Andover Elementary School
Early Learning Center

35 School Road
Andover, CT 06232
Tel. (860) 742-7339
Fax (860) 742-8288
www.andoverelementaryct.org

Taylor M. Parker
Preschool Administrator/Principal

Dear Parents/Guardians of Preschool Children,

Thank you for considering our preschool program as you make your first important decision regarding your child's preschool experience.

Our program is accredited by the National Association for the Education of Young Children (NAEYC). This accreditation assures you that the Andover Elementary School Early Learning Center is a high quality preschool program.

We are a tuition-based program that runs Monday through Friday and follows the Andover School District academic calendar. The cost of the preschool program is based on family size and household gross income (not to exceed $6,000 annually), payable in ten equal monthly installments. Parents may apply for reduced tuition, which is available for qualifying families who meet the Connecticut Office of Early Childhood sliding fee scale requirements. This opportunity is offered through our School Readiness and Smart Start grants.

Attached you will find information regarding enrollment dates and examples of calculating reduced tuition eligibility, as well as forms to be completed in order for your child to be considered for enrollment in the preschool program.

Once all completed enrollment paperwork is received, you will be contacted for an appointment to review your information and confirm your child's enrollment. If there are more children applying than placements available, families will be put on a waitlist determined by their application date.

If you have any questions, please feel free to call or email me directly at parkert@andoverelementaryct.org.

Sincerely,
Taylor M. Parker
Preschool Administrator

Enclosures

Andover Elementary School Early Learning Center does not discriminate on the basis of diverse racial, ethnic, religious, or economic backgrounds, and includes children with special needs.

Andover Elementary School
EARLY LEARNING CENTER

ANDOVER EARLY LEARNING CENTER ♦ 35 SCHOOL ROAD ♦ ANDOVER, CT 06232 ♦ PH (860) 742-7339 ♦ FAX (860) 742-8288

The Andover Elementary School Early Learning Center offers preschool programs for all children ages three (3) and four (4).

Enrollment begins **the first week of February of the preceding school year**.

Registration forms can be accessed through the school website at andoverelementaryct.org or by calling the Main Office at (860) 742-7339.

Students enrolling in a second year of preschool must fill out a registration packet, submitted **no later than March 15 of the current school year**.

The cost of the school-day, school-year program is $600/month, or $6,000/year.

The Andover Elementary School Early Learning Center receives funding for reduced tuition rates from two State Grants:

→ *The School Readiness Grant*
→ *The Smart Start Grant*

For both programs, families may apply for reduced tuition rates if they meet the Connecticut Sliding Fee Scale qualification:

E.G.

Family Size		Income
3	***Earning less than***	$ 83,905
4		$ 99,887
5		$115,869
6		$131,851

Guidance for Preschool Eligibility:

Children must be 3 years old on or before December 31st of the current school year, or 4 years old to be eligible for our preschool program. Children who will turn 5 years old on or before September 1st of the current school year are not eligible for preschool.

Students determined eligible for Special Education services are entitled to enrollment in the preschool program as required by FAPE (Free and Appropriate Public Education) guidelines.

The Andover Elementary School Early Learning Center encourages children of all racial, ethnic, and economic backgrounds to apply to the preschool program.

Children enrolled in the School Readiness program are not required to be residents of Andover. School Readiness slots will be available to non-Andover residents based on availability.

Andover Elementary School Early Learning Center also has an allotted number of Smart Start slots available to Andover families who meet income guidelines. Children enrolled in the Smart Start program must be residents of Andover. Families must provide written proof of residency.

To be eligible for a reduced tuition rate, families must present income eligibility proof that meets the State Office of Early Childhood's sliding fee scale guidelines.

All paperwork needs to be filled out in order to be considered for a preschool slot.

If there are more children applying than placements available, families will be put on a waitlist, determined by their application date.

Guidelines for Preschool Enrollment:

1. Preschool grant slots will be available first to four year old resident students whose families meet the income eligibility guidelines.
2. Preschool grant slots will then be available to three year old resident students whose families meet the income eligibility guidelines.
3. If any income eligibility School Readiness grant slots remain, they will be open to out of town residents who meet the income eligibility requirements.
4. 40% of the School Readiness and Smart Start slots will be available to Andover residents who will pay full tuition.
5. If any of the 40% full time School Readiness slots remain, they will be available to out of town residents who will pay full tuition.

