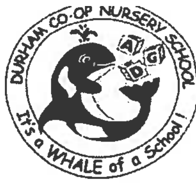


Enrollment Agreement

Official Start Date: __/ ___/___

Child's Name: ______________________________________Birth Date ___/ ___/ ___

I hereby enroll this child in the Durham Cooperative Nursery School for the school year 2015/ 2016 term. I have read and will abide by the Durham Cooperative Nursery School's "Rules and Policies" document and shall accept full responsibility, as a member, set forth in the "Articles of Incorporation" and "By-Laws" of the school.

Signature of the Parent or Guardian ____________________________ Date _________

Tuition Agreement

Having enrolled my child in the Durham Cooperative Nursery School, I agree to pay a monthly tuition of $ ____.____ for the school year 2015 / 2016 due the first of each month. Today I agree to pay the $50 (non-refundable) registration fee, the $90 (one-time and refundable only up to July 15 if decide not to enroll) insurance fee, and one month's tuition (refundable / please see Enrollment Agreement for details on this). This one month's tuition (collected today) actually covers payment for the month of June in 2014 and September's tuition will still be expected at the beginning of the school year. In addition, a music fee (a one-time fee assessed biannually to be determined) will be collected in September with your 1st monthly payment to secure a music teacher that comes to the classroom monthly.

Signature of the Parent or Guardian ____________________________ Date _________

Field Trips (Child)

My child **may** go on field trips _______________

My child **may not** go on field trips _______________

Signature of the Parent or Guardian ____________________________ Date _________

Durham Cooperative Nursery School Association

Registration Form

Child's full name____ Sex____________

Nickname (if used instead of full name)

____ Birth Date ____/____/____

Home Address

____ Phone_____________________

E-Mail_____________________________________ Cell Phone_________________

Father's Name_________________________________ Occupation_______________

Does father work during school hours? Y/ N If yes, give:

Business Address________________________________ Work Phone_____________

Mother's Name _________________________________ Occupation______________

Does mother work during school hours? Y / N If yes, give:

Business Address_______________________________ Work Phone_____________

Do both parents live with child? Y / N , If not, are both parents allowed to pick up child from school? Y / N

List names and ages of other children in your family:1.__________________________

2.____________________________________ 3. _______________________________

Does parent have any special hobby or interest that they would be able to share with the child's class? (i.e. gardening, carpentry, are, musical ability, dance, etc.) Please indicate:

____

Was there difficulty with the pregnancy or delivery? Y / N If yes, please specify on back or mention it to Teacher/Director.

Has the child had previous group experience or does the child play with other children of same age?

____.

Is the child comfortable with adults?____.

What words do parents apply when praising/punishing their child?

____.

What are your child's fears and reactions to those fears?

____.

What is you child's reaction to frustration?

____.

What is the parents approach to comforting the child?

____.

What methods of discipline, if any, are used by the parents?

____.

What rules are considered important at home?

____.

What are your child's sleeping habits (naps, difficult to put to bed, requires lots of sleep)

____.

What is the child's reaction to being left by parent?

____.

Does your child have difficulty with bowel movements? (afraid to do them)

____.

What allergies does your child have? (food, drug, soap, etc.)

____.

Does the child have a present illness or condition of which the school should be made aware? Y/ N If yes, describe in detail any emergency treatment that should be administered while medical help is sought.

____

____.

What do parents expect child to gain from nursery school experience? (i.e. social experience, emotional development, etc.)

____

____.

Additional Information:

____

____

____.

Durham Co-Operative Nursery School

16 Main Street Durham, CT 06422 (860) 349-9885

Emergency Care Permission Slip for ______________________________
(Child's Name)

I give permission to Durham Co Op Teachers to make whatever emergency, (e.g., first aid, disaster evacuation) measures as judged necessary for the care and protection of my child while under the supervision of the Durham Cooperative Nursery School.

In case of a medical emergency, I understand that my child will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource (Police, Rescue Squad) deems it necessary. The child will be transported at the expense of myself.

It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician, and/or other adult acting on the parent's behalf.

DATE: ________________ SIGNATURE ______________________________
(Parent of Guardian)

- To be kept by telephone and taken on all field trips. Programs providing transportation should carry a duplicate set in vehicle.

