



# SCOPE EDUCATION SERVICES 2017-2018 PRE-KINDERGARTEN REGISTRATION IS NOW OPEN!

## 3 year old program

M-W-F

8:30 AM-11:00 AM

Or

12:00 PM-2:30 PM

**Tuition \$260.00**

## 4 year old program

Mon-Fri

8:30 AM-11:00 AM

Or

12:00 PM-2:30 PM

**Tuition \$319.00**

## Program Location

**Norwood Elementary  
290 Norwood Avenue  
Port Jefferson Station,  
NY 11776**

Visit us at  
[www.scopeonline.us](http://www.scopeonline.us)

SCOPE Education Services in cooperation with Comsewogue School District is pleased to provide a financially self-supporting Pre-K Program for the 2017- 2018 school year.

There is a non-refundable annual registration fee of \$40 (\$20 for each additional child from the same family). Please complete and mail the application along with the \$40 registration fee and first month's tuition. Please refer to the checklist and include all required information with your registration form.



Children must turn 3 or 4 by December 1, 2017. There is a 10% sibling discount for a second child. For further information, please contact us at (631) 360-0800 ext. 133 or [dingarozza@scopeonline.us](mailto:dingarozza@scopeonline.us)

- Curriculum aligned with the New York State Pre-Kindergarten Learning Standards
- A NYS Certified Teacher and Teacher Assistant for every 16 students in the 3 year old program and for every 18 students in the 4 year old program
- The program will operate from September 2017 through June 2018, in accordance with the Comsewogue School District Calendar



District residents are given priority during the registration process. Once district registration is complete, non-resident registrations will then be accepted.



Mail completed registration forms to:  
SCOPE Education Services/Pre-K Registration  
100 Lawrence Avenue  
Smithtown, NY 11787

\*\* Fees for the 2017-2018 school year are subject to change.\*\*



100 Lawrence Ave  
Smithtown, NY 11787

Dear Parent /Guardian,

Thank you for your interest in the SCOPE Pre-Kindergarten Program. Enclosed are materials to be completed for the registration of your child, as well as an outline of our program.

Please refer to the checklist below to be sure all necessary information is completed and returned to SCOPE.

- SCOPE Pre-School Registration
- Medical Statement (Pages 1 and 2)
- Proof of Residency (i.e. utility bill, tax bill, mortgage statement)  
Driver's License will not be accepted as proof
- Copy of Birth Certificate
- Registration and First Month's tuition fee

**If paying by credit card:**

- Credit Card payment form
- Automatic Payment Service form

**\*PLEASE REVIEW PAYMENT SCHEDULE INFORMATION INCLUDED IN THIS PACKET\***

Please keep the **SCOPE PRE-SCHOOL PROGRAM REGISTRATION AGREEMENT**

If you have any questions or concerns, please contact the Student Services Pre-Kindergarten Department at 631-360-0800 ext 133.



# SCOPE Education Services 2017-2018 Pre-Kindergarten Registration Application

SCOPE ID#
For office use only

100 Lawrence Avenue, Smithtown, NY 11787 Telephone: 631-360-0800 Ext. 133

FOR  
SCOPE  
OFFICE  
USE

Business Office Received By: _____ Date: _____ Budget Code _____
Registration Fee _____ Payment Method _____

\_\_\_\_ Birth Cert  
\_\_\_\_ Medical  
\_\_\_\_ Proof of Res

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F

Home Address \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Program Site \_\_\_\_\_

Program: 3 year old \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_

4 year old \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_

**Parent/Guardian Information:** (Both parents must be listed)

Child may be released to both parents? \_\_\_\_ Yes \_\_\_\_ No \* Note: If **NO**, legal documentation is required.

1. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Cell phone \_\_\_\_\_ email \_\_\_\_\_

Home Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Place of work \_\_\_\_\_ Address \_\_\_\_\_

Work Hours \_\_\_\_\_ Work Phone \_\_\_\_\_

2. Name \_\_\_\_\_ Relationship to child \_\_\_\_\_

Cell phone \_\_\_\_\_ email \_\_\_\_\_

Home Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Place of work \_\_\_\_\_ Address \_\_\_\_\_

Work Hours \_\_\_\_\_ Work Phone \_\_\_\_\_

**List a minimum of 2 emergency contact names who can be reached during program hours. Contacts must be 18 years or older and authorized to pick up your child. (A neighbor is strongly suggested).**

1) Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address: \_\_\_\_\_

2) Name: \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address: \_\_\_\_\_

3) Name: \_\_\_\_\_ Phone \_\_\_\_\_ Cell \_\_\_\_\_

Address: \_\_\_\_\_

**Pick Up Restrictions** \_\_\_\_\_



**Pre-Kindergarten  
Registration Application  
Page 2**

Indicate areas of child's special needs by circling Yes or No:

**Emotional: Yes No Social: Yes No Medical: Yes No Psychological: Yes No Educational: Yes No**

Explain each Yes circled item. List and include allergies, medications, etc...

