

Faith Preparatory School

600 Danbury Rd. Suite 2

New Milford, CT 06776

www.faithprep.cc

Application for Enrollment---



Application for Enrollment School Year 20__ - 20__

Name of applicant (legal) _____ M _____ F _____
Last first middle

Address _____ Phone _____

_____ Cell Phone _____
City State Zip Code

Alternate phone number where you can be reached during the school day _____

Birth Date _____ Birthplace _____ Grade Applying For _____

Present School _____ Grade _____
Name Address

Applicant's grades have been: below average _____ average _____ above average _____ superior _____

Does applicant attend church? Yes _____ No _____ Name of Church _____

Ethnic Origin _____ Applicant's SS # _____

Family Information:

Father's Name _____ **Employer** _____

Position _____ **Business Phone** _____

Father's E-Mail _____ **Father's Cell Phone #** _____

Does father attend church? _____ **Name of Church** _____

Mother's Name _____ **Employer** _____

Position _____ **Business Phone** _____

Mother's E-Mail _____ **Mother's Cell Phone #** _____

Does mother attend church? _____ **Name of Church** _____

Custody of Child: Mother _____ Father _____ Both _____ Other (explain) _____

*Has applicant been involved in P.P.T or I.E.P conferences? Yes _____ No _____

*Has applicant been diagnosed as having Learning Disabilities? Yes _____ No _____

*Does applicant have and health conditions or physical disabilities that require special attention or may limit full participation in the School's program? Yes _____ No _____

****Please elaborate on a separate sheet of paper if you answered yes to any of the above questions.***

Names of children in the family not applying to Faith Preparatory School:

Name _____ Age _____ School _____

Name _____ Age _____ School _____

Name _____ Age _____ School _____

Person authorized to care for your child if parents cannot be reached

Name _____ Phone # _____ Relationship _____

General Information

How did you hear about Faith Preparatory School? _____

Please give a brief description of your child's strengths and weaknesses. _____

Please explain why you desire a Christian Education for your child.

Parental Statement

I understand that meeting my financial obligation to Faith Preparatory School is essential to keep the school financially sound. If I should become more than 2 months in arrears, it may be necessary for my child to be withdrawn until arrangements can be made to bring my account up to date.

I give permission for my child to take part in school-sponsored activities, sports and field trips. Faith Preparatory School is absolved from liability to my child and myself should an injury occur at school or during after school activities.

I appreciate the standards of Faith Preparatory School, both academic and moral, and will not tolerate profanity, obscenity in word or action, dishonor to God or the Word of God, or disrespect to staff and faculty of Faith Preparatory School. I agree to encourage my child to uphold the high academic standard of the school and support all regulations and academic requirements as per the ***Parent-Student Handbook***. I authorize the school to employ disciplinary action as deemed wise an expedient for the training and welfare of my child.

Faith Preparatory School reserves the right to dismiss any student who fails to comply with the established regulations and standards. I agree to attend all compulsory parent-teacher conferences and will become familiar with all Faith policies as indicated in the ***Parent-Student Handbook***.

Signature of Father

Signature of Mother

Date

Date

TEACHER / PARENT EMERGENCY CONTACT

Child's Name –Last & First Child's Cell Phone Number: Child's E-Mail:	Birth Date: Age: Grade Entering:
Father's Name: Father's Cell Phone Number: Father's Home Phone Number: Father's E-Mail:	Mother's name: Mother's Cell Phone Number: Mother's Home Phone Number: Mother's E-Mail:
Father's Address- Street & City	State & Zip Code
Father's Occupation & Employer Occupation _____ Employer Name _____ Work Phone Number _____	Employer Address:
Mother's Address- Street and City	State & Zip Code
Mother's Occupation & Employer Occupation _____ Employer Name _____ Work Phone Number _____	Employer Address:
If Parent's are separated, with whom does the Child reside? (circle) Father / Mother / Both	Send Mail to: (circle) Father / Mother / Both
Last school attended:	Church you now attend:
EMERGENCY CONTACTS: (relation to child) Name: _____	Relation to Child: Home Phone Number: Cell Phone Number:
Name: _____	Relation to Child: Home Phone Number: Cell Phone Number:
Name: _____	Relation to Child: Home Phone Number: Cell Phone Number:
Child's Physician: Phone Number:	Any Physical Difficulties:

