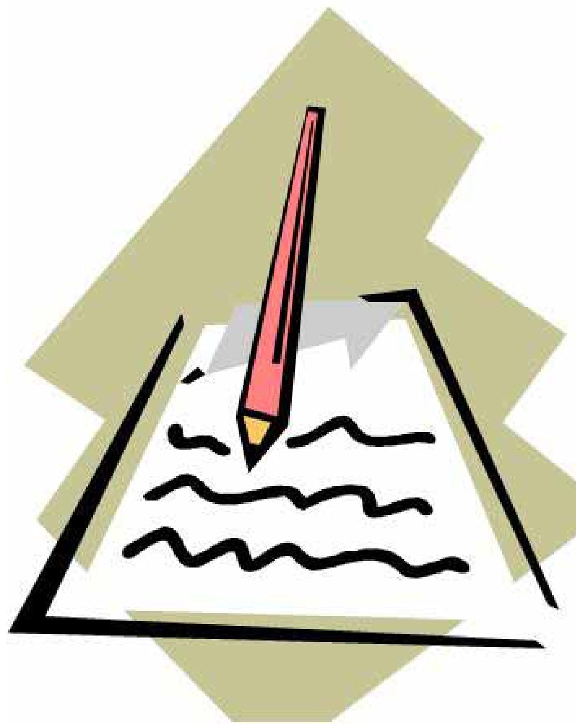
Forms

These forms must be completed and returned to your child's teacher at your "Meet the Teacher" appointment.



For children to begin the school year, these forms must be on file with our office.

Enrollment Agreement

Rabbi Joseph Weinberg ECC & WHC Primary School 2011-2012

Please read the following items carefully. **Two copies are provided so that you may keep one for your records.** This copy must be signed and returned to the school/camp office.

1. Students are registered for an entire school year, or from the time they enter until the end of the school year.

2. No refunds, adjustments, or deductions of any kind will be made from fees, charges or tuition paid due to absence or withdrawal of any student by a parent or guardian during the school year. The school shall not be required to mitigate damages.

3. The school reserves the right to exclude, withdraw or dismiss any student from classes or from the school for any cause whatsoever, including, but not limited to, violation of any rules or regulations, non-payment of fees and tuition, or for any other reason, if exclusion, withdrawal or dismissal is deemed by the school to be in the best interest of the school or student.

4. **For Maryland Residents Only:** Maryland State law requires that the child must be at least two years of age to participate without a parent/guardian in the program. A copy of the child's birth certificate is required.

5. All children will be accepted for a period of six weeks to determine adaptability to our school. Without limiting the provisions of (3) above, the school expressly reserves the right to require the withdrawal of any child who, after this period, is not adjusting satisfactorily. Withdrawals for adaptability/adjustment reasons will be made by the school administration in writing, and in this event, any unused portion of tuition will be refunded on a pro-rated basis.

6. If, in the judgment of a teacher, director or other responsible WHC employee or representative (collectively, "WHC employees"), emergency treatment is necessary for the student, a doctor, ambulance or other appropriate assistance may be summoned, as the WHC employee deems necessary. In such cases, WHC will promptly notify a parent/guardian or other designated responsible person. The undersigned hereby release WHC and any and all of its officers, directors, staff members, agents and other representatives (collectively, "WHC representatives") from, and hereby agree to indemnify any and all of the WHC representatives from and against, any and all claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representative's good faith effort to summon or administer medical assistance.

7. A recent medical checkup and medical form noting current dates of all immunizations is required **prior** to the time the student enters the school.

8. Temple members must participate in our fair share program and be current through June 30 of the school year for which the child has been registered.

I understand and agree that tuition payments are due according to the dates designated in the Fee and Payment Schedule issued by the Rabbi Joseph Weinberg Early Childhood Center, a copy of which is enclosed with this Enrollment Agreement.

I have carefully read the above and I agree to comply with the terms expressed therein, without exception, and to be bound by the school regulations.

