St. Anthony de Padua
Pre-K Discipline Policy

Children's development must be nurtured through caring, patient, and encouraging guidance. While caring for your child, we may have to respond to his/her misbehavior. Hitting, kicking, spitting, hostile verbal behavior, and other behaviors which will hurt other children are not permitted.

In response to misbehavior we will:

- Establish clear rules
- Be consistent in enforcing rules
- Use positive language to explain desired behavior
- Speak calmly while bending down to the child's eye level
- Give clear choices
- Remove the child from an activity if necessary until the child is ready to return to the group

If your child's behavior is consistently disruptive or harmful to himself/herself, or other children, we will work with you on a behavior plan to help your child manage his/her behavior. If the situation cannot be resolved, you may be asked to withdraw your child from our program.

As a parent, you may have some concerns or wish to offer suggestions. Please add any additional techniques you have found to be successful in helping your child manage his/her behavior.

____

____

____

____________________________________ ____________________________________

Child's name Date of birth

Parent/Guardian signature ______________________________________ Date ___________

BUREAU OF CHILD CARE
DIVISION OF FAMILY RESOURCES

SAFE TRANSPORTAION OF FOOD RESPONSIBILITY

Food must be brought to the facility in clean, insulated, sanitizable containers, which keeps cold food at 41° F or below and hot food at 135° or above. Containers must be clearly labeled with the child's name and date of preparation.

Upon receiving the food from the parent, the facility shall verify the temperature of the food. When potentially hazardous food temperature is not correct, the facility will not accept the food.

Upon accepting the food, the facility shall maintain correct food temperatures until served.

PARENT AGREEMENT

I, ____ (Parent's name) will

provide food for______________________ (Child's name).

I take full responsibility for the safety of my child's food during preparation, storage, and transportation to the facility.

(Parent's Signature):____

(Date):________________________

PARENT'S NOTICE

State Form 49444 (R / 1-09) / BCC 0035

I understand that this day care ministry is not licensed under the laws of Indiana. However, I understand that this day care ministry complies with the State rules concerning sanitation and fire safety for the primary use of the structure in which it is conducted. I understand that it is my responsibility to ensure that the nutritional and health needs of my child are met while my child is at the day care ministry.

Signature of Parent or Guardian
Name(s) of children enrolled

This notice does not absolve a day care ministry from liability for injury to a child while the child is at the day care ministry if the cause of the injury is negligence or intentional wrongdoing on the part of the day care ministry or an employee of the day care ministry.

Name of facility
Address of facility (*number and street, city, state, and ZIP code*)
County

SAINT JOSEPH
HEALTH SYSTEM
A Member of Trinity Health

Dear Parents and Guardians,

The enclosed packet of information will need to be completed and returned by the first day of school. The law in the State of Indiana requires that your child have certain immunizations in order to attend school. **Please make sure that the immunization information is read carefully as the Indiana State Department of Health and the Indiana Department of Education have made mandatory requirements by grade level for the 2019-2020 school year.** Below is the minimum number of immunizations required according to grade level:

- Pre-school-Pre-Kindergarten: 4 DTaP, 3 Polio, 3 Hepatitis B, 1 MMR, 1 Varicella, or physician written documentation of history of disease, including month and year
- Kindergarten – Fifth Grade: 5 DTaP, 4 Polio, 3 Hepatitis B, 2 Hepatitis A, 2 MMR, and 2 Varicella, or physician written documentation of history of disease, including month and year
- Sixth – Seventh Grades: 5 DTaP, 4 Polio, 3 Hepatitis B, 2 Hepatitis A, 2 MMR, 1 Meningococcal, 1 Tdap, and 2 Varicella, or physician written documentation of history of disease, including month and year
- Eighth Grade: 5 DTaP. 4 Polio, 3 Hepatitis B, 2 MMR, 1 Meningococcal, 1 Tdap, and 2 Varicella, or physician written documentation of disease including month and year.

Once your child is accepted at school, please send in the forms found in this packet. We will accept exams that were completed within the last twelve months. **Please make sure there is a physician generated copy of immunizations included with the forms sent to school.** The State of Indiana only recognizes objection to immunizations for medical and religious reasons. There is a form that must be completed annually and on file by the first day of each school year. Please note, a physician is the only health care provider who can sign for a medical objection. Only a parent need to complete the religious objection. You may send in or fax all health documents to the school as well.

Sincerely yours,

Beth Clemans, RN, BSN   Maureen VerVaet, RN, BSN

Medical Centers

Mishawaka Medical Center
5215 Holy Cross Pkwy
Mishawaka, IN 46545
574.335.5000

Rehabilitation Institute
60205 Bodnar Blvd.
Mishawaka, IN 46544
574.335.8800

Plymouth Medical Center
1915 Lake Ave.
Plymouth, IN 46563
574.948.4000

Senior Services

Holy Cross
17475 Dugdale Dr.
South Bend, IN 46635
574.247.7500

Saint Joseph PACE
250 E. Day Rd.
Mishawaka, IN 46545
574.247.8700

St. Paul's
3602 S. Ironwood Dr.
South Bend, IN 46614
574.284.9000

Trinity Tower
316 S. Dr. Martin Luther King Jr. Blvd
South Bend, IN 46601
574.335.1900

VNA Home Care
3838 N. Main St., Ste. 100
Mishawaka, IN 46545
574.335.8600

510 W. Adams St., Ste. GL-50
Plymouth, IN 46563
574.335.7950

Community-Based Programs

The Foundation
707 E. Cedar St., Ste. 100
South Bend, IN 46617
574.335.4540

Health Insurance Services
5215 Holy Cross Pkwy.
Mishawaka, IN 46545
1.855.88.SJMED (1.855.887.5633)

Community Health & Well-Being
707 E. Cedar St., Ste. 100
South Bend, IN 46617
574.335.4685

Physician Network
707 E. Cedar St., Ste. 220
South Bend, IN 46617
574.335.6758

Physician Certificate of Examination Form

(To be completed by a physician/healthcare provider)
Please Print!