Faith Preparatory School Uniform

Land's End School Uniform Information: School Code: #90002930-7

- **Tops:** Interlocking Polo, Mesh Polo or Feminine Fit Polo in either white or red. You can choose long or short sleeve. These shirts require the embroidered school logo.

- **Pants:** Khaki Chinos purchased from Land's End.

- **Sweaters:** You may choose the Crew neck sweater, V-neck Sweater, Drifter Cardigan or the Drifter Zip-Front Cardigan (most popular with students). The required color is red with the embroidered school logo.

- **OPTIONAL PIECE:** Mid-weight Fleece Jacket in red with the embroidered school logo. Cozy and warm for the winter months.

- **Gym Uniform is four pieces:**
 - ✓ Boys or Girls basic tee in red with school logo
 - ✓ Boys or Girls crew sweatshirt in navy blue with school logo
 - ✓ Boys and Girls – red gym shorts
 - ✓ Boys and Girls sweatpants in navy blue (bottoms have no logo)

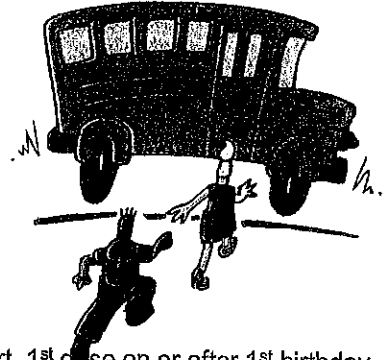
- **Shoes:** Clean, neat, sensible footwear. No heels or backless shoes.



STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

IMMUNIZATION REQUIREMENTS FOR ENROLLED STUDENTS IN CONNECTICUT SCHOOLS 2020-2021 SCHOOL YEAR



PRESCHOOL

- Hep B: 3 doses, last one on or after 24 weeks of age
- DTaP: 4 doses (by 18 months for programs with children 18 months of age)
- Polio: 3 doses (by 18 months for programs with children 18 months of age)
- MMR: 1 dose on or after 1st birthday
- Varicella: 1 dose on or after 1st birthday or verification of disease
- Hepatitis A: 2 doses given six calendar months apart, 1st dose on or after 1st birthday
- Hib: 1 dose on or after 1st birthday
- Pneumococcal: 1 dose on or after 1st birthday
- Influenza: 1 dose administered each year between August 1st-December 31st (2 doses separated by at least 28 days required for those receiving flu for the first time)

KINDERGARTEN

- Hep B: 3 doses, last dose on or after 24 weeks of age
- DTaP: At least 4 doses. The last dose must be given on or after 4th birthday
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday
- MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
- Varicella: 2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
- Hepatitis A: 2 doses given six calendar months apart, 1st dose on or after 1st birthday
- Hib: 1 dose on or after 1st birthday for children less than 5 years old
- Pneumococcal: 1 dose on or after 1st birthday for children less than 5 years old

GRADES 1-6

- Hep B: 3 doses, last dose on or after 24 weeks of age
- DTaP/Td: At least 4 doses. The last dose must be given on or after 4th birthday. Students who start the series at age 7 or older only need a total of 3 doses.
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday
- MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
- Varicella: 2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
- Hepatitis A: 2 doses given six calendar months apart, 1st dose on or after 1st birthday

GRADE 7-8

- Hep B: 3 doses, last dose on or after 24 weeks of age
- Tdap/Td: 1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday
- MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
- Varicella: 2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
- Hepatitis A: 2 doses given six calendar months apart, 1st dose on or after 1st birthday
- Meningococcal: 1 dose

