CAST PRESCHOOL

REQUEST FOR ADMISSION
~ 2018-2019 ~

(Name of Parent)

(Home Address)

(Home Phone) (Work/Cell Phone) (Email Address)

PLEASE NOTE THE FOLLOWING MINIMUM ENROLLMENT REQUIREMENTS

LOWER SCHOOL = 2 DAYS PER WEEK **UPPER SCHOOL (4 & 5 Year Olds) = 3 DAYS PER WEEK**

For children enrolling 3 days per week, please choose a *Monday or a Friday* as one of your days.

ENROLL BY JANUARY 31, 2018 TO RESERVE YOUR CHOICE OF DAYS.

1) _____
Child's Name Date of Birth

2) _____
Child's Name Date of Birth

MON ☐ TUE ☐ WED ☐ THU ☐ FRI ☐

DROP-OFF TIME: _____ _____ _____ _____ _____
PICK-UP TIME: _____ _____ _____ _____ _____

PLEASE CHECK ONE OF THE FOLLOWING OPTIONS: **CHECK BELOW**

ENROLLING FOR THE "SCHOOL YEAR" (42 WEEKS) - 08/29/18 THRU 06/28/19 _____

ENROLLING FOR THE "FULL YEAR" (49 WEEKS) - 08/29/18 THRU 08/16/19 _____

A *NON-REFUNDABLE* REGISTRATION FEE MUST ACCOMPANY THIS FORM

NEW REGISTRATION FEE = $100.00 PER FAMILY or RE-REGISTRATION FEE = $ 25.00 PER FAMILY

IMPORTANT: Acceptance of this form and registration fee DO NOT guarantee that the days requested are available. We will make every effort to accommodate your request and we will notify you prior to proceeding if we are unable to place your child in a program on the days requested above. (01/03/17)

CAST Preschool
And Childcare Center

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Explore, Discover, Grow!

Application & Registration Agreement

Name of Child____ Date of Birth_________________________

Address____ Zip Code_____________________

Home Phone (____) ____________________________________ E-mail address_____________________________________

Enrollment Date_______________________________

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PARENT 1____ Cell phone (____) ________________________

Home Address____ Home phone (____) _______________________

Employer/Address____ Work phone (____) _______________________

PARENT 2____ Cell phone (____) _________________________

Home Address____ Home phone (____) _______________________

Employer/Address____ Work phone (____) _________________________

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We have a security system at both the front and back doors of our main building. In order for anyone to gain access to this facility they will have to enter the last four digits of their Social Security number into the keypad. Please list below your name and last four digits of your SS#:

1. ____ ____________________________

Parent #1 Last 4 digits – SS#

2. ____ ____________________________

Parent #2 Last 4 digits – SS#

PARENT SIGNATURE____**DATE**____________________

ENROLLMENT POLICY – Initial and continued enrollment will be at the discretion of CAST Preschool based upon the best interest of the child, the expectation that he/she will benefit from the program, and the welfare of the other enrolled children. Enrollment shall be without regard to race, creed, sex, religion or national origin.

124 South Pomperaug Avenue, Woodbury, Connecticut 06798

castpreschool@gmail.com * www.castkidz.com * (203)266-4392

CAST Emergency Information

Student's Name _____
Last First

Address _____

Birth Date ___/___/___ Home Phone _____

Parent #1 Name _____Parent #2 Name_____
Last First Last First

Parent 1 work # _____ Parent 2 cell # _____

Parent 2 work # _____ Parent 2 cell # _____

Emergency Contacts

CAST requires that you provide us with the phone #'s of 2 emergency contacts who can be called and will be available to come to CAST in case of an emergency if you cannot be reached:

Name _____Home Phone_____Cell Phone_____

Name _____Home Phone_____Cell Phone_____

In the event that CAST is not able to reach any of the above contacts, I give permission to CAST to provide first aid for my child and to take appropriate measures including contacting the EMS system and arranging for transportation to _____ or the closest emergency medical facility.
Name of Hospital

Please list your child's allergies or handicaps, if any: _____

_____

Name of Pediatrician _____

Address _____Phone # _____

Dentist _____Phone # _____

Parent's Signature_____Date_____

CAST Consent Form

I grant permission for my child to:

take part in all program activities including the use of all indoor and outdoor equipment _____ _____
Yes No

go on nature walks around the CAST buildings and surrounding property, weather permitting _____ _____
Yes No

appear in the CAST Directory _____ _____
Yes No

appear on classroom documentation boards _____ _____
Yes No

appear on the CAST website, including Journal pages _____ _____
Yes No

appear in advertising & marketing, including facebook _____ _____
Yes No

appear in educational presentations published by CAST _____ _____
Yes No

*I give CAST permission to take whatever emergency measures are judged necessary for the care and protection of my child while under the care and supervision of the school.

*I understand that in case of a medical emergency my child will be transported to a local emergency unit for treatment at my expense.

*I understand that in some medical situations the staff will need to contact the local EMS before the child's parent, physician and others acting on the child's behalf.

