

mayo, 2011

Queridos padres del Anchor Center:

Este año, su hijo/hija va a empezar en el programa preescolar de Anchor Center for Blind Children! Estamos esperando una transición buena para su hijo/hija. El programa del otoño empieza el día martes, 16 de agosto, 2011.

En el paquete, van a encontrar los materiales de inscripción para el programa preescolar de Anchor Center. Todas las formas son importantes, pero nuestra licencia requiere que tenemos los documentos de las vacunas para todos los niños/niñas. Si no tenemos esta forma, no se permite entrar al programa del Anchor Center. Por favor, por favor, por favor llene todas las formas y traígalas antes del 9 de agosto, 2011.

Adjunto:

- Historia del niño/niña (2 lados)
- Contrato de matrícula
- Permiso para sacar fotos de su hijo/hija
- Declaración de la salud anual (el doctor puede usar su propia forma)
- Forma de vacunas (el doctor puede usar su propia forma)
- Autorización para emergencias médicas
- Forma de información para emergencias
- Forma de autorización general
- Calendario escolar del año 2011-2012, Calendario del grupo Anchor Compass, y el Horario de juntas para padres – favor de anotar las fechas importantes y los días de vacaciones (y anote las fechas y horas de juntas para los padres)

Favor de traer lo siguiente en su primer día de la escuela:

- Pañales (si se necesita)
- Ropa extra (incluso ropa interior y una chaqueta)
- Una comida para compartir (nada con cacahuete, por favor)
- Una caja de bolsas de plástico (“sandwich”)
- Una caja de colores (crayons)
- Una caja de marcadores
- Unas tijeras
- Un paquete de papel para la fotocopidora
- Una caja de curitas

Frecuentemente el Anchor Center ofrece “juegos sucios”, por eso es mejor mandar a su hijo/hija con ropa “de jugar” que se puede ensuciar. Les avisaremos antes de ocasiones especiales cuando los niños pueden usar ropa más bonita.

Usted y su hijo/hija van a tener una persona de contacto principal. Ella le llamará por lo menos una vez al mes para discutir preocupaciones y contestar cualquier pregunta. También es la responsabilidad de ella informarle de cambios del programa o de información adicional. Le invitamos a contactarle a ella con cualquier pregunta.

Horario de la escuela:

El programa preescolar va a ser los martes, jueves y algunos viernes. El equipo preescolar está trabajando ahora con confirmar las horas y las maestras para las clases del otoño. Le vamos a avisar en junio el nombre de la maestra de su hijo/hija y las horas de su clase. Sabemos que ya quieren conocer la maestra de su hijo/hija y el horario de la escuela, pero por favor tenga paciencia mientras tratamos de hacer el horario de nuestra escuela que está siempre creciendo. Queremos que sea un año feliz y memorable para su hijo/hija.

Otra información:

- Favor de llegar a tiempo! Es mejor para todos, especialmente para su hijo/hija, tener una rutina consistente.
- Es importante llegar a tiempo para recoger a los niños al fin del día para aliviar ansiedad y para apoyar a las maestras quienes tienen otros trabajos, visitas a casas, y juntas de IFSP.

Preguntas? Favor de llamar. Se puede dejar un mensaje en la extensión 110 y regresaremos la llamada tan pronto como posible.

Si no tiene una copia de nuestra Libro para Padres, favor de avisarnos y le daremos una copia.

Estamos esperando un año espectacular empezando en agosto. Gracias por todo que hacen Ustedes para ayudarnos a ayudar a su hijo/hija!