GRADES 9-12

- Hep B: 3 doses, last dose on or after 24 weeks of age
- Tdap/Td: 1 dose for students who have completed their primary DTaP series. Students who start the series at age 7 or older only need 3 doses of tetanus-diphtheria containing vaccine, one of which must be Tdap
- Polio: At least 3 doses. The last dose must be given on or after 4th birthday
- MMR: 2 doses separated by at least 28 days, 1st dose on or after 1st birthday
- Varicella: 2 doses separated by at least 3 months-1st dose on or after 1st birthday; or verification of disease. 28 days between doses is acceptable if the doses have already been administered.
- Meningococcal: 1 dose

- DTaP vaccine is not administered on or after the 7th birthday.
- Tdap can be given in lieu of Td vaccine for children 7 years and older unless contraindicated.
- Hib is required for all Pre-K and K students less than 5 years of age.
- Pneumococcal Conjugate is required for all Pre-K and K students less than 5 years of age.
- Hep A requirement for school year 2020-2021 applies to all Pre-K through 8th graders born 1/1/07 or later.
- Hep B requirement for school year 2020-2021 applies to all students in grades K-12.
Spacing intervals for a valid Hep B series: at least 4 weeks between doses 1 and 2; 8 weeks between doses 2 and 3; at least 16 weeks between doses 1 and 3; dose 3 must be administered at 24 weeks of age or later.
- Second MMR for school year 2020-2021 applies to all students in grades K-12.
- Meningococcal Conjugate requirement for school year 2020-21 applies to all students in grades 7-12
- Tdap requirement for school year 2020-2021 applies to all students in grades 7-12
- If two live virus vaccines (MMR, Varicella, MMRV, Intra-nasal Influenza) are not administered on the same day, they must be separated by at least 28 days (there is no 4 day grace period for live virus vaccines). If they are not separated by at least 28 days, the vaccine administered second must be repeated.
- Lab confirmation of immunity is **only** acceptable for Hep A, Hep B, Measles, Mumps, Rubella, and Varicella.
- **VERIFICATION OF VARICELLA DISEASE:** Confirmation in writing by a MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

For the full legal requirements for school entry visit:

<https://portal.ct.gov/DPH/immunizations/immunization--Laws-and-Regulations>

If you are unsure if a child is in compliance, please call the Immunization Program at (860) 509-7929.

New Entrant Definition:

*New entrants are any students who are new to the school district, including all preschoolers and all students coming in from Connecticut private, parochial and charter schools located in the same or another community. **All pre-schoolers, as well as all students entering kindergarten**, including those repeating kindergarten, and those moving from any public or private pre-school program, even in the same school district, **are considered new entrants**. The one exception is students returning from private approved special education placements—they are not considered new entrants.

Commonly Administered Vaccines:

<u>Vaccine:</u>	<u>Brand Name:</u>	<u>Vaccine:</u>	<u>Brand Name:</u>
DTaP-IPV-Hib	Pentacel	MMRV	ProQuad
DTaP-HIB	TriHibit	PCV7	Prevnar
HIB-Hep B	Comvax	PCV13	Prevnar 13
DTaP-IPV-Hep B	Pediarix	DTaP-IPV	Kinrix, Quadracel
Hepatitis A	Havrix, Vaqta	Influenza	Fluzone, FluMist, Fluviron, Fluarix, FluLaval Flucelvax, Afluria



State of Connecticut Department of Education

Health Assessment Record



To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form requests information from you (Part 1) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part 2) and the oral assessment (Part 3).

State law requires complete primary immunizations and a health assessment by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physi-

cian assistant, licensed pursuant to chapter 370, a school medical advisor, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to school entrance in Connecticut (C.G.S. Secs. 10-204a and 10-206). An immunization update and additional health assessments are required in the 6th or 7th grade and in the 9th or 10th grade. Specific grade level will be determined by the local board of education. This form may also be used for health assessments required every year for students participating on sports teams.