- Please fill out other side -

DURHAM COOPERATIVE NURSERY SCHOOL

PERMISSION FOR EMERGENCY TREATMENT

I, ____, grant permission for my child,

____ to be given emergency treatment, if the Durham Cooperative Nursery School personnel are unable to contact me.

Signature of Parent or Guardian________________________________Date___________School year ___/___

****

EMERGENCY FORM

Child's Name____

Mother's Name____Home Phone__________________

If employed, list company name and address:

____Work Phone__________________

Father's Name____Home Phone__________________

If employed, list company name and address:

____Work Phone__________________

Please list names and phone numbers of two persons who may be contacted in case of an emergency if parents cannot be located to attend and/or pick-up your child until parent is reached:

1. Name____Phone______________________

   Relationship to child____

2. Name____Phone______________________

   Relationship to child____

Child's Doctor Name____Phone_________________

Child's Dentist Name____Phone_________________

Hospital Preference____

Signature of Parent or Guardian_______________________________________ Date______________

release/nml/win

School Shirt Order Form

Tee Shirt
$10.00

Sweat Shirt
$ 15.00

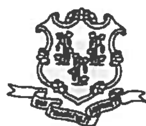
The Durham CO-OP school shirt is a white tee shirt or sweat shirt with the above black logo. School shirts will be worn on field trips and "wear your school shirt" days throughout the year. **Shirts will be delivered once payment is received at the start of the school year.**

Child's Name:____ Phone________________________

Class ____ 2 day ___3 day am____ 3 day pm

☐ I do not plan to buy a shirt.

Child Tee Shirt	Child Sweat Shirt	Adult Tee Shirt	Adult Sweat Shirt
Small (6-8) _______	Small (6-8) _______	Small _____	Small ______
Med. (10-12) _____	Med. (10-12) _____	Med. ______	Med. _______
Large (14-16)_____	Large (14-16)_____	Large ______	Large _______
		XL ________	XL _______



State of Connecticut Department of Education

Early Childhood Health Assessment Record

(For children ages birth – 5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑ Male ❑ Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑ American Indian/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		

Does your child have health insurance? Y N
Does your child have dental insurance? Y N
Does your child have HUSKY insurance? Y N

If your child does not have health insurance, call **1-877-CT-HUSKY**

* If applicable

Part I — 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	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	Y	N				Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place to another	Y	N	6. Interaction with others	Y	N	Eating concerns	Y	N
			7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program.

Signature of Parent/Guardian Date

Part II — Medical Evaluation

ED 191 REV. 8/2011

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name ______________________ Birth Date __________ (mm/dd/yyyy) Date of Exam __________ (mm/dd/yyyy)

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

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT** ____ in/cm ____% ***Weight** ____ lbs. ____ oz / ____% **BMI** ____ / ____% ***HC** ____ in/cm ____% (Birth – 24 months) ***Blood Pressure** ____ / ____ (Annually at 3 – 5 years)

Screenings

***Vision Screening**

❑ EPSDT Subjective Screen Completed (Birth to 3 yrs)
❑ EPSDT Annually at 3 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑ Unable to assess
❑ Referral made to: ______________

***Hearing Screening**

❑ EPSDT Subjective Screen Completed (Birth to 4 yrs)
❑ EPSDT Annually at 4 yrs (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑ Pass
	❑ Fail	❑ Fail

❑ Unable to assess
❑ Referral made to: ______________

***Anemia:** at 9 to 12 months and 2 years

*Hgb/Hct:	*Date

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

Lead poisoning (≥ 10ug/dL)
❑ No ❑ Yes

*Result/Level: *Date

Other:

***TB:** High-risk group? ❑ No ❑ Yes

Test done: ❑ No ❑ Yes Date: ______
Results: ______________
Treatment: ______________

***Dental Concerns** ❑ No ❑ Yes

❑ Referral made to: ______________

Has this child received dental care in the last 6 months? ❑ No ❑ Yes

***Developmental Assessment:** (Birth – 5 years) ❑ No ❑ Yes **Type:**

Results:

*IMMUNIZATIONS ❑ Up to Date or ❑ Catch-up Schedule: <u>MUST HAVE IMMUNIZATION RECORD ATTACHED</u>

***Chronic Disease Assessment:**

Asthma ❑ No ❑ Yes: ❑ Intermittent ❑ Mild Persistent ❑ Moderate Persistent ❑ Severe Persistent ❑ Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑ Rescue medication required in child care setting: ❑ No ❑ Yes

Allergies ❑ No ❑ Yes: ______________
Epi Pen required: ❑ No ❑ Yes
History/risk of Anaphylaxis: ❑ No ❑ Yes: ❑ Food ❑ Insects ❑ Latex ❑ Medication ❑ Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑ No ❑ Yes: ❑ Type I ❑ Type II **Other Chronic Disease:** ______________
Seizures ❑ No ❑ Yes: Type: ______________ ______________

❑ This child has the following problems which may adversely affect his or her educational experience:
❑ Vision ❑ Auditory ❑ Speech/Language ❑ Physical ❑ Emotional/Social ❑ Behavior
❑ This child has a developmental delay/disability that may require intervention at the program.
❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* ______________

❑ No ❑ Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.
❑ No ❑ Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.
❑ No ❑ Yes This child may fully participate in the program.
❑ No ❑ Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)
____

