



## Letter of Intent 2018-19 Academic Year

Dear Ridgewood Parents,

Each year at this time, we open our enrollment process for the upcoming academic year. Though the start of a new year is still months away, it is important for us to begin planning to accommodate students for next year.

We expect our enrollment to grow significantly. With more than 22 new students with us this year, that number will continue to climb next year. Inquiries are steady, and we will begin testing new students in April.

As a current Ridgewood family, you have the first opportunity to secure seats for your child(ren) for the upcoming school year *before* we offer admission to new students. As interest in Ridgewood continues to grow, we anticipate that many classes will reach capacity in 2018-19. So with that in mind, please be aware that Ridgewood enrollment for *current* families begins March 13, 2018.

During the month of March, all current Ridgewood families will have the opportunity to save your child(ren)'s seat(s) by sending a \$100 deposit for each child by April 5, 2018. After that date, we will begin to fill classes until we reach the capacity of 16 students.

*\*These deposits are non-refundable and are required, and will be applied to your first month's tuition.*

The year is passing quickly, and we hope your family is enjoying the nurturing and comprehensive hands-on learning environment that is the tradition of Ridgewood School.

Thank you for your support in this year of transition, and for your help in making it all come together. Your willingness to be an active part of your child's education has truly made the difference.

Warmest regards,

Aliya Ranginwala, Head of School

**Please return this form with your required deposit by April 5, 2018. The deposit is \$100 per student.**

Family Name \_\_\_\_\_

The following child(ren) will return to Ridgewood School for the 2018-2019 academic year:

Yes  No Child's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_

Yes  No Child's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_

Yes  No Child's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_

Yes  No Child's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_

Yes  No Child's Name \_\_\_\_\_ Grade Entering \_\_\_\_\_

Enclosed is my check for \$\_\_\_\_\_ (Deposit must be included with Intent Form.)



## Registration

PLEASE PRINT AND BE AS THOROUGH AS POSSIBLE

School Year \_\_\_\_\_

### Student Information

Currently located in what school district? \_\_\_\_\_

Gender  Male  Female U.S. citizen?  Yes  No Grade \_\_\_\_\_

Please check one:  Alaskan  African-American  White/Caucasian  Multi-Racial  Hispanic  
 East Asian/Asian-American  South Asian/Indian American  Pacific Islander  
 Middle Eastern/Arab American  Native American/American Indian

Full name of student \_\_\_\_\_

Date of birth (mm/dd/yyyy) \_\_\_\_\_ Place of birth (city/state) \_\_\_\_\_

Home street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Child's Cellphone \_\_\_\_\_ Child's Email \_\_\_\_\_

### Parent/Guardian Information (where you can be contacted while your child is in this school/program)

Guardian 1 name \_\_\_\_\_ Guardian 2 name \_\_\_\_\_

Address, if different \_\_\_\_\_ Address, if different \_\_\_\_\_

Phone number \_\_\_\_\_ Phone number \_\_\_\_\_

Cell number \_\_\_\_\_ Cell number \_\_\_\_\_

Email \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Work phone \_\_\_\_\_ Work phone \_\_\_\_\_

### Family Information

Names of brothers and sisters	Age	School and grade
_____	_____	_____
_____	_____	_____

List any siblings who have attended Ridgewood School \_\_\_\_\_  
\_\_\_\_\_

Paternal grandparents (if living) \_\_\_\_\_

Full address \_\_\_\_\_

Maternal grandparents (if living) \_\_\_\_\_

Full address \_\_\_\_\_

### School History

List any schools that have been attended by the student (current school first):

Name	Address	Grade(s)
_____	_____	_____
_____	_____	_____

What grades, if any, have been skipped? \_\_\_\_\_ Repeated? \_\_\_\_\_

Please list any extracurricular activities in which the applicant has participated \_\_\_\_\_  
\_\_\_\_\_

### General Information

List any languages, other than English, that are spoken at home \_\_\_\_\_

Does your child have physical handicaps or allergies that would limit participation in school activities?

Yes  No

Has your child had any serious physical or emotional illness?  Yes  No

Is your child under care of a physician, psychiatrist, or psychologist?  Yes  No

If you answered yes to any of the question above, please provide details \_\_\_\_\_  
\_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



## Allergies, Special Health or Medical Conditions and Food Supplements Form

Fill in this section accurately and completely. Please note that if your child has a current health or medical condition requiring school staff to perform child-specific care, such as: to monitor the condition, provide treatment, care, or to give medication, our Emergency Medical Authorization Form and/or our Non-Prescription Medication Form must be completed and be kept on file at the school.

### Does your child have any food, medication or environmental allergies?

No

Yes (check all that apply)  Food  Medication  Environmental Please list and explain:

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### Does your child's allergy/allergies require school staff to monitor your child for symptoms, take action if a reaction occurs, or give emergency medication to your child? Check one.

