A Typical Day at Kid's Kottage Preschool

Arrival
Free Play
Learning Centers

*

Circle Time
Daily Job Chart
Music & Movement
Group Activity
Special Visitor
Social & Cultural Studies
Group Discussion

*

Arts & Crafts
Cooking
Math Games
Science Experiments
Language Arts
Pre-Writing Skills
Dramatic Play

*

Group Story Time
Show and Tell
Snack Time

*

Outdoor Play
Dismissal

Kid's Kottage

Located at: 100 Myrtle Avenue Mahopac, NY 10541
Mailing Address: 1055 U.S. Route 6 Mahopac, NY 10541
Phone: (845) 621-2425

REGISTRATION FOR 2026-2027

Pre-Kindergarten Program - M-F

If you need additional hours please fill-in time and check all that apply

[ ] Before School Care (starts 7:00 am)

_____ : _____ to **8 :30 am**
(drop off)

[ ] After School Care (until 6:00pm)
1:30 PM to _____
(Pick up)

DAYS if needed for Before/After Care (please circle):
Monday Tuesday Wednesday Thursday Friday

Child's Name: _____
first middle last

Gender: _____ BirthDate: _____ Starting Date: _____

Street Address: _____

City/State/Zip: _____

E-mail Address: _____

Would you prefer receiving school information via e-mail or paper copy? _____

1. Mother's Name: _____ Birthday: _____
first last month/day

Home Telephone : _____ Cell Phone: _____

Employer: _____ Bus. Phone: _____

2. Father's Name: _____ _____ Birthday: _____
first last month/day

Home Telephone: _____ Cell Phone: _____

Employer: _____ Bus. Phone: _____

Siblings Names/ Ages (if any): _____

_____

What is your elementary school? (check one) _____Austin Road _____Fulmar _____Lakeview

Please provide the following information if someone other than parents picking up your child:

Pick Up Password: _____ Hint Word: _____

EMERGENCY CONTACTS:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone _____

Physician's Name: _____ Phone: _____

Any physical limitations? _____ Explain: _____

_____

Any allergies? _____ Explain: _____

_____

Any health problems? _____ Explain: _____

_____

Dentist 's Name _____ Phone: _____

Any other concerns? _____

_____

Please tell us in addition to any food allergies, if there are any dietary restrictions or limitations you would like us to observe:

_____

_____

Has your child previously attended preschool, daycare, play groups, or any type of specialized class? If so, please list their experiences

_____

_____

_____

What would you hope for your child to gain from their school experience?

_____

_____

_____

Would you be able to assist in the classroom or during a class trip at least once during the school year?_____ If so, are there any hobbies or areas of special interest that you might be willing to share with the class?_____ If so, please elaborate: _____

_____

_____

What, if any, holidays are celebrated or observed in your home?_____

_____

Would you have any objections to discussions and class projects relating to awareness of holidays that are celebrated in our country or in other parts of the world? If so, please elaborate:

_____

_____

_____

Does your child have any special interests?_____

_____

Favorite toy:_____

Specific fears? (animals, loud noises, etc.)_____

_____

Are there any special problems or concerns you may have about your child or school that we should know about?

_____

_____

_____

[ ] If you do not wish to be included on a class list directory that is distributed to other parents in your child's class please check here.

[ ] If you do not wish your child to be photographed for a private class Facebook page please check here.

Please send this completed registration form ASAP to our Main Office at:

Kid's Kottage Preschool

1055 U.S. Route 6

Mahopac, NY 10541

or

email: Julie@kidskottage.com

(845) 621-2425

OCFS-LDSS-4433 (Rev. 7/2005) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

Medical Statement of Child in Childcare

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

Name of Child:	Date of Birth:	Date of Examination:

Immunizations

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). ☐ Yes ☐ No

DPT / DT	1st Date	2nd Date	3rd Date	Booster Date	Booster Date
Polio	1st Date	2nd Date	3rd Date	Booster Date	Booster Date
Hib (conjugate preferred)	1st Date	2nd Date	3rd Date	4th Date	
Hepatitis B	1st Date	2nd Date	3rd Date		
MMR	1st Date	2nd Date			
Varicella / Chicken Pox	1st Date	2nd Date			

Other Immunizations

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.

If positive, or if x-ray ordered, attach physician's statement documenting treatment and follow-up.

Lead Screening Date: _____

Attach lead level statement

Health Specifics		Comments
Are there allergies? (Specify)	☐ Yes ☐ No	
Is medication regularly taken? (Specify drug and condition)	☐ Yes ☐ No	
Is a special diet required? (Specify diet and condition)	☐ Yes ☐ No	
Are there any hearing, visual or dental conditions requiring special attention?	☐ Yes ☐ No	
Are there any medical or developmental *conditions requiring special attention*?	☐ Yes ☐ No	

ADDITIONAL INFORMATION ON REVERSE SIDE ➔

Medical Statement of Child in Childcare (cont.)

Summary of Physical Exam

Include special recommendations to Day Care Providers

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 day care. ☐ Yes ☐ No

Signature of Examiner

Address

Please Print Name

City, State, Zip

Title

( ) Phone

Date

Religious Exemptions

In accordance with Public Health Law, the sincere religious beliefs of the child's parents prohibit immunization. Do you wish to exercise those rights? ☐ Yes ☐ No

Any child not fully immunized for any reason must be excluded from care whenever there is an outbreak. The child may return only upon approval of the local county health department.

Signature of Parent or Person Legally Responsible

Date