❑ No ❑ Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped *Provider* Name and Phone Number

Child's Name: ______________________ **Birth Date:** ____________ REV. 8/2011

Immunization Record

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

Vaccine (Month/Day/Year) ______________________

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Disease history for varicella (chickenpox) ______________________

(Date) (Confirmed by)

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

†Recertify Date _________ †Recertify Date _________ †Recertify Date ________

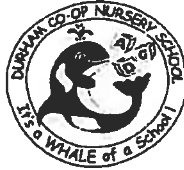
Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2-3 years of age (24-35 mos.)	3-5 years of age (36-59 mos.)
DTP/DTaP/DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped *Provider* Name and Phone Number



Health Guidelines

In an effort to maintain a healthy environment for our children during the school year, we request your cooperation in following the health recommendations listed below.

Please do not bring your child to school if he/she exhibits any of the following symptoms:

1. A temperature of 100 degrees Fahrenheit, or higher, within the past 24 hours. The child should be fever-free for **48 hours** before returning to school.
2. Flat, red spots/ blisters on face, scalp, or body indicating the possibility of chicken pox.
3. Diarrhea or numerous loose stools indicating the possibility of infectious diarrhea. Child should be free of diarrhea for **48 hours**.
4. A blotchy rash on the stomach and back or a fine, red rash all over the body indicating the possibility of measles or scarlet fever.
5. Discharge from the eyes or crusted eyelids indicating infectious conjunctivitis. (Must be on medication for **48 hours** before returning to school).
6. Stomachache or headache
7. Nausea and / or vomiting. Child must be kept home for **48 hours**.
8. A sore throat as indicated by difficulty swallowing, refusal to eat or drink, red throat, or swollen tonsils suggesting streptococcal infection. The child must stay home for **48 hours** after the first dose of antibiotic is given.
9. Listless, lethargic behavior, lack of appetite, extreme irritability, or any unusual behavior for your child, which persists indicating the possibility of oncoming illness.
10. Body or head lice. The child must be kept home until **48 hours** after treatment starts. Teachers must be notified so appropriate measures can be taken to minimize spread of lice.
11. Persistent runny nose with discolored discharge.
12. A sharp, barking cough, severe cough or noisy breathing.
13. Any suspicious undiagnosed rash.
14. Any combination of the symptoms listed above.

Should your child exhibit or develop any of these symptoms while at school you will be called and asked to come pick him/her up as soon as possible. A staff member will stay with your child until you arrive. In the event we cannot reach you, we will call your back-up emergency contact numbers.

Lastly, please encourage your child to practice thorough and frequent hand washing, using soap, as this will help to combat the spread of illness.
Please be considerate of yourselves and others and help us in our effort to maintain a healthy school environment for all children, teachers, parents and siblings.

Just a reminder, our health policy is that all children must have all immunizations up to date before entering school.

*Additional Early Childhood Heath forms can be downloaded from:
http://www.sde.ct.gov/sde/lib/sde/PDF/deps/student/health/EC_HAR.pdf

Durham Co-op 2013

DISCIPLINE POLICY-ABUSE/NEGLECT

The definition for child abuse is defined as: <u>a child who has had non-accidental physical injury(ies) inflicted upon him/her, or has injuries which are at variance with the history given of them, or is in a condition which is the result of maltreatment, such as, but not limited to: malnutrition, sexual molestation or exploitation, deprivation of necessities, emotional maltreatment or cruel punishment. (Connecticut Statutes 46b-120).</u>

While children are in attendance at the Durham Co-operative Nursery School program the director and staff shall not engage in, nor allow, abusive, neglectful, physical, corporal, humiliating or frightening treatment or punishment and shall not tie nor bind children and shall not physically restrain children except for the protection and safety of the child or others, using least restrictive methods as appropriate.

The director and staff or the Durham Co-operative Nursery School shall not engage in, nor allow, anyone else to engage in any sexual activity with the day care children while in attendance at the program.

The director and staff shall report actual or suspected child abuse or neglect or the imminent risk of serious harm of any child to the Department of Children and Families as mandated by section 17a-101 to section 17a-101e, inclusive, of the Connecticut General Statures.

It is required that if there is reasonable cause to suspect or believe that a child under the age of 18 has been abused or neglected by a person responsible for the child's health, welfare or care, or by a person given access to the child by the responsible person, the Department of Health and the Dept. of Children and Families be notified orally within 12 hours of suspecting that a child has been abused or neglected. Then a written report must be submitted within 48 hrs. (DCF-136form) to DCF.

After making the report to DCF and DPH a copy of the written report will be submitted to the director of Durham Co-operative Nursery School. The Board will then meet and begin internal investigation proceures immediately. This would include interviews with the person suspected of being accused and the provision of all reports to them.

