



SUMMER PROGRAM IMPORTANT INFORMATION

- ◆ The dates of the program are Monday, June 28th – Friday, August 6th 2010
- ◆ Sign up begins now!! Applications can be found in the school office or classrooms.
- ◆ All summer classes are held in the morning 9:00-11:30am.
- ◆ Miss Karen Famularo and Miss Theresa Healy will lead the program.
- ◆ The costs for the entire six week program are as follows:

2 Days	\$310.00
3 Days	\$370.00
4 Days	\$490.00
5 days	\$610.00

- ◆ You may choose what days you would like your child to attend, but you must indicate on your registration forms so that we can set the class lists. You must be consistent throughout the six weeks.
- ◆ Parent Participation is not required during the summer months. If you wish to make yourself available as a volunteer, an extra pair of hands is always appreciated.
- ◆ Each child will be responsible to bring snack once for the entire class.
- ◆ If your child is new to our school, you must fill out an immunization form before the program begins.
- ◆ Checks should be made out to ICNS and must be submitted with an application. All money is non-refundable.
- ◆ Remember that space is limited and registration is on a first come, first served basis.
- ◆ Call (516) 593-3443 with questions or concerns.



www.intercommunitynurseryschool.com
20 Thompson Place ♥ Lynbrook, NY 11563 ♥ 516-593-3443

SUMMER APPLICATION AND PARENT CONTRACT



20 Thompson Place
Lynbrook, New York 11563
(516) 593 - 3443

Child's Name: _____
(First) (Middle) (Last)

Address: _____

Birthdate: _____ Sex: _____ Home Phone: _____
(mo/day/yr)

Mother's Name: _____ Father's Name: _____

Mother's Work Phone: _____ Father's Work Phone : _____

Mother's Cell Phone: _____ Father's Cell Phone : _____

Days of the week your child will be attending this summer: _____

PARENT CONTRACT

I, the undersigned parent of _____
(Child's full name)

hereby apply for membership in the InterCommunity Nursery School 2010 Summer Program.

Upon acceptance as a member and enrollment of my child in the school, I agree:

1. To sign permission and emergency treatment forms.
2. To supply nutritious snack for all students in my child's class on the date assigned.

Furthermore, I understand that should I decide to withdraw my child at any time after the registration fee has been paid that no refund will be issued.

Parent Signature: _____ Date: _____

NOTICE OF NON-DISCRIMINATORY POLICY AS TO STUDENTS

ICNS admits students of any race, color, national and ethnic origin to all the rights privileges programs and activities generally accorded or made available to students at the school. It does not discriminate on basis of race, color, national and ethnic origin in administration policies, scholarship and loan programs, and athletic and other programs

EMERGENCY TREATMENT PERMISSION – Summer Program 2010

Child's Name: _____ Home Phone: _____
(First) (Last)

If my child should require medical attention due to an accident or illness during school hours and neither parents, emergency name, or family physician can be reached, I hereby give my permission to have emergency treatment administered at this time by a physician available to the school or at the local hospital.

PRINT ALL INFORMATION CLEARLY:

Physician's Name: _____ Phone: _____

Physician's Address: _____

1. Emergency Name: _____ Phone: _____

Relationship to child: _____

2. Emergency Name: _____ Phone: _____

Relationship to child: _____

Does the above child have ANY allergies? _____

Are there any conditions of the child that should be known by an attending physician or health care worker? _____

Has your child been hospitalized recently? _____

If yes, please state the nature of the illness and the length of the stay: _____

Parent's Name: _____

Parent's Signature: _____ Date: _____

NOTARY PUBLIC:

Sworn before me this day _____

CERTIFICATE OF IMMUNIZATION

Child's Name _____ Entering Summer Program 2010
(First/Middle/Last)

Birth Date: _____ Date of Last Check-up: _____
(Month/Day/Year)

Parents Name: _____ Home Phone: _____

Home Address: _____
(Street Address, City, State & Zip)

In accordance with New York State Public Health Law 2164 a Certificate of Immunization, signed by a Physician, listing exact dates, *must be on file with the school on the first day of classes.*

Minimum 3 full dose rates required for school attendance.

Legal requirements waived because of: Religious Exemption: _____. If yes, written statement attached

	Month / Day / Year				
	Dose #1	Dose #2	Dose #3	Booster	Booster
DPT <small>(Diphtheria, Pertussis, Tetanus)</small>					
DT <small>(Diphtheria, Tetanus)</small>					
TOPV <small>(Trivalent Oral Polio Vaccine)</small>					
Mumps					
Measles					
Rubella					
MMR <small>(Measles, Mumps, Rubella)</small>					
HIB <small>(Haemophilus Influenza Type B)</small>					
Varicella / Chicken Pox Vaccine					

Tine Test (TB): _____ Other: _____

Date of Last Tetanus Immunization: _____

Vaccines waived due to temporary conditions: _____

Physician's Medical Exemption: _____

Physician's statement attached with list of vaccine's waived _____

Physician's Name: _____ Physician's Phone: _____

Physician's Address: _____

Physician's Signature: _____ Date: _____