Sinceramente,

Lisa Roll, MA
Early Childhood Special Educator
Preschool Lead

School Year: 2011-2012

Enrolled in:
Infant group _____
Toddler Group _____

CHILD RECORD
(2-sided)

1. Child's Full Name _____
Birth Date _____
Address _____ City _____
County _____ Zip Code _____

2. Father's Name _____
Address _____
Telephone: (home) _____ (cell) _____ (work) _____
Email _____
Employment Address _____

3. Mother's Name _____
Address _____
Telephone: (home) _____ (cell) _____ (work) _____
Email _____
Employment Address _____

4. Parent(s) or Guardian(s) with whom child resides:

Name _____ Relationship _____
Name _____ Relationship _____

5. Person(s) who may attend program with your child: (Grandparents, Aunts, Uncles, Friends, etc.)

Name _____ Relationship _____
Address _____
Telephone: (home) _____ (cell) _____ (work) _____

Name _____ Relationship _____
Address _____
Telephone: (home) _____ (cell) _____ (work) _____

Name _____ Relationship _____
Address _____
Telephone: (home) _____ (cell) _____ (work) _____

6. Pediatrician's name (or Medical Practice name) _____
Address _____ Phone _____
Name of Preferred Hospital _____
Address _____ Phone _____

7. Other children in family: **Sibling care?**
5-year-old and under

Name _____ DOB _____ Yes _____ No _____
Sibling Care: Mon _____ Wed _____

Name _____ DOB _____ Yes _____ No _____
Sibling Care: Mon _____ Wed _____

Name _____ DOB _____ Yes _____ No _____
Sibling Care: Mon _____ Wed _____

8. Allergies:

9. List any current prescription drug(s) child is taking:

10. Other major service providers:
Agency: _____ Contact Person: _____
Address _____ Phone _____

Parent Signature

Date

**Tuition Contract -- Preschool
2011-2012**

Anchor Center for Blind Children is a private non-profit organization funded by gifts from foundations and individuals, reimbursements from county and school agencies, and tuition paid by families of toddlers and preschoolers. The budgeted cost for one preschooler is \$21,530 for the year.

Donations make it possible for us to subsidize tuition. However, it is with regret that we are, for the first time in over ten years, raising tuition. Families with children attending the infant program will, as always, not be charged anything. **The parent portion of tuition cost for your preschooler to attend Anchor Center for Blind Children for the 2011-2012 school year is \$1,500.**

Discounts are given to families paying in full by September 30, 2011. See options below. Please indicate your payment option, sign and return this form to Anchor Center by August 16, 2011. Monthly tuition payments are due by the 1st of each month.

_____ My county agency or school district is paying my child's Anchor Center Tuition. School District: _____
School contact: _____

_____ \$1,200.00 if paid in full by September 30, 2011 -- 20% discount.

_____ \$1,350.00 if paid in two payments of \$675.00 each due September 30, 2011 and October 31, 2011 -- 10% discount

_____ \$150.00 per month paid on the first of each month from September 2011 through June 2012.

_____ Amount we can pay per month.

_____ We are unable to pay any of the tuition options above and would like to meet with Anchor Center's Executive Director or Family Specialist to set up an acceptable payment plan.

We are willing to exchange volunteer services for tuition. _____

I/We agree to pay tuition to Anchor Center for Blind Children as indicated above.

Child's Name _____ (Please print)

Parent/Guardian Name _____ (Please print)

Signature _____ Date _____



PERMISO PARA SACAR FOTOS

Doy mi permiso que los trabajadores o voluntarios del Anchor Center for Blind Children puedan sacar fotos o grabar video de mi hijo/hija se llama _____.

Otras agencias que tienen un objective educativo o promocional que promueva la misión del Anchor Center también pueden sacar fotos con el permiso de nuestras maestras o trabajadores.

Las fotos y el video que incluye mi hijo/hija pueden ser publicados o usados para enseñar, las promociones, pedir fondos, las relaciones públicas, y en el internet.

Firma de padre/tutor

Fecha

(ésta forma se aplica durante todos los años que mi hijo/hija sea estudiante en el programa de Anchor)

mayo, 2009

Permission to Participate

Dear Parents:

As you know we have a delightful tree house in our motor area of the building. Elements of the tree house are there to provide opportunities for the children to learn to climb using hand and foot holds.

We will use belay and harness equipment with the children and there will always be an adult in the area supervising and managing the activities.

Please sign below to acknowledge that you are willing to have your child participate in activities in the tree house. Please contact any staff member for more specifics.