Child's Name (print) ____

Parent/Guardian's Name (print) ____

Parent/Guardian's Signature ______________________________ Date ______________

Please retain for your files

Enrollment Agreement

Rabbi Joseph Weinberg ECC & WHC Primary School 2011-2012

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2. No refunds, adjustments, or deductions of any kind will be made from fees, charges or tuition paid due to absence or withdrawal of any student by a parent or guardian during the school year. The school shall not be required to mitigate damages.

3. The school reserves the right to exclude, withdraw or dismiss any student from classes or from the school for any cause whatsoever, including, but not limited to, violation of any rules or regulations, non-payment of fees and tuition, or for any other reason, if exclusion, withdrawal or dismissal is deemed by the school to be in the best interest of the school or student.

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6. If, in the judgment of a teacher, director or other responsible WHC employee or representative (collectively, "WHC employees"), emergency treatment is necessary for the student, a doctor, ambulance or other appropriate assistance may be summoned, as the WHC employee deems necessary. In such cases, WHC will promptly notify a parent/guardian or other designated responsible person. The undersigned hereby release WHC and any and all of its officers, directors, staff members, agents and other representatives (collectively, "WHC representatives") from, and hereby agree to indemnify any and all of the WHC representatives from and against, any and all claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representative's good faith effort to summon or administer medical assistance.

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I have carefully read the above and I agree to comply with the terms expressed therein, without exception, and to be bound by the school regulations.

Child Emergency Contact Information

School Year 2011-2012

Child's Name: ______________________________

Address: ______________________________

PLEASE PROVIDE CONTACT INFORMATION FOR EACH PARENT/GUARDIAN PLUS ONE OTHER INDIVIDUAL WITH WHOM WE MAY CONSULT AND TO WHOM WE MAY RELEASE YOUR CHILD IN THE EVENT OF AN EMERGENCY:

Parent/Guardian #1 ______________________________ Relationship ______________________________

Home Phone ______________________________

Business Phone ______________________________

Mobile Phone ______________________________

Email Address ______________________________

Parent/Guardian #2 ______________________________ Relationship ______________________________

Home Phone ______________________________

Business Phone ______________________________

Mobile Phone ______________________________

Email Address ______________________________

Emergency Contact ______________________________ Relationship ______________________________

Home Phone ______________________________

Business Phone ______________________________

Mobile Phone ______________________________

Name of physician or clinic ______________________________ Phone ______________

Name of dentist ______________________________ Phone ______________

Hospital Preference ______________________________

Recurring illnesses (asthma, allergies, etc.) ______________________________

Dietary restrictions (Kashrut, allergies, etc.) ______________________________

In the event of an emergency, after an effort has been made to contact parents/guardians or those listed on this or any emergency form provided by WHC, I hereby give permission to the physician selected by the WHC, or the WHC teachers, administrators, staff members, agents or other representatives (collectively, "WHC representatives") to summon an ambulance, hospitalize, secure proper treatment for and/or order injection, anesthesia or surgery for my child; I authorize WHC and WHC representatives to take any other action a physician deems necessary or appropriate in the particular circumstances. I hereby release WHC and all WHC officers, directors, and other WHC representatives from all liability or responsibility or responsibility in connection therewith. I hereby agree to indemnify any and all of the WHC representatives from and against any and all claims, demands, losses, obligations, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to, reasonable attorney's fees, that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representatives' good faith effort to obtain medical assistance for my child.

Parent's Name: ______________________________

Parent's Signature: ______________________________ **Date**: ______________________________

Student Medical Checklist

School Year 2011-2012

To be completed by parent or guardian

Child's full name:____

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or be important for school staff to know?

	Yes	No	Comments
Allergies (drugs, food, insects)	______	______	
Asthma	______	______	
Behavioral or emotional problems	______	______	
Birth defects	______	______	
Bleeding problems	______	______	
Chronic diseases	______	______	
Chronic infectious diseases	______	______	
Diabetes	______	______	
Dietary restrictions	______	______	
Hearing problems	______	______	
Heart problems	______	______	
Hospitalizations (when/where)	______	______	
Limits on activity	______	______	
Medications	______	______	
Premature birth	______	______	
Problems with bladder	______	______	
Problems with bowels	______	______	
Seizures	______	______	
Speech problems	______	______	
Surgeries	______	______	
Vision problems	______	______	
Other medical conditions	______	______	
Is your child toilet trained	______	______	

If necessary, please use the reverse side of this form to elaborate on any of the above or for any additional information.