No

Yes: our Emergency Medical Authorization Form and our Request for Administration of Medication Form must be completed.

### Does your child have any food, medication or environmental allergies?

No

Yes (please explain)

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### Does the special health or medical condition require school staff to perform a procedure, or perform child-specific care such as: to monitor your child for symptoms or administer medication during child care hours? Check one.

No

Yes: our Emergency Medical Authorization Form and, if administering medication, Request for Administration of Medication Form must be completed.

**Is your child currently using any medicine, food supplement or medical food (such as electrolyte solution)?**

- No
  - Yes (please explain)
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**If yes, does this medication, food supplement, or medical food need to be administered at the school?**

- No
- Yes: our Emergency Medical Authorization Form and/or our Request for Administration of Medication Form must be completed.
- NA – program does not need to administer any medications

**Does your child have any dietary restrictions, including those for medical, religious, or cultural reasons? (check one)**

- No
  - Yes (please explain)
- 
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**Does this dietary restriction require a modified diet that eliminates all types of fluid milk or an entire food group? Check one.**

- No
- Yes: our Emergency Medical Authorization Form and/or our Request for Administration of Medication Form must be completed.
- NA – program does not need to administer any medications



## Emergency Medical Authorization Form

This release is to authorize Ridgewood School to provide emergency medical treatment for children who become ill or injured while under school authority, and when parents or guardians cannot be reached.

Student Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Cellphone \_\_\_\_\_

### Residential Parent or Guardian

Mother or Guardian One Name \_\_\_\_\_

Email \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Cellphone \_\_\_\_\_

Father or Guardian Two Name \_\_\_\_\_

Email \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Cellphone \_\_\_\_\_

Other Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

### Emergency Contact (if parents/guardians can't be reached)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Cellphone \_\_\_\_\_

Email \_\_\_\_\_

*Note: Part 1 or Part 2 on page 2 of this form must be completed and signed.*

**Part 1: To Grant Consent**

I hereby give consent for the following medical care providers and local hospital to be called:

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Phone \_\_\_\_\_

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named practitioners, or, in the event the designated practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child’s medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

**Part 2: Refusal to Consent**

I DO NOT give my consent for emergency medical treatment or transport of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_



## Request for Administration of Medication Form

**The following section must always be completed by the parent/guardian.**

Check all that apply and complete all of the information.

- Prescription Medication       Non-prescription Medication       Food Supplement  
 Topical Product of Lotion       Refrigeration Required       Modified Diet

Name of Child \_\_\_\_\_ Date of Birth \_\_\_\_\_ Weight \_\_\_\_\_

Name of Medication \_\_\_\_\_ Exact Dosage \_\_\_\_\_

To be administered at the following times: \_\_\_\_\_ For the following period of time: \_\_\_\_\_

I understand that my child must receive one dose of medication before arriving at school (unless the medication is used for emergencies).

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**The following section must be completed by a licensed physician, licensed dentist, advanced practice registered nurse or certified physician's assistant if:**

1. The medication contains codeine or aspirin.
2. A physician's instruction is needed for a nonprescription medication (e.g. child does not meet minimum age or weight requirements as listed on the label instructions).
3. It is a sample medication without a prescription label.
4. The nonprescription medication is to be given longer than three consecutive days within a 14-day period.
5. The topical product or lotion and the physician's instructions exceed the manufacturer's instructions or use.

Name of Child \_\_\_\_\_ Name of medication \_\_\_\_\_

Dosage \_\_\_\_\_ Possible side effects to watch for are \_\_\_\_\_

Expiration Date (May not exceed twelve months from the date of this request for medications or food supplements). \_\_\_\_\_

Instructions \_\_\_\_\_

This child is under my care and should receive the above medication as written.

Signature of Practitioner \_\_\_\_\_

Date \_\_\_\_\_ Phone Number \_\_\_\_\_

This form is valid for no longer than twelve months and must be kept on file at the school for at least one year following the last administration of the medication or product. One form must be used for each medication.







## Non-Prescription Medication Form

This form grants permission for non-prescription medications to be administered to your child. We must have the signed form on file prior to administering any of the following medications.

If you want the non-prescription medication available to your child, please fill out, sign and return the form as soon as possible.

Any prescription medications can be administered to your child with instructions in the office only.

Medications	Child May Have	Amount Of Dosage
Ibuprofen 100 mg 'Chewable'	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Tylenol Acetaminophen 325mg	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Ibuprofen Tablets 200mg	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Acetaminophen 500mg	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Tums	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3
Cough Drops	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Guardian Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Cellphone \_\_\_\_\_

Email \_\_\_\_\_

Signature of Guardian \_\_\_\_\_