My child _____ has permission to participate in supervised climbing activities in the tree house area of the motor room at Anchor Center for Blind Children.

Printed Name

Date

Signature

ANNUAL HEALTH STATEMENT

DATE _____

This letter is to certify that _____ is under my care, is in good physical condition, and has had all necessary immunizations.

Signed _____
(Child's Physician)

If there is any pertinent information about this child's general health (such as allergies, physical or emotional problems etc.) that might have an effect on the way he/she functions in the program, please list below:

COLORADO LAW REQUIRES THIS FORM BE COMPLETE AND PROVIDED TO THE SCHOOL

Name _____ Date of Birth _____
 Parent/Guardian _____

COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT—CERTIFICATE OF IMMUNIZATION

Vaccine	Enter complete date each immunization was given				
Hep B	Hepatitis B				
DTaP/Tdap	Diphtheria, Tetanus, Pertussis				
DT/Td	Tetanus, Diphtheria				
Hib	<i>Haemophilus influenzae</i> type b				
IPV/OPV	Polio				
PCV7	Pneumococcal Conjugate				
MMR	Measles, Mumps, Rubella				
Varicella	Chickenpox			Healthcare Provider Documentation Date _____	Lab Verification Date _____
Vaccines recorded below this line are recommended. Recording of dates are optional.					
HPV	Human Papillomavirus				
Rota	Rotavirus				
MCV4/MPSV4	Meningococcal				
Hep A	Hepatitis A				
TIV/LAIV	Influenza				
Other					

To the best of my knowledge, the person named above has received the above immunizations.

DO NOT SIGN UNLESS ALL IMMUNIZATION REQUIREMENTS ARE MET

Signed _____ Title _____ Date _____
 (Physician, nurse, or school health authority)

Table 1. MINIMUM NUMBER OF DOSES REQUIRED FOR CERTIFICATE OF IMMUNIZATION

Vaccine*	Level of School/Age of Student											
	Child Care 2 to 3 mos	Child Care 4 to 5 mos	Child Care 6 to 7 mos	Child Care 8 to 11 mos	Child Care 12 to 14 mos	Child Care 15 to 17 mos	Child Care 18 to 23 mos	Preschool 2 to 4 yrs	K Entry 4 to 6 yrs	Grades K to 5 5 to 10 yrs	Grades 6 to 12 11 to 18 yrs	College
Pertussis/Tetanus/Diphtheria	1	2	3	3	3	4	4	4	5/4 ^b	5/4 ^{b,c}	6 ^{c,d}	
Polio ^e	1	2	3	3	3	3	3	3	4/3 ^f	4/3 ^f	4/3 ^f	
Measles/Mumps/Rubella ^g					1	1	1	1	2 ^h	2 ^h	2 ^h	2 ^{h,i}
<i>Haemophilus influenzae</i> type b (Hib)	1	2	2	3/2	3/2	3/2/1	3/2/1	3/2/1				
Pneumococcal Conjugate ^k	1	2	3/2	3/2	4/3/2	4/3/2	4/3/2					
Hepatitis B ^l	1	2	2	2	3	3	3	3	3	3	3	
Varicella ^m					1	1	1	1	2 ⁿ	2 ⁿ	2 ^{n,o}	
Meningococcal												^p

a: Vaccine doses administered ≤ 4 days before the minimum interval or age are to be counted as valid.

b: Five doses of pertussis, tetanus, and diphtheria vaccines are required at school entry in Colorado unless the 4th dose was given at ≥ 48 months (i.e., on or after the 4th birthday) in which case only 3 doses are required.

c: For students ≥ 7 years who have not had the required number of pertussis doses, no new or additional doses are required. Any student ≥ 7 years at school entry in Colorado who has not completed a primary series of 3 appropriately spaced doses of tetanus and diphtheria vaccine may be certified after the 3rd dose of tetanus and diphtheria vaccine (or tetanus, diphtheria, and pertussis vaccine if 10 or 11 years) if it is given > 6 months after the 2nd dose.