Parent/Guardian name (please print) ____

Parent/Guardian signature ______________________________ Date ______________

Allergy Addendum

School Year 2011-2012

Child's name (please print)________________________________

Classroom teacher's name ______________________________

To the best of my knowledge:

________ My child has no allergies

________ My child has allergies

My child is allergic to the following:

- **If your child requires medication at school, please complete and return the School Medication Administration Authorization Form for each medication needed.**
- **If your child has a food allergy, please complete the Food Allergy Action Plan and the Authorization & Release of Liability statement.**

Additional comments, medications and/or instructions:

Please initial any of the following over-the-counter topical medications that the school nurse may apply to your child:

MEDICATIONS	USES	I approve the use of the following: (initial each below)
Neosporin ointment	small cuts/rug burns/abrasions	
1.0% hydrocortisone anti-itch gel	bee stings/bug bites/poison ivy	
Vaseline petroleum jelly	chapped lips	
Aquaphor ointment	dry, itchy, chapped skin	

Parent/guardian name (please print)____

Parent/guardian signature ____________________________ Date __________________

FOOD ALLERGY ACTION PLAN

Child's Photograph

NAME:_____________________________ **DOB:**____/____/______

ALLERGY TO:____

Asthma: ☐Yes (higher risk for a severe reaction) ☐ No.

Weight _____lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough

HEART: Pale, blue, faint, weak pulse, dizzy, confused

THROAT: Tight, hoarse, trouble breathing/ swallowing

MOUTH: Obstructive swelling (tongue)

SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- CALL 911
-Begin Monitoring (see below)
-Additional medications:
  -Antihistamine
  -Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis)→ Use Epinephrine.
When in doubt, use epinephrine. Symptoms can rapidly become more severe

MILD SYMPTOMS ONLY
Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: mild nausea/discomfort

GIVE ANTIHISTAMINE

-Stay with child, alert health care professionals and parent
IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten (extremely reactive).**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten (extremely reactive)**

MEDICATIONS/DOSES
EPINEPHRINE (BRAND AND DOSE): ______________________________

ANTIHISTAMINE (BRAND AND DOSE):______________________________

OTHER (e.g., inhaler-bronchodilator if asthma):______________________________

MONITORING: Stay with the child. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached. See back/attached for auto-injection technique.

For insect sting allergy, inject epinephrine for any symptoms other than localized swelling at sting site

CONTACTS: CALL 911 (Rescue squad: (___)________) Doctor:______________________ Phone: (___)_____-_________

Parent/Guardian:____________________________________ Phone: (____)________________________________

OTHER EMERGENCY CONTACT: NAME/Relationship______________________________ Phone: (___)_____-___________

NAME/Relationship______________________________ Phone: (___)_____-__________

____________________	__________	______________________________	__________
PARENT/GUARDIAN SIGNATURE	**DATE**	**PHYSICIAN/HEALTHCARE PROVIDER SIGNATURE**	**DATE**

Rabbi Joseph Weinberg Early Childhood Center
Washington Hebrew Congregation Primary School

Authorization and Release of Liability

(For students with food and/or bee sting allergies that may result in anaphylaxis)

I understand that Washington Hebrew Congregation ("WHC") cannot promise or assure that an environment be created or maintained that is free of a food and/or bees that my child is allergic to, or that he/she will not suffer an allergic reaction, despite the fact that WHC has taken certain precautions and asked parental cooperation in order to minimize the risk of exposure to such food and/or bees.