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**In the event parents cannot be reached in a medical emergency, I give SCOPE permission to seek medical attention from a physician or hospital.**

**\*Signature of parent or guardian (required)**

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Physician's Name \_\_\_\_\_

Office Phone# \_\_\_\_\_

MEDIA RELEASE STATMENT

**I DO/DO NOT** (circle one) give permission for my child to appear in any media coverage approved by the SCOPE Program.

I have read, understand and agree to adhere to the SCOPE Student Services Pre-School Registration Agreement included in my Pre-School Registration Packet and give my child permission to fully participate in this program. Attached is my non-refundable annual registration fee of \$40.00 and first month's tuition.

**\*Signature of parent or guardian (required)**

\_\_\_\_\_ Date \_\_\_\_\_



## SCOPE EDUCATION SERVICES 2017-2018

### COMSEWOGUE SCHOOL DISTRICT PRE-KINDERGARTEN FEE SCHEDULE

**There is a non-refundable monthly tuition fee that is due on or before the 15<sup>th</sup> of each month. This payment reflects tuition for the upcoming month. Tuition for September is due upon registration. Fees are subject to change.**

\$40 non-refundable one time registration fee (\$40 first child, \$20 each additional child)

\$260 Monthly Tuition Three year old program / 3 days a week

\$319 Monthly Tuition Four year old program / 5 days a week

**There is a 10% discount for each additional sibling  
PREPAY YOUR ANNUAL TUITION & SAVE 5%!**

#### **PAYMENT OPTIONS FOR 1<sup>ST</sup> TUITION PAYMENT:**

The first month's tuition can be paid by:

- credit card (see attached Autopay & One Time Credit Card Forms)
- check
- money order

**Mail your registration fee, 1<sup>st</sup> month's tuition payment and registration packet to:**

**SCOPE Education Services/Registration  
100 Lawrence Avenue, Smithtown, NY 11787**

**NOTE:** Parents will be notified by mail of their enrollment status

#### **Payment options for all subsequent tuition payments**

**CREDIT CARD/AUTOPAY: COMPLETE SEPARATE FORM AND FAX TO (631) 881-9672 OR MAIL TO:**

**SCOPE PAYMENT CENTER  
100 Lawrence Avenue  
Smithtown, NY 11787**

**ONLINE (CHECK/CREDIT CARD ONLINE): Go to: [www.scopeonline.us](http://www.scopeonline.us). Student ID# required.**

#### **MAIL CHECK/MONEY ORDER TO:**

**SCOPE EDUCATION SERVICES, GENERAL P.O. BOX 30550  
NEW YORK, NY 10087-30550  
(Include Student ID#)**

**PLEASE DO NOT INCLUDE OTHER PAPERWORK WITH YOUR CHECK**

**There is a \$15.00 fee for phone-in payments.  
Contact SCOPE Payment Center for more information @ 631-360-0800 ext. 207**

**SCOPE EDUCATION SERVICES  
2017-2018 AUTOMATIC PAYMENT SERVICE**

**COMSEWOGUE PRE-KINDERGARTEN**

SCOPE IS PLEASED TO PROVIDE A SAFE, QUICK AND CONVENIENT PAYMENT SERVICE FOR PARENTS WHO WISH TO PAY BY CREDIT CARD.

I authorize SCOPE Education Services to automatically charge my credit card on or about the 15<sup>th</sup> of each month, for the upcoming month's tuition. I further understand that any additional fees incurred (adding days, late pick-up fees, extended care, etc.) will be automatically charged separately to my credit card. I understand all payments are non-refundable.

Please check appropriate amount:

\_\_\_\_\_ \$40 non-refundable one time annual registration fee (\$40 first child; \$20 each additional child)

\_\_\_\_\_ \$260 Monthly Tuition - Three year old program / 3 days a week

\_\_\_\_\_ \$319 Monthly Tuition - Four year old program / 5 days a week

**All information must be completed in order to process credit card.**

Please check form of payment:

\_\_\_\_\_ VISA    \_\_\_\_\_ MC    \_\_\_\_\_ AMEX    \_\_\_\_\_ DISCOVER

Credit Card Number \_\_\_\_\_ Exp. Date \_\_\_\_\_

CSV# \_\_\_\_\_ (3 digit # on signature panel on back of card; AMEX is 4 digits on front of card.)