If you have any questions, please feel free to contact:

Taylor Parker, Preschool Administrator
(860) 742-7339
parkert@andoverelementaryct.org

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2025 – 2026
Preschool Registration Checklist

Please submit the following:

- ☐ Andover School District's Registration Form *
- ☐ Early Childhood Health Assessment Record (yellow form)
- ☐ **Birth Certificate (available for photocopy) ***
- ☐ Proof of Residency (two forms of proof must be presented; see the enclosed form for acceptable documents of verification) *
- ☐ Preschool Grant Information Form (requires proof of income)
- ☐ Transportation Request (4 year olds and up)
- ☐ Nutrition Questionnaire
- ☐ Health and Safety File Permission Slip
- ☐ Permission to Send/Receive Student Records & for Verbal Communication (if applicable)
- ☐ Cool Program Information

Once your registration packet is received and processed, an agreement will be developed indicating your child's required tuition fee for the 2025-2026 school year. Tuition is based on income and follows the Office of Early Childhood's sliding-fee scale.

Failure to return all or part of this registration packet may result in your child being ineligible for our preschool program.

*Returning students do not need to resubmit these forms, unless information has changed.

ANDOVER SCHOOL DISTRICT

School Registration Form - Grades PK through 6

TO BE FILLED OUT BY PARENTS, GUARDIANS OR PERSONS WITH WHOM THE STUDENT LEGALLY RESIDES. PLEASE PRINT AND FILL OUT FORM COMPLETELY.

LEGAL NAME OF STUDENT		
LAST:	**FIRST:**	**MIDDLE:**
STREET ADDRESS:	**CITY:**	
STATE:	**ZIP CODE:**	**P.O. BOX:**
BIRTHPLACE (CITY AND STATE):		**BIRTH DATE:**
GENDER: M or F or N (Non-binary)		**AGE:**

Homeless: ☐ **Not Homeless** ☐ **Shelter** ☐ **Doubled Up** ☐ **Unsheltered** ☐ **Hotel/Motel**
Immigrant Status: Y or **N** _____(Defined as children who are ages 3 – 21; not born in any state, the District of Columbia or the Commonwealth of Puerto Rico; and have not been attending one or more schools in any one or more States for more than 3 full academic years.)
Military Family: Y or **N** _____(If child's parent or guardian is a member of the Armed Forces on **active duty** or serves on **full-time National Guard duty**.)
Migrant: Y or N _____ A child whose parent is a migratory agricultural worker and has moved in the past 36 mos.

DATE OF REGISTRATION:	**STARTING DATE:**	**GRADE ENTERING:**
Transferring from (Name of School or Pre-School):		
Address of School:		**Years Attended:**
Is this an Accredited Pre-School? YES_____ or NO_____		
If student has repeated a grade, please indicate which grade.		

PARENT(S) / LEGAL GUARDIAN(S) WITH WHOM STUDENT LEGALLY RESIDES			
Family Status: Married ☐ Divorced ☐ Remarried ☐ Single ☐ Separated ☐			
NAME:		**RELATIONSHIP TO STUDENT:**	
HOME PHONE:	**CELL PHONE:**	**E- MAIL:**	
EMPLOYER:		**WORK PHONE:**	**EXT:**
NAME:		**RELATIONSHIP TO STUDENT:**	
HOME PHONE:	**CELL PHONE:**	**E-MAIL:**	
EMPLOYER:		**WORK PHONE:**	**EXT:**

OTHER LEGAL GUARDIAN (TYPE)	FULL:	VISITATION:	OTHER:
NAME:	**RELATIONSHIP TO STUDENT:**		
HOME PHONE:	**CELL PHONE:**	**E-MAIL:**	
EMPLOYER:	**WORK PHONE:**		

LANGUAGE SURVEY
1. What is the primary language spoken in the home, regardless of the language spoken by the student?_____
2. What is the language most often spoken by the student?_____
3. What is the language that the student first acquired?_____

OTHER OCCUPANTS IN THE HOME	
Names: (Grandparents, etc.)	
Other minor children in the family: (Names and Birth Dates)	
Child's Name:	**Birth Date:**
(Optional) Child is: Natural ☐ Foster ☐ Adopted ☐ Relative ☐	

If there is any other information you feel would be helpful to the school, please indicate below:

_____

_____

Please answer both of the following sections per the Connecticut State Department of Education.