◯ Immunization Documentation Attached!

Name: ______________________________ Date of Birth: _____/_____/_____

Allergies: ___________________________ ◯ Epi Pen Needed

Current Medications: (List name, dosage, and time):

1. ______________________ Dosage: _____________ Time: ____________
2. ______________________ Dosage: _____________ Time: ____________

Height: _______________ Weight: _________________ B/P: ________________

Eyes: ______________________

Ears: ______________________

Nose: _____________-__________

Throat: ____________________

Chest: ________-______________

Heart: _____________________

Hernia: ____________________

Extremities: _________________

Posture/Scoliosis: ________________

____

Lead Level (if indicated): ______________

Sickle Cell (If indicated): ______________

TB Test: (Recommended)

Date Given: __________________

Date Read: ___________________

Results:

- Physically fit to participate in all physical education programs? ◯ YES ◯ NO
- If "No" please explain:
  ____
- Please list any condition that should be considered in planning this child's school day:
  ____

Physician/Healthcare Provider Completing this Form: _________________________

Please Print/Stamp

Physician/Healthcare Provider's Signature: ______________________ Date: ________

Certificate of Dental Examination

Teeth:

1. Cavities: ____
2. Soft Tissue: ____
3. Oral Hygiene: ____

Present Status:

- Does the patient presently have any tooth decay or other dental defects which may reduce his/her efficiency or prevent him/her from receiving the full benefit of his/her school work?
  - If yes, please explain: ______________________________________

Recommendations: ____

Dentist's Name (Stamp or Print): ___________________________________

Dentist's Signature: ___________________________________ Date: ____________

Health Questionnaire

(Parent/Guardian needs to complete)

Please Print!

Student:____________________________________ Date of Birth:____/____/____

Address: ____

City: __________________ Zip: _____________ Phone Number:______________

School: __________________________________ Entering Grade: _____________

Father's Name: ___________________ Mother's Name: _____________________

Student Lives With: ____

Disease/Condition	**Yes** **(List month/year)**	**No**	**Disease/Condition**	**Yes** **(List month/year)**	**No**
Asthma			Mumps		
Diabetes			Rheumatic Fever		
Seizures			Rubella		
Chickenpox			Measles		
Food Allergy			Other		

Has your child had an infections/communicable disease other than those listed above? Please explain giving relevant dates: ____

Please list any of the following with the month/year:

- Operations: ____
- Illnesses (Eye, ear, heart, stomach, kidney): ______________________________
- Severe Injuries (Head injury, fractures, etc.): ______________________________

Is there any other information about your child's health status that you think the school should know which may be relevant to your child's health and safety or the health and safety of others in the school environment? ____

Please list any condition that should be considered in planning your child's school day:

____

Allergies/Reactions: ____

◯ Allergy Care Plan Needed ◯ Epi Pen Needed

Physician Name: ______________________________ Phone #: ____________________

Dentist Name: ________________________________ Phone #: ____________________

To the best of my knowledge the above information is complete and accurate. I acknowledge that I have a continuing obligation to inform the school of any changes in my child's health status that are relevant to the information requested by this form.

Parent Signature: ______________________________ Date: ______________________

Student's Name: ____________________ # of Times Sent Home: ________ Grade: _________

Diocese of Fort Wayne-South Bend Schools

Dear Parent/Guardian,

The Indiana State Department of Health maintains an immunization registry entitled CHIRP. CHIRP allows all health care providers within the state of Indiana to enter immunization data as a method of electronic documentation. CHIRP ensures that the most up-to-date record of immunizations is available to all health care providers. The Indiana Department of Education mandated that all schools within the state of Indiana utilize CHIRP to document annual immunization reports. Schools are required to submit these immunization reports to maintain the schools' accreditation. The school is requesting your permission to submit the immunization status of your child using this format. Please make a copy of this consent for each of your student's.

I ___________________________, give the Diocese of Fort Wayne/South Bend Schools, permission to release the following information concerning my child ___________________

To the Indiana State Department of Health's: Children and Hoosiers Immunization Registry Program (CHIRP):

Student's full name, date of birth, immunization data, and demographic data such as address, telephone number, and the school in attendance.

I understand that the information in the registry may be used to verify that my child has received proper immunizations and to inform me if my child's immunization status or that an immuzation is due according to the recommended immunization schedules.

I understand that my child's information may be available to the immunization data registry of another state, a healthcare provider or a provider's designee, a local health department, an elementary or secondary school, a child care center, the office Medicaid policy and planning or a contractor of the office of Medicaid policy planning, a licensed child placing agency, and a college or university. I also understand that other entities may be added to this list through amendment to I.C. 16-38-5-3.

________________________________ ________________________________

Signature of Parent/Guardian Date

________________________________ ________________________________

Printed Name of Parent/Guardian Grade Level

____

Complete Address City Zip

________________________________ ________________________________

Child's Name School

PLEASE RETURN THIS FORM BY THE FIRST DAY OF SCHOOL!