d: The student must meet the minimum prior requirement for the 4th or 5th doses of diphtheria, tetanus, and pertussis vaccine and have 1 tetanus, diphtheria, and pertussis vaccine dose.

e: For polio, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

f: Four doses of polio vaccine are required at school entry in Colorado unless the 3rd dose was given ≥ 48 months (i.e., on or after the 4th birthday) in which case only 3 doses are required. Four valid doses are a complete series regardless of age at completion.

g: For measles, mumps, and rubella, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable for the specific disease tested. The 1st dose of measles, mumps, and rubella vaccine must have been administered at ≥ 12 months of age (i.e., on or after the 1st birthday) to be acceptable.

h: The 2nd dose of measles vaccine or measles, mumps, and rubella vaccine must have been administered at least 28 calendar days after the 1st dose.

i: Measles, mumps, and rubella vaccine is not required for college students born before January 1, 1957.

j: The number of Hib vaccine doses required depends on the student's current age and the age when the vaccine was administered. If any dose was given ≥ 15 months, the Hib vaccine requirement is met. For students who began the series < 12 months, 3 doses are required of which at least 1 dose must have been administered at ≥ 12 months (i.e., on or after the 1st birthday). If the 1st dose was given at 12 to 14 months, 2 doses are required. If the current age is ≥ 5 years, no new or additional doses are required.

k: The number of pneumococcal conjugate vaccine doses depends on the student's current age and the age when the 1st dose was administered. If the 1st dose was administered at: (i) ≤ 6 months, 3 doses are required at 6 to 14 months and 4 doses are required at 15 to 23 months with 1 dose administered on or after the 1st birthday; (ii) 7 to 11 months, 2 doses are required at 6 to 14 months and 3 doses are required at 15 to 23 months with 1 dose on or after the 1st birthday; (iii) 12 to 23 months, 2 doses are required. If the current age is ≥ 2 years, no new or additional doses are required.

l: For hepatitis B, in lieu of immunization, written evidence of a laboratory test showing immunity is acceptable.

m: For varicella, written evidence of a laboratory test showing immunity or a documented disease history from a health care provider is acceptable. The 1st dose of varicella vaccine must have been administered at ≥ 12 months of age (i.e., on or after the 1st birthday) to be acceptable.

n: The second dose of varicella vaccine must have been administered at least 28 calendar days after the 1st dose. See Table 2 for the year of implementation for the second dose of varicella; for school year 2007–2008, the second dose of varicella is only required for kindergarten entry.

o: If the 1st dose of varicella vaccine was administered at ≥ 13 years, 2 doses are required, separated by a minimum of 4 to 8 weeks.

p: Information concerning meningococcal disease and the meningococcal vaccine shall be provided to each new student or if the student is under 18 years, to the student's parent or guardian. If the student does not obtain a vaccine, a signature must be obtained from the student or if the student is under 18 years, the student's parent or guardian indicating that the information was reviewed.

EMERGENCY MEDICAL AUTHORIZATION

I, _____ hereby give my permission to Anchor Center for Blind Children to call a doctor for medical or surgical care for my child _____ should an emergency arise. It is understood that a conscientious effort will be made to locate me or my husband/wife _____ before any action will be taken, but if it is not possible to locate us, this expense will be accepted by us.

Parent/Guardian

Date

Anchor Center For Blind Children
2550 Roslyn Street
Denver, CO 80238
303-377-9732

Student Name _____ Date of Birth _____
 Address _____

Emergency Information

Parent/Guardian _____ Home Phone _____
 Address _____ Cell Phone Dad _____
 _____ Cell Phone Mom _____
 _____ W. Phone _____
 _____ (Number in Order of Preference)
 Emergency Contact: _____ Phone Number _____
 _____ Phone Number _____
 Emergency Contact: _____ Phone Number _____
 _____ Phone Number _____
 Health Care Provider: _____ Phone Number _____
 Hospital Preference: _____ Phone Number _____
 Cardiologist _____ Phone Number _____
 Neurologist _____ Phone Number _____

Diagnosis: _____

Allergies: _____ Reactions: _____

Medications used on a daily basis (include doses)

Other useful information: (calming techniques, etc.)