*I understand that I must supply CAST with a physician's report form or religious exemption form prior to my child's attendance at CAST.

Parent's Signature _____Date_____

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 I) which will be helpful to the health care provider when he or she completes the health evaluation (Part II). 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/Alaskan Native ❑ Hispanic/Latino ❑ Black, not of Hispanic origin ❑ Asian/Pacific Islander ❑ White, not of Hispanic origin ❑ Other	
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 I — 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 examination in the last 6 months	Y	N	Any heart problems	Y	N
Any daily/ongoing medications	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 to another	Y	N	6. Interaction with others	Y	N	Eating concerns	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

Part II — 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 ❑ No ❑ Yes

*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
Seizures ❑ No ❑ Yes: Type: _____

Other Chronic Disease: _____

❑ 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

Child's Name: _____ **Birth Date:** _____ REV. 3/2015

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	
Influenza						
Tdap/Td						

Disease history for varicella (chickenpox) _____
(Date) (Confirmed by)

Exemption: **Religious** _____ **Medical: Permanent** _____ **†Temporary** _____ **Date** _____
†Recertify Date _____ †Recertify Date _____ †Recertify Date _____

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 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	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]	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 on or 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

CAST Discipline Policy

Positive Intervention

Our Reggio inspired programs view the goal of discipline as a means of supporting children as they develop the ability to self-regulate their emotions, impulses, and attention. Our disciplinary interactions are always respectful of the child and promote self-esteem and confidence. Behaviors are not labeled in a way that might reflect on the integrity of the child, e.g. "babyish", "naughty", "selfish", or "bad". Children's feelings are acknowledged, e.g. "you look very sad" rather than telling the child "there's no reason to cry."

Teachers establish routines and set limits as a way to provide boundaries that are reassuring for children. Below are some of the techniques that teachers use to define the boundaries and set limits on behavior:

- Limits are stated clearly – "The blocks are ONLY for building, but the balls may be thrown outside."
- Expectations are stated in a positive way – "Please keep your feet on the floor" rather than "Don't climb on the table."
- Redirection is used – "Let's go see what John is doing at the sensory table."
- Teachers support children's efforts to problem solve and negotiate with each other, e.g. "How can you tell John that you would like to have a turn with the truck?"
- There are logical consequences for behavior – "You are having a hard time playing with the blocks without throwing. Please make another choice."
- Children are presented with choices – "Would you like to work with clay or would you rather paint at the easel?"
- Teachers model appropriate and effective ways to express feelings and emotions – "I do not like when you grab the book from my hands. What can you say to me to let me know that you would like to have the book?"

The State of Connecticut has determined that licensed schools and daycares must publish their Discipline Policy and parents must confirm reading and having the opportunity to discuss the policy. Please read both sides of this document and then sign and return this part. Thank you. Julie

CAST will take the following steps to address on-going challenging behaviors:

1. Head Teacher will meet with an Administrator.
2. A meeting will be arranged between Head Teacher, Parent & Administrator to share information and strategies. CAST will obtain permission from parents to proceed with in-house and outside observations of the child.
3. Head Teacher will follow the CAST "Child Study Procedure".
4. Observations will be conducted and documented.
5. An individualized Behavior Plan will be implemented.
6. A meeting will be arranged between Head Teacher, Parent & Administrator to assess the success of the Behavior Plan.
7. Recommendations will be made to continue with Behavior Plan or parents will be advised to contact developmental specialists. If necessary for the purposes of the health and safety of the child, parents will be asked to provide a one-on-one aide for their child.
8. CAST will confer with specialists to support outside programs and/or therapies.
9. If child continues to present behavior that endangers him/herself or others, child will be dismissed. A certified letter will be sent to parents to advise of the dismissal.

I have read and had the opportunity to discuss the **CAST Discipline Policy**. I will cooperate with CAST and comply with decisions made on behalf of my child.

_____ _____

Child's Name Parent's Name

_____ _____

Parent's Signature Date

CAST Policy Regarding Illness

It is our policy to have teachers…

- …conduct a quick health scan of every child at drop off time. At this time teachers will note each child's general demeanor and will have the opportunity to speak to parents regarding any health concerns.

- …call the office to alert Miss Katie regarding any developing health concerns during the course of the day at which time Katie may call parents to give a "heads up" and possibly suggesting a call or visit to the pediatrician.

- …ask Miss Katie to call a parent for a fever over 100.5 degrees or an indication of a contagious illness such as coxsackie or pink eye. Should Miss Katie call and ask a parent to bring a child home or to the pediatrician, this must be done within a reasonable time in order to protect other children and teachers. Sick children will be cared for and kept comfortable until a parent arrives.

Should an infant show signs of fever due to teething, parents may speak to Miss Katie in the office in order to get the proper forms and information that will allow teachers in our Nursery to administer Tylenol. Tylenol will not be given to children other than for teething pain.

If your child will be absent from school, please call and let us know. Miss Katie will post an advisory outside your child's classroom door to alert parents if a contagious illness has been diagnosed in the classroom. No names will be mentioned.