ETHNIC BACKGROUND		
Check the Appropriate Box	**YES**	**NO**
Hispanic or Latino – see description below		

RACIAL BACKGROUND		
Check the appropriate box for EACH category below.	**YES**	**NO**
American Indian or Alaskan Native		
Asian		
Black or African American		
Native Hawaiian or Other Pacific Islander		
White		

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

American Indian or Alaskan Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa.

Native Hawaiian or Other Pacific Islander: a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa

The Andover board of Education prohibits harassment and discrimination in educational programs, services, or employment on the basis of race, color, religious creed, age, national origin, sexual orientation, or past or present physical or mental disability in accordance with Titles VI, VII of the Civil rights Act of 1964, Title XI of the Educational Amendments Act of 1973, Section 504 Rehabilitation Act of 1973, The Americans with Disabilities Act of 1991, and Appropriate State Laws.

Please check if you would like information regarding any of the following assistance programs:			
☐ Literacy / Adult Education	☐ Town Social Services	☐ Mental Health Support	
Would you like a copy of the Andover Human Resources Guide?		☐ Yes	☐ No

PARENT SIGNATURE:_____ **DATE:**_____

Rev. 1/28/19 / rhc

State of Connecticut Department of Education
Early Childhood Health Assessment Record
(For children ages birth–5)

To Parent or Guardian: In order to provide the best experience, early childhood providers must understand your child's health needs. This form requests information from you (Part 1) which will be helpful to the health care provider when he or she completes the health evaluation (Part 2) and oral health assessment (Part 3). State law requires complete primary immunizations and a health assessment by a physician, an advanced practice registered nurse, a physician assistant, or a legally qualified practitioner of medicine, an advanced practice registered nurse or a physician assistant stationed at any military base prior to entering an early childhood program in Connecticut.

Please print

Child's Name (Last, First, Middle)	Birth Date (mm/dd/yyyy)	❑Male ❑Female
Address (Street, Town and ZIP code)		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone
Early Childhood Program (Name and Phone Number)	Race/Ethnicity ❑American Indian/Alaska Native ❑Native Hawaiian/Pacific Islander ❑Asian ❑White ❑Black or African American ❑Other ❑Hispanic/Latino of any race	
Primary Health Care Provider: Name of Dentist:		
Health Insurance Company/Number* or Medicaid/Number*		
Does your child have health insurance? Y N Does your child have dental insurance? Y N Does your child have HUSKY insurance? Y N	If your child does not have health insurance, call **1-877-CT-HUSKY**	

* If applicable

Part 1 — To be completed by parent/guardian.
Please answer these health history questions about your child before the physical examination.

Please circle **Y** if "yes" or **N** if "no." Explain all "yes" answers in the space provided below.

Any health concerns	Y	N	Frequent ear infections	Y	N	Asthma treatment	Y	N
Allergies to food, bee stings, insects	Y	N	Any speech issues	Y	N	Seizure	Y	N
Allergies to medication	Y	N	Any problems with teeth	Y	N	Diabetes	Y	N
Any other allergies	Y	N	Has your child had a dental			Any heart problems	Y	N
Any daily/ongoing medications	Y	N	examination in the last 6 months?	Y	N	Emergency room visits	Y	N
Any problems with vision	Y	N	Very high or low activity level	Y	N	Any major illness or injury	Y	N
Uses contacts or glasses	Y	N	Weight concerns	Y	N	Any operations/surgeries	Y	N
Any hearing concerns	Y	N	Problems breathing or coughing	Y	N	Lead concerns/poisoning	Y	N
Developmental — Any concern about your child's:						Sleeping concerns	Y	N
1. Physical development	Y	N	5. Ability to communicate needs	Y	N	High blood pressure	Y	N
2. Movement from one place			6. Interaction with others	Y	N	Eating concerns	Y	N
to another	Y	N	7. Behavior	Y	N	Toileting concerns	Y	N
3. Social development	Y	N	8. Ability to understand	Y	N	Birth to 3 services	Y	N
4. Emotional development	Y	N	9. Ability to use their hands	Y	N	Preschool Special Education	Y	N