Diet Restrictions (Please Check One)

For Food Allergies:	<input type="checkbox"/> Parents will monitor school lunch menus or provide & communicate w/ school personnel
	<input type="checkbox"/> student will self-monitor food choices
	<input type="checkbox"/> teacher will assist child unable to self-select food choices
	<input type="checkbox"/> other

If your child experiences a change in health condition (such as a change in medication or hospitalization) please contact the School Nurse (RN) so that this Health Care Plan can be revised, if needed. Parent/guardian signature indicates permission to contact the child's health care provider(s) listed above, as needed. I also understand that this information may be shared with necessary school personnel on a need-to-know basis to help ensure this child's safety and well-being while at school or during school related activities.

Parent/Guardian Signature: (Required) _____ Date _____
 School Nurse (RN) Signature: (Required) _____ Date _____
 Administrator Signature: (Preferred) _____ Date _____

Allergy & Anaphylaxis Action Plan

Student's Name: _____ D.O.B. _____ Grade: _____
 School: _____ Teacher: _____

ALLERGY TO: _____

History: _____

Asthma: YES NO *Higher risk for severe reaction

◇ STEP 1: TREATMENT

To be completed by healthcare provider

SYMPTOMS: GIVE CHECKED MEDICATION(S)		
➤ Suspected ingestion or sting, but <i>no symptoms</i>	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine	Antihistamine
MILD SYMPTOMS: Itchy mouth, few hives, mild itch, mild nausea/discomfort		<input type="checkbox"/>
		Antihistamine
MOUTH Itching, tingling, or mild swelling of lips, tongue, mouth	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine	Antihistamine
SKIN: Flushing, hives, itchy rash	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine	Antihistamine
STOMACH Nausea, abdominal pain or cramping, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine	Antihistamine
‡ THROAT Tightening of throat, hoarseness, hacking cough	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine	Antihistamine
‡ LUNG Shortness of breath, repetitive coughing, wheezing <input type="checkbox"/> Inhaler	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine	Antihistamine
‡ HEART Weak or thready pulse, dizziness, fainting, pale, or blue hue to skin	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine	Antihistamine
➤ If reaction is progressing (several of the above areas affected), give	<input type="checkbox"/>	<input type="checkbox"/>
	Epinephrine	Antihistamine

‡ Potentially life threatening: give epinephrine first, then can give antihistamine!
Remember - severity of symptoms can quickly change!

DOSAGE

Epinephrine: inject intramuscularly (check one):

EpiPen® 0.3 mg EpiPen® Jr. 0.15 mg

Administer 2nd dose if symptoms do not improve in 15 – 20 minutes

Antihistamine: give _____

(Medication/dose/route)

****ATTENTION..If Antihistamine given, the parents will be notified to pick up their child for closer observation!

Asthma Rescue (if asthmatic): give _____

(Medication/dose/route)

Student has been instructed and is capable of self administering own medication. Yes No

Provider (print) _____ Phone Number: _____

Provider's Signature: _____

Start Date: _____ End Date: _____

◇ **STEP 2: EMERGENCY CALLS** :If epinephrine given, **call 911**. State that an allergic reaction has been treated and additional epinephrine, oxygen, or other medications may be needed.

1. Parent: _____ Phone Number: _____

2. Emergency contacts: Name/Relationship _____ Phone Number(s) _____

a. _____ 1) _____ 2) _____

b. _____ 1) _____ 2) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED; DO NOT HESITATE TO ADMINISTER EMERGENCY MEDICATIONS

I give permission for school and/or child care facility personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our health care provider. I assume full responsibility for providing the school and/or childcare facility with prescribed medication and delivery/monitoring devices. I approve this Severe Allergy Care Plan for my child. **This Health Care Plan will be effective for one year or unless parents and/or physician request to have changes made sooner**

Parent/Guardian's Signature:

_____ Date: _____

School Nurse: _____ Date: _____

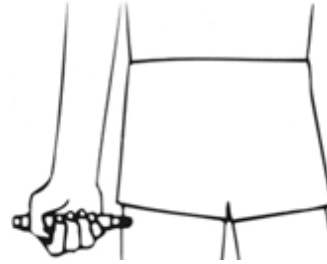
Student Name: _____ DOB: _____

- Pull off blue activation cap.