Name as it appears on credit card: \_\_\_\_\_

Billing Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_ Phone # \_\_\_\_\_

**Cardholder's Signature:** \_\_\_\_\_

Child's Name: \_\_\_\_\_ SCOPE ID # \_\_\_\_\_

Program: \_\_\_\_\_

PLEASE NOTE THE FOLLOWING:

- Fax to (631) 881-9672 or mail to: SCOPE Payment Center, 100 Lawrence Ave, Smithtown, NY 11787
- You may stop the Automatic Payment Service at any time by directly notifying SCOPE Education Services, in writing via mail or fax. Mail to: SCOPE Payment Center, 100 Lawrence Ave, Smithtown, NY 11787. Fax to (631) 881-9672. To change credit card information, a new form must be filled out.
- If your credit card is declined you will be charged a \$25.00 fee (\$20.00 late fee and \$5.00 reprocessing fee).
- SCOPE FEDERAL ID #: 112073576 (please retain a copy of this form for income tax purposes)

**QUESTIONS? Call 631-360-0800 EXT. 207**



## CREDIT CARD PAYMENT FORM

I authorize **SCOPE** Education Services to charge my credit card for my **child's first month's tuition**, plus a \$15 processing fee. I understand this will be a **ONE-TIME ONLY** charge to my credit card. I also understand all payments are non-refundable.

**PLEASE COMPLETE BELOW AND MAIL WITH YOUR REGISTRATION FORM TO:**

**SCOPE PAYMENT CENTER  
100 LAWRENCE AVENUE  
SMITHTOWN, NY 11787**

Please indicate amount to be charged: \$ \_\_\_\_\_

+ \$15.00 (processing fee)

Total \$ \_\_\_\_\_

Please check method of payment: \_\_\_\_\_ **VISA** \_\_\_\_\_ **MC** \_\_\_\_\_ **AMEX** \_\_\_\_\_ **DISCOVER**

CREDIT CARD NUMBER \_\_\_\_\_ EXP. DATE \_\_\_\_\_

CSV# \_\_\_\_\_ (3 digit # on signature panel on back of card; AMEX is 4 digit # on front of card)

Name as it appears on credit card: \_\_\_\_\_

Billing Address \_\_\_\_\_

\_\_\_\_\_

**CARDHOLDER'S SIGNATURE** \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ SCOPE ID# \_\_\_\_\_

HOME SCHOOL \_\_\_\_\_ PROGRAM \_\_\_\_\_

PHONE NUMBER \_\_\_\_\_ EMAIL \_\_\_\_\_

**PLEASE NOTE THE FOLLOWING:**

If your credit card is declined, you will be charged a \$25.00 fee (\$20.00 late fee and \$5.00 reprocessing fee).

**SCOPE'S FEDERAL ID# 112073576** (please retain a copy of this form for income tax purposes)

**QUESTIONS? CALL 631-360-0800 EXT 207**

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**CHILD IN CARE MEDICAL STATEMENT**

**To Be Completed By Licensed Physician, Physician's Assistant or Nurse Practitioner**

Name of Child:	Date of Birth:	Date of Examination:
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**Immunizations required for entry into day care**

Yes  No

**Medical Exemption** The physical condition of the named child is such that one or more of the immunizations would endanger life or health. Attach certification specifying the exempt immunization(s).

	1 <sup>st</sup> Date	2 <sup>nd</sup> Date	3 <sup>rd</sup> Date	4 <sup>th</sup> Date	5 <sup>th</sup> Date
Diphtheria, Tetanus and Pertussis (DPT) Diphtheria and Tetanus and acellular Pertussis (DTaP)					
Polio (IPV or OPV)					
Haemophilus influenzae type B (Hib)				4 <sup>th</sup> Date <b>OR</b> 1 <sup>st</sup> Date (if given on or after 15 months of age)	
Pneumococcal Conjugate (PCV) for those born on or after 1/1/08)				4 <sup>th</sup> Date	
Hepatitis B			3 <sup>rd</sup> Date		
Measles, Mumps and Rubella (MMR)		2 <sup>nd</sup> Date			
Varicella (also known as Chicken Pox)		2 <sup>nd</sup> Date			

**Other Immunizations may include the recommended vaccines of Rotavirus, Influenza and Hepatitis A**

Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:
Type of Immunization:	Date:	Type of Immunization:	Date:

**Tests**

Tuberculin Test Date: \_\_\_ / \_\_\_ / \_\_\_ Mantoux Results:  Positive  Negative \_\_\_\_\_ mm  
 TB Tests are at the physician's discretion. Acceptable tests include Mantoux or other federally approved test.  
 If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: \_\_\_ / \_\_\_ / \_\_\_  
 Attach lead level statement  
**Lead Screening (Include All Dates and Results)**

1 year \_\_\_ / \_\_\_ / \_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary  
 2 years \_\_\_ / \_\_\_ / \_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary

**Most recent date of lead screening (if different from above):**  
 \_\_\_ / \_\_\_ / \_\_\_ Result: \_\_\_\_\_ mcg/dL  Venous  Capillary

**Per NYS law, a blood lead test is required at 1 and 2 years of age and whenever risk of lead poisoning is likely.**  
 If the child has not been tested for lead, the day care provider may not exclude the child from child day care, but must give the parent information on lead poisoning and prevention, and refer the parent to their health care provider or the county health department for a lead blood screening test.