Explain all "yes" answers or provide any additional information:

Have you talked with your child's primary health care provider about any of the above concerns? Y N

Please list any **medications** your child will need to take during program hours:

*All medications taken in child care programs require a separate **Medication Authorization Form** signed by an authorized prescriber and parent/guardian.*

I give my consent for my child's health care provider and early childhood provider or health/nurse consultant/coordinator to discuss the information on this form for confidential use in meeting my child's health and educational needs in the early childhood program. Signature of Parent/Guardian Date

C.G.S. Section 10-16q, 10-206, 19a.79(a), 19a-87b(c); P.H. Code Section 19a-79-5a(a)(2), 19a-87b-10b(2); Public Act No. 18-168.

Part 2 — Medical Evaluation

Health Care Provider must complete and sign the medical evaluation, physical examination and immunization record.

Child's Name_____ Birth Date_____ (mm/dd/yyyy) Date of Exam _____ (mm/dd/yyyy)

❑I have reviewed the health history information provided in Part I of this form

Physical Exam

Note: *Mandated Screening/Test to be completed by provider.

***HT**____in/cm____% ***Weight**____lbs.____oz /____% **BMI**____/____% ***HC**____in/cm____% (Birth–24 months) ***Blood Pressure**____/____ (Annually at 3–5 years)

Screenings

***Vision Screening**
- ❑ EPSDT Subjective Screen Completed (Birth to 3 yrs.)
- ❑ EPSDT Annually at 3 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
With glasses	20/	20/
Without glasses	20/	20/

❑Unable to assess

❑Referral made to: _____

***Hearing Screening**
- ❑ EPSDT Subjective Screen Completed (Birth to 4 yrs.)
- ❑ EPSDT Annually at 4 yrs. (Early and Periodic Screening, Diagnosis and Treatment)

Type:	Right	Left
	❑ Pass	❑Pass
	❑ Fail	❑Fail

❑Unable to assess

❑Referral made to: _____

***Anemia:** at 9 to 12 months and 2 years

***Hgb/Hct:** | ***Date**

***Lead:** at 1 and 2 years; if no result screen between 25 – 72 months

History of Lead level ≥ 5µg/dL ❑nNo ❑nYes

***TB:** High-risk group? ❑No ❑Yes

Test done: ❑No ❑Yes Date: _____

Results: _____

Treatment: _____

***Dental Concerns** ❑No ❑Yes

❑Referral made to: _____

Has this child received dental care in the last 6 months? ❑No ❑Yes

***Result/Level:** ***Date**

Other:

***Developmental Assessment:** (Birth–5 years) ❑No ❑Yes **Type:**

Results:

*IMMUNIZATIONS ❑Up to Date or ❑Catch-up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

***Chronic Disease Assessment:**

Asthma ❑No ❑Yes: ❑Intermittent ❑Mild Persistent ❑Moderate Persistent ❑Severe Persistent ❑Exercise induced
*If yes, please provide a copy of an **Asthma Action Plan***
❑Rescue medication required in child care setting: ❑No ❑Yes

Allergies ❑No ❑Yes: _____
Epi Pen required: ❑No ❑Yes
History/risk of Anaphylaxis: ❑No ❑Yes: ❑Food ❑Insects ❑Latex ❑Medication ❑Unknown source
*If yes, please provide a copy of the **Emergency Allergy Plan***

Diabetes ❑No ❑Yes: ❑Type I ❑Type II **Other Chronic Disease:** _____

Seizures ❑No ❑Yes: Type: _____ _____

❑ This child has the following problems which may adversely affect his or her educational experience:
❑Vision ❑Auditory ❑Speech/Language ❑Physical ❑Emotional/Social ❑Behavior

❑ This child has a developmental delay/disability that may require intervention at the program.

❑ This child has a special health care need which may require intervention at the program, e.g., special diet, long-term/ongoing/daily/emergency medication, history of contagious disease. *Specify:* _____

❑No ❑Yes This child has a medical or emotional illness/disorder that now poses a risk to other children or affects his/her ability to participate safely in the program.

❑No ❑Yes Based on this comprehensive history and physical examination, this child has maintained his/her level of wellness.

❑No ❑Yes This child may fully participate in the program.

❑No ❑Yes This child may fully participate in the program with the following restrictions/adaptation: (Specify reason and restriction.)