Photo of child

- Hold orange tip near outer thigh (always apply



- Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen® unit **CALL 911**
- Student to remain lying down

COLORADO SCHOOL ASTHMA CARE PLAN

Name:	Birth date:
Teacher:	Grade:
Parent/Guardian:	Cell Phone:
Home Phone:	Work Phone:
Other Contact:	Phone:
Preferred Hospital:	

Triggers: Weather (cold air, wind) Illness Exercise Smoke Dog/Cat Dust Mold Pollen
 Other: _____

GREEN ZONE: PRETREATMENT STEPS FOR EXERCISE (Health provider initial all that apply)

- Give 2 puffs of rescue med _____ 15 minutes before activity (Circle indication: Phys Ed class, exercise/sports, recess) Explanation: _____
- Repeat in 4 hours if needed for additional or ongoing physical activity

YELLOW ZONE: SICK – UNCONTROLLED ASTHMA (Health provider complete dosing for rescue inhaler)

IF YOU SEE THIS:	DO THIS:
<ul style="list-style-type: none"> ▪ Difficulty breathing ▪ Wheezing ▪ Frequent cough ▪ Complains of chest tightness ▪ Unable to tolerate regular activities but still talking in complete sentences ▪ Other: 	<ul style="list-style-type: none"> ▪ Stop physical activity ▪ Give rescue med (<i>name</i>): _____ <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> other: _____ <input type="checkbox"/> Via spacer ▪ If no improvement in 10-15 minutes, repeat use of rescue med: <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> other: _____ <input type="checkbox"/> Via spacer ▪ If student’s symptoms do not improve or worsen, call 911 ▪ Stay with student and maintain sitting position ▪ Call parents/guardians and school nurse ▪ Student may resume normal activities once feeling better

- If there is **no rescue inhaler at school**:
 - Call parents/guardians to pick up student and/or bring inhaler/ medications to school
 - Inform them that if they cannot get to school, 911 may be called

RED ZONE: EMERGENCY SITUATION (Health provider complete dosing for rescue inhaler)

IF YOU SEE THIS:	DO THIS IMMEDIATELY:
<ul style="list-style-type: none"> ▪ Coughs constantly ▪ Struggles or gasps for breath ▪ Trouble talking (only able to speak 3-5 words) ▪ Skin of chest and/or neck pull in with breathing ▪ Lips or fingernails are gray or blue ▪ ↓ Level of consciousness 	<ul style="list-style-type: none"> ▪ Give rescue med (<i>name</i>) : _____ <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Via spacer ▪ Repeat rescue med if student not improving in 10-15 minutes <input type="checkbox"/> 1 puff <input type="checkbox"/> 2 puffs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Via spacer ▪ Call 911 Inform attendant the reason for the call is asthma ▪ Call parents/guardians and school nurse ▪ Encourage student to take slower deeper breaths ▪ Stay with student and remain calm ▪ <i>School personnel should not drive student to hospital</i>

INSTRUCTIONS for RESCUE INHALER USE: (HEALTH PROVIDER: PLEASE CHECK APPROPRIATE BOX(ES))

- Student understands the proper use of his/her asthma medications, and in my opinion, can carry and use his/her inhaler at school independently
- Student is to notify his/her designated school health officials after using inhaler
- Student needs supervision or assistance to use his/her inhaler. If not self carry, the inhaler is located: _____
- Student has life threatening allergy, the epipen is located: _____

HEALTH CARE PROVIDER SIGNATURE _____

PLEASE PRINT PROVIDER’S NAME _____

DATE _____

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary,

contact our physician. I assume full responsibility for providing the school with prescribed medication and delivery/monitoring devices. I approve this Asthma Care Plan for my child.