I further understand that it is the policy of Washington Hebrew Congregation not to administer medicine of any kind to its students (or campers) and that WHC encourages parents and physicians to follow procedures that result in all medications being administered at home, to the extent possible. Nevertheless, in the event of a situation that a teacher, administrator, school nurse, staff member, or other WHC representative deems to be a medical emergency, I hereby authorize them to administer care and/or emergency medications in accordance with my physician's instructions that have separately been provided to WHC. I understand that such care may not be administered by a trained professional.

I hereby release WHC and any and all of its clergy, officers, directors, staff members, school nurses or other representatives (collectively, "WHC Representatives") from, and hereby agree to indemnify any and all of the WHC Representatives from and against, any and all lawsuits, claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including but not limited to, reasonable attorney's fees (collectively, "liabilities"), that any of the WHC Representatives may incur or sustain, and directly or indirectly relates to, or arises from or in connection with:

1. Any allergic reaction or anaphylaxis that was or may have been caused, in whole or in part, by exposure to said allergens while at WHC or in connection with school-related activities or events; and,
2. Any WHC Representative's effort to give (or decision to refrain from giving) treatment to my child in connection with an allergic reaction or symptoms that appear to indicate an allergic reaction.

____
Student's Name (please print)

Allergic to: ________________________

____
Parent/Guardian Name (please print)

____
Parent/Guardian Signature

____
Date

Physician Medical Form

School Year 2011-2012

To be completed by child's physician

Child's full name____
(Last) (First)

Address ____
(Street) (City) (State) (Zip)

Home phone_______________________ Birth date: ___________ Weight: _________ Sex:__________

This child has the following condition(s) that may adversely affect his/her education experiences:

_______Visual
_______ Hearing
_______ Speech/language
_______ Mental, emotional, behavioral
_______ Other physical illness/impairment
_______ **Medication taken regularly**

Please specify:____

____

This child has a health condition that may require action while he is at school.

(Please specify, e.g. seizures, bee sting allergies, diabetes, etc.)______________________________

____

Recommendations for above____

____

Special learning or emotional or social problems this child has experienced are__________________

____

Special schools or assistance received____

Currently ____________________________________ In the past __________________________________

NON-PRESCRIPTION MEDICATIONS THAT MAY BE GIVEN BY SCHOOL NURSE ON A P.R.N. BASIS:

MEDICATIONS	DOSAGE	WHEN TO GIVE	ROUTE
Children's Motrin100mg/5ml			orally
Children's Tylenol 160mg/5ml			orally
Children's Benadryl 12.5mg/5ml			orally

Except as noted above, this child is otherwise in good physical and mental health, is free of communicable disease, has no problems that may interfere with his/her learning and may participate fully in all activities.

Physician's name (please print): ____

Physician's signature: ____

Phone _________________________________Date_____________________________________

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE IMMUNIZATION CERTIFICATE

CHILD'S NAME____
LAST FIRST MI

SEX: MALE ☐ FEMALE ☐ BIRTHDATE_______/_______/_______

COUNTY _________________ SCHOOL_____________________ GRADE_______

PARENT OR GUARDIAN NAME _______________________ PHONE NO. _______________

ADDRESS _______________________ CITY _____________ ZIP________

RECORD OF IMMUNIZATIONS (See Notes On Other Side)

Vaccines Type

Dose #	DTP-DTaP-DT Mo/Day/Yr	Polio Mo/Day/Yr	Hib Mo/Day/Yr	Hep B Mo/Day/Yr	PCV Mo/Day/Yr	Rotavirus Mo/Day/Yr	MCV Mo/Day/Yr	HPV Mo/Day/Yr	Dose #	Hep A Mo/Day/Yr	MMR Mo/Day/Yr	Varicella Mo/Day/Yr	History of Varicella Disease Mo/Yr
1									**1**				
2									**2**				
3										Td Mo/Day/Yr	Tdap Mo/Day/Yr	FLU Mo/Day/Yr	Other Mo/Day/Yr
4										______	______	______	______
5										______ ______	______	______	______

To the best of my knowledge, the vaccines listed above were administered as indicated.

1. ____
Signature Title Date
(Medical provider, local health department official, school official, or child care provider only)

2. ____
Signature Title Date

3. ____
Signature Title Date

Lines 2 and 3 are for certification of vaccines given after the initial signature.

