Street
Boston, Massachusetts 02111

SCHOOL IMMUNIZATION LAW

CHAPTER 76, SECTION 15 OF THE GENERAL LAWS OF MASSACHUSETTS

Section 15.

No child shall, except as hereinafter provided, be admitted to school except upon presentation of a physician's certificate that the child has been successfully immunized against diphtheria, pertussis, tetanus, measles and poliomyelitis and such other communicable diseases as may be specified from time to time by the department of public health.

A child shall be admitted to school upon certification by a physician that he has personally examined such child and that in his opinion the physical condition of the child is such that his health would be endangered by such vaccination or by any of such immunizations. Such certification shall be submitted at the beginning of each school year to the physician in charge of the school health program. If the physician in charge of the school health program does not agree with the opinion of the child's physician, the matter shall be referred to the department of public health, whose decision will be final.

In the absence of an emergency or epidemic of disease declared by the department of public health, no child whose parent or guardian states in writing that vaccination or immunization conflicts with his sincere religious beliefs shall be required to present said physician's certificate in order to be admitted to school.