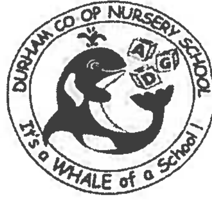
If a staff member has been accused of abuse or neglect the child's parents would be immediately notified that a report has been made and action is being taken. If a parent is suspected of serious physical abuse or sexual abuse DCF would be notified before talking with the parent. If a child is suspected of abusing another child the parents of both children would be notified immediately and proper action would be taken.

If it is a school employee who is being accused and there is reasonable cause to believe that a child has been abused that employee will be suspended and provided the records concerning such investigation. The suspension will remain in effect until resolved by the school.

The children will be protected during an investigation by maintaining their anonymity and privacy as much as possible. Health care professionals, mental health professionals and members of the clergy would be invited in for support and guidance.

As a preventive education policy the staff will be asked to attend workshops and seminars on awareness training. Discussions of the child abuse policy will be a regular part of staff monthly meetings.

Child Abuse/Neglect Hotline
24 hrs. a day
1-800-842-2288



DISCIPLINE POLICY-ABUSE/NEGLECT

By signing this form you are acknowledging that were spoken to by School Director, read and agree to the Durham Cooperative Nursery School Discipline Policy.

Please sign and date below and return to Durham Cooperative Nursery School.

Child's Name:_________________________________

Parent/Guardian: _________________________________ **Date:** ___________

Accepted Discipline Policy

The emphasis is on positive reinforcement, thereby eliminating most discipline problems.

Try to settle conflicts peaceably. Encourage the child to use his/her words in dealing with situations. E.g. If someone is bothering you, you can say "stop it, you're bothering me." It's O.K. to be mad, but hitting is not allowed. I don't want you to hurt anyone and I don't want anyone to hurt you either.

A child can be asked to leave the play area and redirected to another activity. If the behavior persists and the child cannot control himself/herself (e.g. physically fighting with another child or throwing things), he or she is given at time-out, usually in their cubby. After a designated amount of time (usually 1 to 2 minutes), the child is asked to rejoin the group if the behavior has changed.

No language/tone of voice that would belittle a child's sense of self-esteem or physical force will ever be allowed in our school.

Classroom Rules

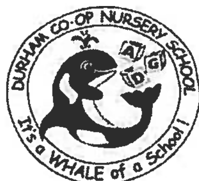
- Take care of yourself
- Respect each other
- Take care of classroom property
- Children can build blocks up to chin high and must be considerate about other children's buildings
- Everyone can go outside when the teachers are ready and say that it's time
- Let's work together to make a peaceable classroom

Suggestions, Complaints and Compliments

If you have any suggestions, complaints or compliments about the way the Durham Co-Op is operated, please feel free to take the following steps:

1. Contact President, Co-President or any other member of the Executive Board.
2. Make an appointment to talk to the teachers after school hours.
3. Use the suggestion box, located on top of the mailboxes, or place a note in one of the Board Member's mailboxes. This can be done anonymously.
4. You can always bring up issues at the Member Meetings for discussion.

Any suggestions, complaints or compliments will be taken to the next scheduled board meeting (if not a personal issue) and discussed. The Board will take whatever steps are necessary to resolve the issue. All members are encouraged to attend the Board Meetings.



Enrollment Fees For 2015-2016 School Year

3-year-old class

$50 Registration Fee (one-time fee that is non-refundable)

$90 This is a one-time insurance fee that is 100% refundable up to July 15 and non-refundable after that if you decide not to enroll.

$150* One month's tuition (that is 100% refundable up to July 15, 50% refundable from July 16 through July 31, and non-refundable after August 1 of the fiscal year if you decide not to enroll.) Notice of withdrawal must be provided in writing to the Executive Board. This tuition payment is for June of 2014, September's tuition is due on the 1st.

TOTAL DUE = **$290.00**

***The only other fee will be a music fee that is assessed bi-annually in September and January, the amount to be determined and due with September and February's tuition.

4-year-old class

$50 Registration Fee (one-time fee that is non-refundable)

$90 This is a one-time insurance fee that is refundable up to July 15 and non-refundable after that if you decide not to enroll.

$200* One month's tuition (that is 100% refundable up to July 15, 50% refundable from July 16 through July 31, and non-refundable after August 1 of the fiscal year if you decide not to enroll.) Notice of withdrawal must be provided in writing to the Executive Board. This payment is for June of 2014, September's tuition is due on the 1st.

$280 a month if choosing extended day option

TOTAL DUE= **$340** (**$420** if choosing the full day option)

***The only other fee will be a music fee that is assessed bi-annually in September and January, the amount to be determined and due with September and February's tuition.