Clinic / Office Name
Office Address/ Phone Number

LOST OR DESTROYED RECORDS: (Must be reviewed and approved by a medical provider or the local health department. See notes)

I hereby certify that the immunization records of this child have been lost, destroyed or are unobtainable.

Signed: ______________________________ Date: _______________
Parent or Guardian

COMPLETE THE APPROPRIATE SECTION BELOW IF THE CHILD IS EXEMPT FROM IMMUNIZATION ON MEDICAL OR RELIGIOUS GROUNDS. ANY IMMUNIZATIONS THAT HAVE BEEN RECEIVED SHOULD BE ENTERED ABOVE.

MEDICAL CONTRAINDICATION:
The above child has a valid medical contraindication to being immunized at this time.

This is a ☐ permanent condition ☐ temporary condition until _______/_______/_______

Check appropriate box, indicate vaccine(s) and reasons: ______________________________

Signed: ______________________________ Date _______________
Medical Provider / LHD Official

RELIGIOUS OBJECTION:
I am the parent/guardian of the child identified above. Because of my bona fide religious beliefs and practices, I object to any immunizations being given to my child. This exemption does not apply during an emergency or epidemic of disease.

Signed: ______________________________ Date: _______________

MARYLAND DEPARTMENT OF HUMAN RESOURCES
Child Care Administration

HEALTH INVENTORY - ADDENDUM

CHILD'S PERSONAL RECORD FOR
CHILD CARE CENTERS, FAMILY CHILD CARE HOMES, AND
NON-PUBLIC NURSERY SCHOOLS AND KINDERGARTENS

Under Maryland law, a child under six years of age who is admitted to child care must have appropriate screening for lead poisoning. Parent(s) or guardian(s) must submit evidence of this screening to the child care provider within 30 days of admission to care. Under Maryland law, children who reside (or have ever resided) in certain areas of the State designated as at-risk for childhood lead poisoning must receive one or more blood lead tests. The at-risk areas requiring blood lead testing (per list revised May 2004 by DHMH), and instructions for that testing, are specified on the back of this form.

To be completed by a HEALTH PRACTITIONER:

____ _______________________
Child's Name **Child's Birth Date**

has received appropriate lead screening and/or blood lead testing.

NOTE - If this child resides, or has ever resided, in an area listed on the back of this form, provide the following information about the child's blood lead testing: Test #1 _______________ Test #2 _______________
Date Date

____ _______________________
Signature of Health Practitioner **Date**

____ _______________________
Address **Telephone**

____
City/Town **State** **Zip Code**

To be completed by the child's PARENT/GUARDIAN:

____ _______________________
Name of Child's Parent or Guardian Telephone

____
Address

____
City/Town State Zip Code

* *

PLEASE RETURN THIS COMPLETED FORM TO:

Name of: ____
(Child Care Center, Family Child Care Home, School)

Address: ____
Street

____
City/Town State Zip Code

TO THE ATTENTION OF: ____

At Risk Areas by Zip Code and Blood Lead Testing Instructions

Under Maryland law, children who reside, or have ever resided, in any of the at-risk zip codes listed below must receive a blood lead test at 12 months and 24 months of age. Two tests are required if the 1st test was done prior to 24 months of age. If a child is enrolled in child care during the period between the 1st and 2nd tests, his/her parents are required to provide evidence from their health care provider that the child received a second test after the 24 month well child visit. If the 1st test is done after 24 months of age, one test is required. The child's health care provider should record the test dates on this form and certify them by signing or stamping the signature section of the form. All forms should be kept on file with the child's health records.