Please print

Student Name (Last, First, Middle)	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
School/Grade	Race/Ethnicity	<input type="checkbox"/> Black, not of Hispanic origin
Primary Care Provider	<input type="checkbox"/> American Indian/ Alaskan Native	<input type="checkbox"/> White, not of Hispanic origin
	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian/Pacific Islander
		<input type="checkbox"/> Other
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance?	Y N	If your child does not have health insurance, call 1-877-CT-HUSKY
Does your child have dental insurance?	Y N	

* If applicable

Part 1 – To be completed by parent/guardian.

Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Hospitalization or Emergency Room visit	Y	N	Concussion	Y	N
Allergies to food or bee stings	Y	N	Any broken bones or dislocations	Y	N	Fainting or blacking out	Y	N
Allergies to medication	Y	N	Any muscle or joint injuries	Y	N	Chest pain	Y	N
Any other allergies	Y	N	Any neck or back injuries	Y	N	Heart problems	Y	N
Any daily medications	Y	N	Problems running	Y	N	High blood pressure	Y	N
Any problems with vision	Y	N	"Mono" (past 1 year)	Y	N	Bleeding more than expected	Y	N
Uses contacts or glasses	Y	N	Has only 1 kidney or testicle	Y	N	Problems breathing or coughing	Y	N
Any problems hearing	Y	N	Excessive weight gain/loss	Y	N	Any smoking	Y	N
Any problems with speech	Y	N	Dental braces, caps, or bridges	Y	N	Asthma treatment (past 3 years)	Y	N
Family History						Seizure treatment (past 2 years)		
Any relative ever have a sudden unexplained death (less than 50 years old)			Y N			Diabetes		
Any immediate family members have high cholesterol			Y N			ADHD/ADD		

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time.

Is there anything you want to discuss with the school nurse? Y N If yes, explain:

Please list any **medications** your child will need to take in school:

All medications taken in school require a separate Medication Authorization Form signed by a health care provider and parent/guardian.

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian

Date

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation and physical examination

Student Name _____ Birth Date _____ Date of Exam _____

I have reviewed the health history information provided in Part 1 of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider under Connecticut State Law

*Height _____ in. / _____% *Weight _____ lbs. / _____% BMI _____ / _____% Pulse _____ *Blood Pressure _____ / _____

	Normal	Describe Abnormal	Ortho	Normal	Describe Abnormal
Neurologic			Neck		
HEENT			Shoulders		
*Gross Dental			Arms/Hands		
Lymphatic			Hips		
Heart			Knees		
Lungs			Feet/Ankles		
Abdomen			*Postural <input type="checkbox"/> No spinal abnormality <input type="checkbox"/> Spine abnormality: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked <input type="checkbox"/> Referral made		
Genitalia/ hernia					
Skin					

Screenings

*Vision Screening	*Auditory Screening	History of Lead level ≥ 5µg/dL <input type="checkbox"/> No <input type="checkbox"/> Yes	Date
Type: Right Left	Type: Right Left		
With glasses 20/ 20/	<input type="checkbox"/> Pass <input type="checkbox"/> Fail	*HCT/HGB:	
Without glasses 20/ 20/	<input type="checkbox"/> Fail <input type="checkbox"/> Fail	*Speech (school entry only)	
<input type="checkbox"/> Referral made	<input type="checkbox"/> Referral made	Other:	

TB: High-risk group? No Yes PPD date read: _____ Results: _____ Treatment: _____

*IMMUNIZATIONS

Up to Date or Catch-up Schedule: **MUST HAVE IMMUNIZATION RECORD ATTACHED**

*Chronic Disease Assessment:

Asthma No Yes: Intermittent Mild Persistent Moderate Persistent Severe Persistent Exercise induced
 If yes, please provide a copy of the **Asthma Action Plan** to School