PARENT SIGNATURE

DATE

School Nurse Signature

DATE

504 Plan or IEP

Copies of plan provided to: Teachers ___ Phys Ed/Coach ___ Principal ___ Main Office ___ Bus Driver ___
Other _____

GENERAL AUTHORIZATION

FOR PRESCHOOLERS

I do hereby release Anchor Center for Blind Children, its successors, agents, and assigns from responsibility for any injury, illness, or accidents that may happen to my child.

I exonerate them completely from any damage my child may cause to any person or property while in their charge.

I do hereby give consent to the Anchor staff, or persons/agencies operating in its authorized behalf, the unqualified right and permission:

To do the necessary evaluation and assessment for my child's enrollment, including video-taping. YES___NO___

To authorize the release of information to and from other professionals. YES___NO___

To take photographs or video-tapes of my child and use them for the purpose of reproduction, publication or illustration in all publicity media whatsoever. YES___NO___

To allow Anchor's volunteers or staff to transport my child to and/or from school. YES___NO___

To take my child on any field trips planned by Anchor staff in insured vehicles provided by staff and volunteers. YES___NO___

To authorize application of sunscreen to my child's exposed skin prior to outside play. YES___NO___

To allow my child to participate in climbing activities. YES___NO___

To authorize the release of name, address, and phone number for directory purposes/parent group. YES___NO___

I have read the foregoing, which I understand fully to be an authorization and a release.

CHILD'S NAME _____

BIRTHDATE _____

SIGNATURE _____

DATE _____ **PARENT** _____ **GUARDIAN** _____



Anchor Parent Programming

Parent programming is a significant part of your experience at Anchor Center. Meeting other parents, grandparents, and caregivers is an important part of your parenting journey. For those of you in the Infant and Toddler program, parenting information, education and support will be part of every center as you work with Anchor staff on developing your child's strength and potential. **Parent Centers** are held twice a month and will address child development as well as unique challenges specific to parenting a child with a disability.

Once a month there are **Parent Pull-Out** sessions in the Community Room during which your child will be cared for by Anchor Center staff and volunteers during regular Infant time and Toddler time. Topics that will be discussed include horticultural therapy; literacy and language; the Feldenkrais Method; sleep challenges; nutrition and feeding issues; development and behavior; and Individual Family Service Plans (IFSPs) and Individual Education Plans (IEPs). Three or four times a year there will be **Diagnostic Groups** to allow you the opportunity to learn and share information specific to a particular diagnosis. Diagnostic Groups are from 11:45 to 1:15 and registration is required as volunteers will care for the children.

The preschool parents, caretakers and alumni meet once a month for a **Brown Bag Lunch** in our Community Room. These lunches are the first Tuesday of each month from 12 to 1:30. The lunches are open discussions providing support and friendship as parents prepare to transition their child to public school. Often teachers of the visually impaired from local school districts or other professionals from the field of visual impairment will join our lunch.

Whether you feel you have much to learn or already have a wealth of knowledge and experience to share; we hope you will participate in our parent groups. We have made them an ongoing vital part of who we are and have learned over the years that you are each others' best support! Please contact your teacher of the visually impaired or any of the Family Program team, Kivanc, Carol Puchalski or Karen Roberts for further information.

anchor center COMPASS

Dear Families,
I would like
to introduce

FAMILIES *Guiding* FAMILIES

you to the Anchor Center parent group, Anchor Center Compass. We are Anchor Center parents who have come together to build a family guided support network. We aim to complement the services already offered by Anchor Center for Blind Children, and we are excited to get to know you and your family. Please take a moment to browse some of our big ideas. Because we are Families *Guiding* Families, we look forward to hearing from you to let us know how Anchor Center Compass can best support you and your family.

Sincerely,

Marlo Naumer
President,



Anchor Center Compass

Big Ideas!