Allegany
- ALL

Anne Arundel
- 20711
- 20714
- 20764
- 20779
- 21060
- 21061
- 21225
- 21226
- 21402

Baltimore
- 21027
- 21052
- 21071
- 21082
- 21085
- 21093
- 21111
- 21133
- 21155
- 21161
- 21204
- 21206
- 21207
- 21208
- 21209
- 21210
- 21212
- 21215
- 21219
- 21220
- 21221
- 21222
- 21224
- 21227

Baltimore (cont.)
- 21228
- 21229
- 21234
- 21236
- 21237
- 21239
- 21244
- 21250
- 21251
- 21282
- 21286

Baltimore City
- ALL

Calvert
- 20615
- 20714

Caroline
- ALL

Carroll
- 21155
- 21757
- 21776
- 21787
- 21791

Cecil
- 21913

Charles
- 20640
- 20658
- 20662

Dorchester
- ALL

Frederick
- 20842
- 21701
- 21703
- 21704
- 21716
- 21718
- 21719
- 21727
- 21757
- 21758
- 21762
- 21769
- 21776
- 21778
- 21780
- 21783
- 21787
- 21791
- 21798

Garrett
- ALL

Harford
- 21001
- 21010
- 21034
- 21040
- 21078
- 21082
- 21085
- 21130
- 21111
- 21160
- 21161

Howard
- 20763

Kent
- 21610
- 21620
- 21645
- 21650
- 21651
- 21661
- 21667

Montgomery
- 20783
- 20787
- 20812
- 20815
- 20816
- 20818
- 20838
- 20842
- 20868
- 20877
- 20901
- 20910
- 20912
- 20913

Prince George's
- 20703
- 20710
- 20712
- 20722
- 20731
- 20737
- 20738
- 20740
- 20741
- 20742
- 20743
- 20746
- 20748

P.G. (cont.)
- 20752
- 20770
- 20781
- 20782
- 20783
- 20784
- 20785
- 20787
- 20788
- 20790
- 20791
- 20792
- 20799
- 20912
- 20913

Queen Anne's
- 21607
- 21617
- 21620
- 21623
- 21628
- 21640
- 21644
- 21649
- 21651
- 21657
- 21668
- 21670

Somerset
- ALL

St. Mary's
- 20606
- 20626
- 20628
- 20674
- 20687

Talbot
- 21612
- 21654
- 21657
- 21665
- 21671
- 21673
- 21676

Washington
- ALL

Wicomico
- ALL

Worcester
- ALL

* Department of Human Resources, Child Care Administration Health Inventory Lead Addendum (DHR/CCA 1215-A)
* Maryland Department of Health and Mental Hygiene Blood Lead Testing Certificate (DHMH 4620, rev. May 2004)
  Both available in PDF format http://www.fha.state.md.us/och/html/lead.html

For more information on blood lead testing, contact your Local Health Department

School Medication Administration Authorization Form

This order is valid only for the **2011-2012** school year including the 2012 summer session.

This form must be completed fully in order for schools to administer the required medication. A new medication form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Non-prescription medication must be in the original container with the label intact.
- An adult must bring the medication to school.
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the child and/or the child's medication.

Prescriber's authorization

Name of Student ______________________________ Date of Birth ______________ Grade ____________

Condition for which the medication is being administered ______________________________

Medication Name ______________________________ Dose ______________ Route ____________

Time/frequency of administration ______________________________

If PRN, for what symptoms ______________________________

Relevant side effects ______________________________

Medication shall be administered from ______________________ to ______________________
Month/Day/Year Month/Day/Year

Prescriber's Name/Title ______________________________
(Type or print)

Telephone ______________________ FAX ______________________

Address ______________________________

____

prescriber's stamp

Prescribers Signature ______________________________ Date ______________

A verbal order was taken by the school RN (Name) ______________________ for the above medication on (Date) __________

PARENT/GUARDIAN AUTHORIZATION

I/We understand that it is the policy of the Washington Hebrew Congregation ("WHC") not to administer medicine of any kind to its students (or campers) and that WHC encourages parents and physicians to follow procedures that result in all medication being administered at home, to the extent possible. Nevertheless, if my child, as named above, requires his/her medication while in the care of WHC, I/We consent to the administration of medication as prescribed by the above prescriber. I/We understand all medication will be given by a Registered Nurse or Certified Medication Technician **except** for emergency medications. I/We hereby release WHC and any and all clergy, officers, directors, staff members, school nurses or other representatives from and against, any and all lawsuits, claims, demands, losses, obligations, actions, causes of action, judgments and liabilities of every kind or nature whatsoever, including, but not limited to, reasonable attorney's fees (collectively, "liabilities"), that any of the WHC representatives may incur or sustain by reason of or in connection with any WHC representative's good faith effort to administer medication to my child in accordance with the physician's instructions set forth above. I/We understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/We authorize the school nurse to communicate with the health care provider as allowed by HIPAA.