Anaphylaxis No Yes: Food Insects Latex Unknown source
Allergies If yes, please provide a copy of the **Emergency Allergy Plan** to School
 History of Anaphylaxis No Yes Epi Pen required No Yes

Diabetes No Yes: Type I Type II **Other Chronic Disease:** _____

Seizures No Yes, type: _____

This student has a developmental, emotional, behavioral or psychiatric condition that may affect his or her educational experience.
 Explain: _____

Daily Medications (specify): _____

This student may: participate fully in the school program
 participate in the school program with the following restriction/adaptation: _____

This student may: participate fully in athletic activities and competitive sports
 participate in athletic activities and competitive sports with the following restriction/adaptation: _____

Yes No Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.
 Is this the student's medical home? Yes No I would like to discuss information in this report with the school nurse.

Signature of health care provider MD / DO / APRN / PA	Date Signed	Printed/Stamped Provider Name and Phone Number
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Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):

State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination Completed by: <input type="checkbox"/> Dentist	Visual Screening Completed by: <input type="checkbox"/> MD/DO <input type="checkbox"/> APRN <input type="checkbox"/> PA <input type="checkbox"/> Dental Hygienist	Normal <input type="checkbox"/> Yes <input type="checkbox"/> Abnormal (Describe) _____ _____ _____ _____	Referral Made: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Risk Assessment <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Describe Risk Factors <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____ </td> <td style="width: 33%; border: none; vertical-align: top;"> <input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____ </td> <td style="width: 34%; border: none;"></td> </tr> </table>			<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____	
<input type="checkbox"/> Dental or orthodontic appliance <input type="checkbox"/> Saliva <input type="checkbox"/> Gingival condition <input type="checkbox"/> Visible plaque <input type="checkbox"/> Tooth demineralization <input type="checkbox"/> Other _____	<input type="checkbox"/> Carious lesions <input type="checkbox"/> Restorations <input type="checkbox"/> Pain <input type="checkbox"/> Swelling <input type="checkbox"/> Trauma <input type="checkbox"/> Other _____					

Recommendation(s) by health care provider: _____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

Signature of Parent/Guardian _____

Date _____

Signature of health care provider	DMD / DDS / MD / DO / APRN / PA / RDH	Date Signed	Printed/Stamped <i>Provider</i> Name and Phone Number
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Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) Note: *Minimum requirements prior to school enrollment. At subsequent exams, note booster shots only.

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP	*	*	*	*		
DT/Td						
Tdap	*				Required 7th-12th grade	
IPV/OPV	*	*	*			
MMR	*	*			Required K-12th grade	
Measles	*	*			Required K-12th grade	
Mumps	*	*			Required K-12th grade	
Rubella	*	*			Required K-12th grade	
HIB	*				PK and K (Students under age 5)	
Hep A	*	*			See below for specific grade requirement	
Hep B	*	*	*		Required PK-12th grade	
Varicella	*	*			Required K-12th grade	
PCV	*				PK and K (Students under age 5)	
Meningococcal	*				Required 7th-12th grade	
HPV						
Flu	*				PK students 24-59 months old – given annually	
Other						

Disease Hx _____
of above (Specify) _____ (Date) _____ (Confirmed by) _____

Exemption: Religious _____ **Medical:** Permanent _____ Temporary _____ **Date:** _____

Renew Date: _____

**Religious exemption documentation is required upon school enrollment and then renewed at 7th grade entry.
Medical exemptions that are temporary in nature must be renewed annually.**

Immunization Requirements for Newly Enrolled Students at Connecticut Schools (as of 8/1/17)

KINDERGARTEN THROUGH GRADE 6

- DTaP: At least 4 doses, with the final dose on or after the 4th birthday; students who start the series at age 7 or older only need a total of 3 doses of tetanus-diphtheria containing vaccine.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Hib: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Pneumococcal: 1 dose on or after the 1st birthday (children 5 years and older do not need proof of vaccination).
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**