As hard as we try to keep CAST clean and germ free, young children and toddlers will become ill during the school year. If you are a working parent, you must have a "BACK-UP PLAN". We will expect you to keep your child home if he/she has a fever or a contagious illness. The CAST Health Guide outlines different illnesses and advises when a child may return to school.

Please cut here and return bottom portion----------

I, _____, have read and I understand the CAST Policy Concerning Illness. I will develop a "back-up" plan for the care of my child when he/she may not come to school due to fever or illness. I understand that this policy is for the protection of my child and other children and teachers in the CAST community.

_____ _____

Parent's Signature Phone # (where I can <u>always</u> be reached)

_____

Date

Parent/Guardian Authorization for the Administration of Non-Prescription Topical Creams & Ointments by Child Care Personnel

I hereby request that the following non-prescription topical medications be administered to my child by a child care staff member of the Creative Arts Studio.

I understand that I must supply the child care program with the non-prescription topical medication in the original container labeled with the child's name, name of the medication, and the directions for the medication administration.

This authorization is limited to the following topical medications:

1. Diaper changing or other ointments free of antibiotic, antifungal, or steroidal medications
2. Medicated powders
3. Teething, gum, or lip medications

Name of Child: _____Date of Birth: _____

Address: _____

Name of Medication: _____

Schedule of Administration: _____

Site of Administration: _____

Reason medication is being administered: _____

Medication shall be administered from: _____to:_____

Name of Parent/Guardian _____Date:_____

I have administered at least one dose of the above medication to my child without adverse side effects.

Signature: _____Relationship to child: _____

Address: _____Telephone:_____

Staff to complete:

Parent authorization form and medication received by: _____
(Signature of staff)

Medication Started: _____ (date and time)
Medication Ended: _____ (date and time)

Parent permission and medication administration record shall become part of the child's health record when the medication has ended.

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PARENT/GUARDIAN AUTHORIZATION FOR THE ADMINISTRATION OF SUNSCREEN BY CHILDCARE PERSONNEL

To Childcare Personnel:

I, _____, will apply sunscreen to my child before school. Print name of Parent or Guardian

If my child remains at CAST after 3:00 pm, I give permission for a CAST faculty member to apply sunscreen – either NO AD SPF 50, which CAST shall provide, or the sunscreen that provide which I have indicated below:

Name of Child: _____

Date of Birth: _____

Name of Sunscreen: NO AD SPF 50 or _____

Sunscreen will be applied to only exposed areas of the skin as required for sun protection.

Signature of Parent/Guardian: _____Date:_____

Relationship to Child: _____

Office Use Only: Parent Authorization Form Received by: _____/_____
Signature Date

124 South Pomperaug Avenue, Woodbury, Connecticut 06798
info@castkidz.com * www.castkidz.com * (203)266-4392

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PARENTS PLEASE NOTE:

If your child has allergies or any other condition that requires prescription medication during the school day, you must get the proper Authorization Form from our Office. If you need the form immediately, please call our Office and we will email it to you along with instructions. 203-266-4392

124 South Pomperaug Avenue, Woodbury, Connecticut 06798
castpreschool@gmail.com * www.castkidz.com * (203)266-4392

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We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature

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procare SOFTWARE®

CAST CALENDAR
2018 - 2019

Faculty In-Service Day **- CLOSED**	August 27	MON
Preschool Orientation (Open for Orientation Only)	August 28	TUE
Preschool/Kidkare Begins	August 29	WED
Labor Day Holiday **- CLOSED**	September 3	MON
Columbus Day **- CLOSED**	October 8	MON
Veterans' Day **- CLOSED**	November 12	MON
Thanksgiving Holiday - Early Dismissal @ 12 PM LS/1 PM US	November 21 (1/2 Day)	WED
Thanksgiving Holiday **- CLOSED**	November 22-23	THU-FRI
Holiday Recess **- CLOSED**	December 24 - January 1	MON-TUES
Martin Luther King Day **- CLOSED**	January 21	MON
Presidents' Day **- CLOSED**	February 18	MON
Good Friday - **CLOSED**	April 19	FRI
Spring Break **-** Included in Full Year Contract (Optional for School Year Only)	April 15-18	MON-FRI
Memorial Day **- CLOSED**	May 27	MON
Preschool Ends **-** (Final Day for School Year Only)	June 28	FRI
Independence Day Holiday **- CLOSED**	July 1-5	MON-FRI
Summer Extension Begins	July 8	MON
Summer Extension Ends (Final Day for Full Year Contract)	August 16	FRI
School Set-Up Week - CLOSED	August 19-23	MON-FRI

WHEN REGION 14 SCHOOLS CLOSE, PLEASE CHECK OUR WEBSITE (www.castkidz.com) AND/OR CHANNEL 3 NEWS (www.wfsb.com) FOR CAST'S STATUS

Revised: 12-5-17 (jlc) NOTE: Calendar Subject to Change