Parent/Guardian Signature ______________________________ Date ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Carpool Permission Form

School Year 2011-2012

Every child must have a carpool permission form on file, even if the child's parents/guardians are the only drivers.

Child's name ____________________

Class Name ____________________

My child ____________________ **has my permission to be picked up from school at any time by the following individuals *(please include parents/ guardians):***

Please print neatly

Name:	Relationship to child:	Home/Mobile Phone:
________	________	H: M: ________
________	________	H: M: ________
________	________	H: M: ________
________	________	H: M: ________
________	________	H: M: ________
________	________	H: M: ________

No child will be released to anyone other than those listed above or on the emergency form unless a note (or phone call) is received from the parent or guardian.

Parent/Guardian Name (please print): ____________________

Parent/Guardian Signature: ____________________ Date: ________

More Forms

If applicable to your child, complete and return the following forms to our school office by
Thursday, September 1.

It's Challah Time!
Fall 2011

The Parents Committee is delighted to offer you the opportunity to order freshly baked challah from the Great Harvest Bakery! It is a wonderful opportunity to bring a taste of Shabbat into your home every week.

You can sign up for our challah program each semester. A challah order for the first semester is $80 and includes 15 weeks of challah, backpacked with your child on Fridays.

Delivery will begin on Friday, September 23, 2011 and will continue every Friday that school is in session through Friday, January 27, 2012. There will be no challah delivery on 9/30, 12/23 or 12/30.

Please return orders to the "challah" folder in the school office by Friday, September 16

Checks should be payable to WHCECC

Karyn Fainbraun
Challah Chairperson
kfainbraun@gmail.com

Please return your challah order form with a check for $80 payable to WHCECC

Child's Name ____

Class Name/Grade ____

Email Address ____

Field Trip Permission Form

(3s, 4s, and Kindergarten only)
School Year 2011-2012

I hereby give permission for (child's name)____
to participate in school-sponsored field trips with his/her class. I understand that I will be notified prior to a scheduled field trip and will be given information regarding transportation, destination, lunch or other food, arrival and departure times.

By below executing this form, I acknowledge that parents of students may drive my child to and from the Rabbi Joseph Weinberg ECC field trips, and hereby release the RJWECC/WHC and any and all of its officers, directors, staff members, agents and other representatives from any and all claims, demands, losses, judgments, actions, causes of actions, obligations and other liabilities that may arise by reason of or in connection with the use of any non-ECC driver.

Maryland law requires that all children up to the age of 8 must be secured in a federally approved safety seat unless the child is at least 4 feet, 9 inches tall or weighs more than 65 pounds.

By below executing this form, I agree to provide an appropriate seat for my child to participate in school field trips.

Parent/Guardian signature____

Please print name____

Home phone____

Business phone____

Cell phone____

Date____

Enrichment Program

First Semester
September 12, 2011 – January 27, 2012

Our *Enrichment Program* gives children the opportunity to participate in many of the special projects and units for which there is limited time during the mornings. **Enrichment is offered daily, Monday – Friday from 11:45 am – 2:00 pm** for children in our 3's & 4's programs. During *Enrichment* the children eat lunch together, enjoy additional indoor and outdoor play time and participate in a different activity each day. Highlights of the *Enrichment Program* include science, cooking, drama, creative movement, art and music.

Children need not be toilet trained to participate in our *Enrichment Program.* Children can either bring their lunch (we are a nut-, pork- and shellfish-free school) or enroll in our Hot Lunch Program (information is available in our Back to School packet).