GRADES 7 THROUGH 12

- Tdap/Td: 1 dose of Tdap required for students who completed their primary DTaP series; for students who start the series at age 7 or older a total of 3 doses of tetanus-diphtheria containing vaccines are required, one of which must be Tdap.
- Polio: At least 3 doses, with the final dose on or after the 4th birthday.
- MMR: 2 doses at least 28 days apart, with the 1st dose on or after the 1st birthday.
- Meningococcal: 1 dose
- Hep B: 3 doses, with the final dose on or after 24 weeks of age.
- Varicella: 2 doses, with the 1st dose on or after the 1st birthday or verification of disease.**
- Hep A: 2 doses given six months apart, with the 1st dose on or after the 1st birthday. See "HEPATITIS A VACCINE 2 DOSE REQUIREMENT PHASE-IN DATES" column at the right for more specific information on grade level and year required.

HEPATITIS A VACCINE 2 DOSE

REQUIREMENT PHASE-IN DATES

- August 1, 2017: Pre-K through 5th grade
- August 1, 2018: Pre-K through 6th grade
- August 1, 2019: Pre-K through 7th grade
- August 1, 2020: Pre-K through 8th grade
- August 1, 2021: Pre-K through 9th grade
- August 1, 2022: Pre-K through 10th grade
- August 1, 2023: Pre-K through 11th grade
- August 1, 2024: Pre-K through 12th grade

**** Verification of disease:** Confirmation in writing by an MD, PA, or APRN that the child has a previous history of disease, based on family or medical history.

Note: The Commissioner of Public Health may issue a temporary waiver to the schedule for active immunization for any vaccine if the National Centers for Disease Control and Prevention recognizes a nationwide shortage of supply for such vaccine.

Parents,

In effort to promote communication between the school and home, the administration of Faith Preparatory School asks that you and your child read this handbook and Honor Code Pledge; sign below and return to the school office.

HONOR CODE PLEDGE

All Faith Preparatory students are required to sign the school's honor code pledge. In accordance with the scriptural principle of a public declaration of faith, this pledge acknowledges that FAITH students agree to exhibit Christian Character, both in school and away from it. Implicit in this pledge is an understanding that the student is willing to be held accountable to that standard in all facets of life.

As a born again Christian, I recognize Jesus Christ as the author and finisher of my faith, and the Bible as the supreme standard for all wisdom and knowledge; it is my aim to follow the will of God for my life by my Christ-like character. I will endeavor to faithfully follow the call of God on my life and develop the gifts and abilities God has given me by prayer, study, and worship.

I will apply myself to my studies and attempt to develop the full powers of my mind in Christ.

I will practice a lifestyle of good health habits and wholesome physical activities and will not damage my body through the use of drugs, alcohol or nicotine.

I will yield my personality to the healing and molding power of the Holy Spirit.

I will seek to share the love of Christ with my community through personal witness and Christian service.

I will learn to accept all school policies with a positive attitude and discourage the habit of being a negative and discontent person.

I will refrain from being disrespectful, irresponsible, or destructive in my attitude towards both students and teachers and will not use profanity, offensive slang, vulgarity and foolish jesting, or rivalry.

I will maintain a high personal code of honor and will not tolerate cheating, lying, or stealing either in myself or in others.

I will submit myself to the leadership of Faith Prep and its rules. I determine to give my best and prayerfully support Faith Prep and its philosophy of providing a quality education without compromising the Word of God.

I understand that following the code will require courage consistency, conviction, diligence, and genuine enthusiastic effort BUT I can do all things through Christ who strengthens me!

I have read and understand the contents of this handbook and I am willing to meet the standards set forth in the school's Honor Code Pledge.

Parent Name _____

Signature _____

Student Name _____ Grade _____

Signature _____

Electronic Devices Permission Slip

Dear Parents,

At your request we will permit your child to bring in their electronic devices (I-pad, laptop-reader etc...) to assist them with their academics.

I give my son/daughter _____ permission to bring their electronic devices to school.