_____

❑No ❑Yes Is this the child's medical home? ❑ I would like to discuss information in this report with the early childhood provider and/or nurse/health consultant/coordinator.

_____

Signature of health care provider MD / DO / APRN / PA | Date Signed | Printed/Stamped ***Provider*** Name and Phone Number

Part 3 — Oral Health Assessment/Screening

Health Care Provider must complete and sign the oral health assessment.

To Parent(s) or Guardian(s):
State law requires that each local board of education request that an oral health assessment be conducted prior to public school enrollment, in either grade six or grade seven, and in either grade nine or grade ten (Public Act No. 18-168). The specific grade levels will be determined by the local board of education. The oral health assessment shall include a dental examination by a dentist or a visual screening and risk assessment for oral health conditions by a dental hygienist, or by a legally qualified practitioner of medicine, physician assistant or advanced practice registered nurse who has been trained in conducting an oral health assessment as part of a training program approved by the Commissioner of Public Health.

Student Name (Last, First, Middle)	Birth Date	Date of Exam
School	Grade	❑Male ❑Female
Home Address		
Parent/Guardian Name (Last, First, Middle)	Home Phone	Cell Phone

Dental Examination	**Visual Screening**	Normal	**Referral Made:**
Completed by: ❑Dentist	Completed by: ❑MD/DO ❑APRN ❑PA ❑Dental Hygienist	❑Yes ❑Abnormal (Describe) _____ _____ _____ _____ _____	❑Yes ❑No

Risk Assessment	**Describe Risk Factors**	
❑Low	❑Dental or orthodontic appliance	❑Carious lesions
❑Moderate	❑Saliva	❑Restorations
❑High	❑Gingival condition	❑Pain
	❑Visible plaque	❑Swelling
	❑Tooth demineralization	❑Trauma
	❑Other_____	❑Other _____

Recommendation(s) by health care provider: _____

_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.

_____

Signature of Parent/Guardian Date

_____

Signature of health care provider DMD / DDS / MD / DO / APRN / PA/ RDH Date Signed Printed/Stamped ***Provider*** Name and Phone Number

Child's Name:_____ **Birth Date:**_____ REV. 1/2022

Immunization Record

To the Health Care Provider: Please complete and initial below.

Vaccine (Month/Day/Year) _____

	Dose 1	Dose 2	Dose 3	Dose 4	Dose 5	Dose 6
DTP/DTaP/DT						
IPV/OPV						
MMR						
Measles						
Mumps						
Rubella						
Hib						
Hepatitis A						
Hepatitis B						
Varicella						
PCV* vaccine					*Pneumococcal conjugate vaccine	
Rotavirus						
MCV**					**Meningococcal conjugate vaccine	
Flu						
Other						

Religious Exemption: _____

Religious exemptions must meet the criteria established in Public Act 21-6: https://www.ctoec.org/wp-content/uploads/2021/07/OEC-Vaccination-QA-Final.pdf.

Medical Exemption: _____

Must have signed and completed medical exemption form attached. https://portal.ct.gov/-/media/Departments-and-Agencies/DPH/dph/infectious_diseases/immunization/CT-WIZ/CT-Medical-Exemption-Form-final-09272021fillable3.pdf

Disease history of varicella: _____(date); _____(confirmed by)

Immunization Requirements for Connecticut Day Care, Family Day Care and Group Day Care Homes

Vaccines	Under 2 months of age	By 3 months of age	By 5 months of age	By 7 months of age	By 16 months of age	16–18 months of age	By 19 months of age	2–3 years of age (24-35 mos.)	3–5 years of age (36-59 mos.)
DTP/DTaP/ DT	None	1 dose	2 doses	3 doses	3 doses	3 doses	4 doses	4 doses	4 doses
Polio	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
MMR	None	None	None	None	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]	1 dose after 1st birthday[1]
Hep B	None	1 dose	2 doses	2 doses	2 doses	2 doses	3 doses	3 doses	3 doses
HIB	None	1 dose	2 doses	2 or 3 doses depending on vaccine given[3]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]	1 booster dose after 1st birthday[4]
Varicella	None	None	None	None	None	None	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]	1 dose after 1st birthday or prior history of disease[1,2]
Pneumococcal Conjugate Vaccine (PCV)	None	1 dose	2 doses	3 doses	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday	1 dose after 1st birthday
Hepatitis A	None	None	None	None	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	1 dose after 1st birthday[5]	2 doses given 6 months apart[5]	2 doses given 6 months apart[5]
Influenza	None	None	None	1 or 2 doses	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]	1 or 2 doses[6]