*(Continued on reverse side)*



## CHILD IN CARE MEDICAL STATEMENT *(continued)*

Health Specifics	Comments
Are there allergies? (Specify) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	<hr/> <hr/>
Is medication regularly taken? (Specify drug and condition) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	<hr/> <hr/>
Is a special diet required? (Specify diet and condition) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	<hr/> <hr/>
Are there any hearing, visual or dental conditions requiring special attention? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	<hr/> <hr/>
Are there any medical or developmental conditions requiring special attention? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	<hr/> <hr/>

### Summary of Physical Exam

Include special recommendations to child day care providers

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On the basis of my findings as indicated above and on my knowledge of the named child, I find that: he/she is free from contagious and communicable disease and is able to participate in child day care.  Yes  No

Signature of Examiner	Address
Please Print Name	City, State, Zip
Title	(      ) Phone <span style="float: right;">Date</span>

### Religious Exemptions

Public Health law Section 2164 allows a child to be religiously exempted from immunization. A written and signed statement from a parent, parents or guardian of the child stating that they object of the immunization of their child due to their sincere and genuine religious beliefs should be submitted to the day care owner, operator or administrator who shall determine whether the statement of religious belief is acceptable.



## Pre-School Program Registration Agreement

100 Lawrence Ave., Smithtown, NY 11787

631-360-0800 Ext 133 Fax: 631-881-9671

[www.scopeonline.us](http://www.scopeonline.us)

1. I understand that I am enrolling my child in the SCOPE Pre-School Program for the school year.
2. I understand there is an annual registration fee for my child which includes insurance. The fee is non-refundable unless the program is canceled due to insufficient enrollment.
3. I understand no payments of any kind will be accepted at the program site.
4. I understand there are specific age requirements for the program and agree to furnish proof of age.
5. I understand my child will not be admitted into the program until I furnish documentation indicating that my child has received the required NYS age-appropriate immunizations and a physical examination.
6. I understand I am responsible for transporting my child to and from the program and for escorting my child promptly to and from the classroom.
7. I understand the program has specific start and end times. If I pick my child up late, I will incur a late fee for every 15 minutes, or part thereof, that I am delayed. If I know that I will be late, I agree to arrange for an authorized person to pick my child up from the program. **Excessive lateness may result in withdrawal of my child from the program.**
8. I understand there is a non-refundable monthly tuition fee. The tuition is due on or before the 15th of each month, in advance for the upcoming month (with exception of the September tuition).
9. **I understand there will be no refunds or credits for absences.**
10. I understand that if my check is returned for insufficient funds, a \$45.00 fee will be charged (\$25.00 administration fee and a \$20.00 late fee). After two returned checks, all tuition fees will be required to be paid by money order or certified check, or credit card. I understand if my credit card is declined it will be charged a \$25.00 fee (\$20.00 late fee and \$5.00 reprocessing fee).
11. I understand that if school is closed or closes early due to inclement weather or any other emergency, the SCOPE Program will also be closed. No refund or credits will be issued for emergency closings.
12. I understand that if my child becomes ill during program hours, I will be contacted. I or an authorized person agree to pick up my child immediately.
13. I agree to inform the teacher immediately of any changes in the information I have provided and of any special needs my child may have.
14. I understand that my child's continued acceptance into the program depends on his/her ability to comply with the rules of the program.
15. I understand that SCOPE is not a special needs program; however, SCOPE will make every effort to reasonably accommodate my child's needs. I must complete a student profile form. Once received, I will be contacted to discuss what SCOPE is able to provide my child, at which time I can make a judgment regarding my child's placement. Failure to disclose pertinent information which would affect staffing/safety may result in my child's exclusion from the program.
16. I UNDERSTAND THAT IF A MEDICAL EMERGENCY ARISES, THE SCOPE STAFF WILL ATTEMPT TO CONTACT ME. IN THE EVENT I CANNOT BE REACHED, I GIVE PERMISSION FOR SCOPE TO SEEK MEDICAL ATTENTION FROM A PHYSICIAN AND/OR HOSPITAL FOR MY CHILD.

**KEEP THIS FOR YOUR RECORDS**