I understand that the school is not responsible for it, if it is lost or damaged.

The rules for the use of electronic devices are:

1. No accessing the public (wireless) internet.
2. It is to be used for school only.
3. The use of this device is at the teacher's discretion.
4. It is a privilege to use it not a right.
5. They are not permitted to allow another student to use the device.

****** Please note: If ANY of these school rules are broken they will forfeit the privilege to bring this device to school******

Student's Name: _____ Grade: _____

Parent's Signature: _____

Cell Phone Permission Slip

Dear Parents,

Schools all over our country are coming into agreement that no cell phones are to be allowed in school.

Therefore we ask that unless it is an absolute necessity, please do not allow your child to bring their cell phone to school.

If you need to contact your child or your child needs to contact you, the office will handle the exchange.

Any cell phone brought to school without permission or not turned into the office will be confiscated. The confiscated phone will have to be picked up by a parent in the school office. From that point on, no permission will be granted.

Please allow my child _____ grade _____ to leave his/her cell phone in the office upon arrival. They will pick it up at the close of the school day.

It is necessary for my child to bring their phone to school because:



FAITH PREPARATORY SCHOOL K - 12

600 Danbury Road New Milford, CT 06776
(860) 210-3677 Fax (860) 210-3685

Frank Santora, Lead Pastor
Judy Dumas, Principal/Administrator

RIGHT TO PRIVACY ACT

Dear Parents/Guardians:

Throughout the year we have numerous events covered by newspapers, public access, social media and local television stations, as well as our own production department which will video tape our children in the school and at athletic and social events throughout the year. These productions are used in advertisements and informational materials. **We would greatly appreciate you granting this permission in all areas because of the positive impact these mediums have for our school.** Please note that promotional and marketing materials are used for extended periods of time and permission granted allows for use beyond the academic year.

My child's photograph may be taken for school publications (yearbook) Yes No

My child's photograph may be used in newspaper, television, or
media presentations, including social media Yes No

My child may be videotaped at school, social, athletic and classroom events Yes
 *No

* If you responded no to this question, your child may not be a participant in our productions or graduation ceremony.

Child's Name: _____ Grade: _____

Parent/Guardian Signature: _____

Comments: _____

Student - School Technology Agreement

I, _____, (student name) understand that the computers at **Faith Preparatory School** are for educational purposes only. This agreement is for the protection of students and for the security of FPS equipment.

I understand that abuse or unauthorized use of **Faith Preparatory School** computers shall result in disciplinary measures including: loss of computer privilege, and/or financial compensation, suspension, and/or expulsion. In addition, any activity that violates state or federal law shall be turned over to the appropriate law enforcement agency.

1. **Any damage to the FPS computer while in the student's care shall be the student's responsibility and should be reported to the office immediately Faith Prep has obtained an insurance policy which will allow us to repair most accidental damage that will prevent the use of the computer. However, the student shall pay for any and all damages that exceed \$400. and/or not covered by insurance.**

While using Faith Preparatory School computers:

2. FPS computer must be stored and carried in an appropriate case provided by the student. (A hard shell/ crushproof case is recommended)
3. Students must take the FPS computer home every day and **charge it nightly.**
4. Students must bring the FPS computer to school each day **fully charged.** (This is their only textbook, without it they will not be able to complete their class work, and will be sent home from school.)
5. Students should not give out any personal, family, or school information such as: name, address, phone number, e-mail, or other such information over the Internet.
6. Students shall login only to their personal account, and must keep their username and password secure at all times.
7. Students may not load any additional software when using school computers, or sign up for Internet accounts; play unauthorized games; use messaging; email; or any other social media sites on the FPS computer.

While **Faith Preparatory School** takes every technological precaution possible to protect their students, we agree to hold **Faith Preparatory School** harmless for student Internet activity.

Any violation of this agreement shall be taken seriously.

Student's Signature

Date

Parent/Guardian's Signature