1. Laboratory confirmed immunity also acceptable
2. Physician diagnosis of disease
3. A complete primary series is 2 doses of PRP-OMP (PedvaxHIB) or 3 doses of HbOC (ActHib or Pentacel)
4. As a final booster dose if the child completed the primary series before age 12 months. Children who receive the first dose of Hib on or after 12 months of age and before 15 months of age are required to have 2 doses. Children who received the first dose of Hib vaccine on or after 15 months of age are required to have only one dose
5. Hepatitis A is required for all children born after January 1, 2009
6. Two doses in the same flu season are required for children who have not previously received an influenza vaccination, with a single dose required during subsequent seasons

_____

Initial/Signature of health care provider MD / DO / APRN / PA Date Signed Printed/Stamped ***Provider*** Name and Phone Number

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CERTIFICATION OF RESIDENCE

NEW ENROLLEE/STUDENT TRANSFER/CHANGE OF ADDRESS

All students attending Andover Elementary School must be town residents unless specifically permitted to attend by the Board of Education. Any out-of-district student seeking admission on a tuition basis must be approved by the Board of Education and pay the actual per-pupil rate.

Students may not enroll in Andover Elementary School unless and until they are actually residing in Andover. For new housing, a Certificate of Occupancy with the residency date must be presented to the Superintendent of Schools for students to enroll. For existing housing in Andover, two of the following three items must be presented to the school office:

____ 1. Rental / Lease Agreement or mortgage papers with the name and address of the new resident,
____ 2. Driver's license with name and Andover address,
____ 3. A utility bill or other business correspondence with the name and Andover address.

The building administration may require additional residence verification if necessary. Students who move during the school year must withdraw from Andover Elementary School or pay the appropriate out-of-district tuition.

Non-residents whose children are enrolled in Andover Elementary School without prior permission from the Superintendent will be assessed tuition for the time children were in attendance in Andover.

Parent/Legal Guardian Statement

I (print name) _____ the parent or legal guardian of student(s) _____/_____ Grade(s) _____
(Andover Address)_____
certify that the above named student actually lives at the above address.
The telephone number at the same address is _____; the emergency telephone number is _____. The Owner/Landlord name is _____ and telephone number is_____.

The information and documentation provided are accurate. I authorize representatives of Andover Elementary School to verify this information, and I understand falsification of any information or documents required for this verification will result in revocation of registration for the student, and may lead to liability for tuition and to criminal penalties for fraud.

Parent/Guardian Signature: _____ Date: _____

Administrator's Signature: _____ Date:_____

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GRANT INFORMATION FORM

IMPORTANT: PLEASE FILL OUT ALL SECTIONS BELOW

Child's Name:_____

Parent/Guardian Name(s):_____

1. ☐ Yes ☐ No Does your child have a primary care physician?

   If YES, doctor's name:_____

2. ☐ Yes ☐ No Does your child have health insurance?

   If YES, with whom (e.g., HUSKY, BC/BS):_____

3. What is your annual household income?:_____

   Income verified by (administrator):_____

   Source of verification (e.g., tax return, W2, pay stubs – COPY ATTACHED):_____

4. How many people are living in your home (include grandparents, aunts, etc.):_____

I understand that tuition is required at Andover Elementary School Early Learning Center in accordance with the State of Connecticut's School Readiness Fee Schedule (based on household size and household gross income).

NOTE: Families shall be notified in writing of any change in the fee schedule (SR Policy B-01) 30 days prior to the date the change is to take place.

_____ _____

Parent/Guardian Signature Date

Please check if you would like information regarding any of the following assistance programs:

☐ Literacy/Adult Education ☐ Town Social Services ☐ Mental Health Support

Would you like a copy of the Andover Human Resources Guide? ☐ YES ☐ NO

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TRANSPORTATION REQUEST

Dear Parents,

We are in the process of setting up bus routes for next year. Please complete the following form and return it to the school as soon as possible. Students must ride the same bus each morning or each afternoon. If your child goes to daycare, they must ride the same bus every day. For further clarification, please do not hesitate to contact the school. Thank you very much for your cooperation.