The first semester *Enrichment Program* will begin on Monday, September 12, 2011 and end Friday, January 27, 2012. You may enroll your child for up to five afternoons per week. Enrollment for our second semester, which will begin on January 30, 2012, will occur in January.

The fees for the first semester are **$388/day WHC members** or **$426/day Non WHC members** **($310 for Temple members on Thursdays and $345 for non-members on Thursdays).** For example, a child of a Temple member who stays three days a week for *Enrichment* would pay $1,164 for the semester ($388 x 3 = $1,164).

Full payment is required with this application. Please return this form, along with your check, payable to WHC, to Donna Levin in the school office.

Enrichment Program Registration 1st Semester: Sept. 2011 – Jan. 2012

Please enroll my child ____

for the following Enrichment Program day(s) for the First Semester:

___MON. ($388/426) ___TUES. ($388/426) ___WED. ($388/426) **___THURS. ($310/345)** ___FRI. ($388/426)

# of days __________ x daily rate _______________ = Total amount due $________________

Child's morning classroom teacher(s)________________________Temple member(Y/N) ______

Parent's name (please print) ____

Parent's signature____ Date ______________

Home phone____________________________ Business phone_________________________

Cell phone ________________________

The Rabbi Joseph Weinberg Early Childhood Center reserves the right to cancel a program due to insufficient enrollment and to limit enrollment on any given day.

Hot Lunch Program
by Potomac Pizza

1st Semester 2011-2012

Service begins Monday, September 12, 2011

Parents of **Kindergarten and 3's and 4's Enrichment Program students** – We have a wonderful opportunity for you to have a complete daily hot lunch provided by Potomac Pizza.

The weekly lunch menu will be as follows:

Mondays:	Chicken Strips
Tuesdays:	Cheese Pizza
Wednesdays:	Chicken Strips
Thursdays:	Penne Pasta (tomato sauce on the side)
Fridays:	Cheese Pizza

All lunches will include:
Bottled water
Fruit/vegetable: may include sliced apples, baby carrots and dip, etc.
Dessert: may include cookie, pudding, chips, etc.

IMPORTANT:
- Children must also be registered for Enrichment for each day you would like lunch delivery
- NO make-up days, refunds or special orders

LUNCH PROGRAM FORMS ARE DUE BY Thursday, September 1st to allow adequate time to process and register your child for lunch. Please complete the following enrollment form and return it with your payment to the school office.

Bonus!
Sign up for four days of lunch and receive a $25 Potomac Pizza gift card!!
Sign up for five days of lunch and receive a $50 Potomac Pizza gift card!!

We know your kids will love the food and you will love the convenience!!

Questions? Please contact Fran Miller, 301-279-7505

Hot Lunch Program by Potomac Pizza

1st Semester, 2011-2012

Please complete this enrollment form and return it with your payment to the front office by September 1st.

Child's name:___________________________ Class name:______________________

Parent's name:__________________________ Phone #:_________________________

Please indicate which day(s) you would like your child to receive a hot lunch from Potomac Pizza.

You may enroll your child for lunch on any day your child is also registered for our Enrichment Program!

Delivery will begin on
Monday, September 12, 2011 and continue until Friday, January 27, 2012
except as noted below:

___ **Mondays: Chicken Strips (16 days x $5) $80.00**
(No lunch on: November 14, December 26, January 2, 16)

___ **Tuesdays: Cheese Pizza (18 days x $5) $90.00**
(No lunch on: November 15, December 27)

___ **Wednesdays: Chicken Strips (16 days x $5)................................... $80.00**
(No lunch on: September 28, November 23, December 21, 28)

___ **Thursdays: Penne Pasta (13 days x $5)...................................... $65.00**
(No lunch on: September 29, October 13, 20, November 24, December 8, 22, 29)

___ **Fridays: Cheese Pizza (15 days x $5) $75.00**
(No lunch on: September 30, October 7, November 25, December 23, 30)

PLEASE MAKE CHECKS PAYABLE TO WHC

The deadline to enroll in Hot Lunch is Thursday, September 1st!!