FAMILY SUPPORT PROGRAMS

- Ice Cream Social – bringing Anchor Center families together – Sept. 11th, 2011 3-5:30 at Anchor Center
- New Family Welcome Bags
- Family generated referral list of favorite pediatric service specialist
- Compass Blog – <http://anchorcentercompass.blogspot.com>

STAFF * TEACHER * VOLUNTEER APPRECIATION

FUNDRAISING TO SUPPORT OUR COMPASS BIG IDEAS

PARENT NIGHT OUT!

ANY OTHER GREAT IDEAS YOU CAN SEND OUR WAY!

For more information please contact: Marlo Naumer by email:
anchorcentercompass@gmail.com

July							August							September									
Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa			
					X	2	1	2	3	4	5	6						1	W	3			
3	X	X	X	X	X	9	7	W	W	W	W	P	13	4	X	6	7	8	W	10			
10	X	X	X	X	X	16	14	15	16	17	18	W	20	11	12	13	14	15	16	17			
17	X	X	X	X	X	23	21	22	23	24	25	26	27	18	19	20	21	22	23	24			
24	X	X	X	X	X	30	28	29	30	31	25	26	27	28	29	30							
31																							

October							November							December										
Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa				
						1	1	2	3	4	5						1	2	3					
2	3	4	5	6	P	8	6	7	8	9	10	P	12	4	5	6	7	8	9	10				
9	W	X	X	X	X	15	13	14	15	16	17	W	19	11	12	13	14	15	W	17				
16	17	18	19	20	21	22	20	X	X	X	X	X	26	18	X	X	X	X	X	24				
23	24	25	26	27	28	29	27	28	29	30	25	X	X	X	X	X	31							
30	31																							

January							February							March										
Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa				
1	X	3	4	5	P	7			1	2	3	4						1	2	3				
8	9	10	11	12	W	14	5	6	7	8	9	P	11	4	5	6	7	8	9	10				
15	X	17	18	19	20	21	12	13	14	15	16	W	18	11	12	13	14	15	P	17				
22	23	24	25	26	27	28	19	X	21	22	23	24	25	18	19	20	21	22	W	24				
29	30	31					26	27	28	29	25	X	X	X	X	X	31							

April							May							June						
Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa	Su	Mo	Tu	We	Th	Fr	Sa
1	X	X	X	X	X	7			1	2	3	W	5						1	2
8	9	10	11	12	13	14	6	7	8	9	10	11	12	3	4	5	6	7	8	9
15	16	17	18	19	P	21	13	14	15	16	17	18	19	10	W	W	W	W	W	16
22	23	24	25	26	W	28	20	21	22	23	24	25	26	17	18	19	20	21	22	23
29	30						27	X	29	30	31	24	25	26	27	28	29	30		

Anchor Center for Blind Children 2011-2012 School Calendar

X = No school

P = TPBA –No school

W = Teacher work day – No school

Parent Teacher Conferences: September 2, 9, 2011; May 4, 2012

Thanksgiving Feast: Tuesday, November 15, 2011

HOLIDAY PARTY: Thursday, December 15, 2011

Teacher Work Day: Friday, December 16, 2011

GRADUATION: Friday, June 8, 2012

Preschool Thanksgiving Feast: Tuesday, November 15

Parent Teacher Conferences: May 4

DATES TO REMEMBER:

Staff returns from Summer Break: August 8

Infants and Toddlers: First day of school – Monday, August 15

Preschoolers: First day of school – Tuesday, August 16

Fall Break: October 10-14

Thanksgiving Break: November 21-25

Winter Break: December 19– January 2

Preschoolers Return: Tuesday, January 3

Infants/Toddlers return Wednesday, January 4

Spring Break: March 26 – April 6

Other Holidays: (No school)

Labor Day September 5

Martin Luther King Day January 16

Presidents' Day February 20

Memorial Day May 28

No school on the following dates: (Teacher work days)

Play-based Assessments

August 12

October 7

November 11

January 6

February 10

March 16

April 20

Writing Days

August 19

September 2, 9 (P/T Conferences)

October 10

November 18

January 13

February 17

March 23

April 27

May 4 (P/T Conferences)