Date: _____

Name of Student(s):_____

Resident Address: _____

Phone Number(s): _____

****

Student should be **PICKED UP** for transportation to school from:

_____Home _____Daycare

Name of Daycare Provider: _____

Address: _____

Telephone: _____

****

Student should be **DROPPED OFF** at the end of the day at:

_____Home _____Daycare

Name of Daycare Provider: _____

Address: _____

Telephone: _____

****

My child will attend **COOL**: _____Mornings _____Afternoons

Andover Elementary School
EARLY LEARNING CENTER

ANDOVER EARLY LEARNING CENTER ♦ 35 SCHOOL ROAD ♦ ANDOVER, CT 06232 ♦ PH (860) 742-7339 ♦ FAX (860) 742-8288

ANDOVER EARLY LEARNING CENTER - NUTRITION QUESTIONNAIRE

Child's Name:_____ Parent/Guardian Name:_____

Date of Birth:_____ Telephone Number:_____

Doctor Name:_____ Parent Email:_____

Height:_____ Weight:_____ Date:_____

Has your child now or ever been seen by a dietician or nutritionist? □ Yes □ No If yes, by whom?_____

DIRECTIONS: Please circle your answers. For every YES, add the number in the last column. For scores of 4 or more, we may refer you to our occupational therapist, with your permission.

1.	Does your child have a health problem (do NOT include colds/flu). If yes, what is it?	YES	NO	1
2.	Is your child: Small for age? □ Too thin? □ Too heavy? □ (if any are checked, circle YES)	YES	NO	3
3.	Does your child have any feeding problems? If yes, what are they?	YES	NO	3
4.	Is your child's appetite a problem? If yes, describe.	YES	NO	1
5.	Is your child on a special diet? If yes, what type of diet?	YES	NO	2
6.	Does your child take medicine for a health problem? (Do NOT include vitamins, iron, fluoride) Name the medicine:	YES	NO	1
7.	Does your child have food allergies? If yes, to what foods?	YES	NO	1
8.	Does your child use a feeding tube or other special feeding method? If yes, explain	YES	NO	4
9.	Does your child have trouble eating any of these foods (check all that apply; circle YES if any checked items) Milk □ Meats □ Vegetables □ Fruits □	YES	NO	1
10.	Does your child have any of these problems? (check all that apply; circle YES for any checked items) Sucking □ Swallowing □ Chewing □ Gagging □ Meals lasting longer than 30 minutes □	YES	NO	3
11.	Does your child have any of these problems? (check all that apply; circle YES if any checked items) Loose stools □ Hard stools □ Vomiting □	YES	NO	3
12.	Does your child eat any non-food items (dirt, clay, etc.)? If yes, what?	YES	NO	2
13.	Does your child refuse to eat, throw food, or do other things that upset you at mealtime? If yes, explain	YES	NO	2
14.	Does your child still drink from a bottle? If so, how often?	YES	NO	1
15.	Circle YES if your child is not using utensils at meals	YES	NO	2

Other comments: TOTAL _____

If my score is 4 or more, I would like the results of this questionnaire shared with AES occupational therapist: Yes □ No □

_____ _____

Parent/Guardian Signature Date

Survey adapted from REACH

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Health & Safety File Permission Slip

_____

At Andover Elementary School Early Learning Center, all records pertaining to each child (including registration, medical forms, assessment reports, or evaluations) are kept in a locked file cabinet in the main office or in the school nurse's office.

In order for the administrator, school teaching staff, or regulatory authority to access the records, we will need a signed consent form from the child's parent/legal guardian.

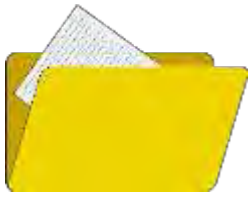
I give permission for my child's confidential file to be accessed by school personnel and any regulatory authority.

Child's Name _____

Parent/Guardian Printed Name _____

Parent/Guardian Signed Name _____

Date _____



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PERMISSION TO SEND/RECEIVE STUDENT RECORDS
AND FOR VERBAL COMMUNICATION

I give permission for _____Andover Elementary School_____
(Name of School)
_____35 School Road, Andover CT 06232_____ to:
(School Address)

__✓__ receive original records __✓__ send records __✓__ verbally exchange information as checked below:

Student's Name _____ **Date of Birth**: _____

___✓___ Health Record

___✓___ Psychological Evaluation(s)

___✓___ Social Work and/or Guidance Records

___✓___ Speech/Language Evaluation(s)

___✓___ Birth to Three information (if applicable)

_____Other (Specify) _____

_____ _____
Signature of Parent/Guardian **Date**

Communication (written and/or verbal) between:

Andover Elementary School
Early Learning Center Staff and _____
(name of contact person)

_____
(name of contact person)

_____
(name of contact person)

Revised: 1/13/20

C.O.O.L.

AFTER SCHOOL

The Community Organized and Operated Latchkey, Inc (COOL), located at Andover Elementary School, will be accepting Applications for enrollment for Pre-K - 6th grade, for the 2025-2026 school year, beginning in April.

The after school session runs from the end of the school day until 6 p.m., when school is in session. Children are given time to PLAY outside and in the gymnasium; organized sports/games and free play. There are ARTS and CRAFTS activities, SENSORY activities, BUILDING, STORIES, GAMES, SCIENCE experiments, MUSIC and more.

The morning session will run from 6:45-8:30 a.m.

Options include:

Full Time Week Afternoons

Part Time Week; Either 3 Days or Leaving by 4:30 p.m. Daily

Mornings Week

COOL FEES* - Please email for updated fee information

Remember NO School = NO COOL

Online Registration and Enrollment Forms will be available in April.

Email Amy at COOLAES35@gmail.com for more information and to receive updates on registration.

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PLAN TO PROVIDE FAMILY WELL-BEING

The Andover Elementary School Early Learning Center actively works with families to provide referrals, resources, and services that address the needs of families. If a family is in need, the following agencies can be accessed for assistance.

-FOOD PANTRIES

Andover Congregational Church Food Pantry
Local Community Based Non-Profit Human Services Provider
Joan Soucy
P.O. Box 55 / 359 Route 6
Andover, CT 06232
(860) 742-7696
Joansoucy2114@yahoo.com

Foodshare
Human Services Non-Profit or State Services Provider with Offices outside Andover, Columbia, Hebron, or Marlborough
Beatrice Maslowski/Community Network Builder
450 Woodland Avenue
Bloomfield, CT 06002-1342
(860) 286-9999
www.foodshare.org
bmaslowski@foodshare.org

-SOCIAL SERVICES
-MENTAL HEALTH ISSUES
-DOMESTIC VIOLENCE
-SUBSTANCE ABUSE

AHM Youth and Family Services
25 Pendleton Drive
Hebron, CT 06248
(860) 228-9488
www.ahmyouth.org

-INCOME SUPPORT
-HOUSING ASSISTANCE
-FINANCIAL ASSET BUILDING

Town of Andover CT
17 School Road
Andover, CT 06232
(860) 742-7305
www.andoverct.org

-ADULT EDUCATION
-COMMUNITY EDUCATION
-EMPLOYMENT & TRAINING PROGRAMS
-ENGLISH LANGUAGE LEARNER SERVICES
-PARENT & FAMILY PROGRAMS

EASTCONN
Central Administration
376 Hartford Turnpike
Hampton, CT 06247
(860) 455-0707

Community Learning Center
Tyler Square, 1320 Main Street
Willimantic, CT 06226
(860) 423-2591

Northeast Learning Center
562 Westcott Road
Danielson, CT 06239
(860) 779-3770

www.eastconn.org

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School Readiness Council
Application of Interest 2025-2026

Please fill out the form if you are interested in serving on our School Readiness Council. We are looking for two parents to volunteer for this committee. Please return this form to Andover Elementary School at your earliest convenience.

Name: _____ Address: _____

Phone number: _____ Email address: _____

What set of skills can you bring to our School Readiness Council?

_____

_____

_____

What other kinds of committees have you served on, and in what capacity?

_____

_____

_____

Are you available to meet after school every other month for about an hour? Meetings are usually on Tuesday or Wednesday. If you are not available at that time, what days would best fit your schedule?

_____

_____

_____

Is there anything else that you would like us to know about you?

_____

_____

_____