



Stepping Stone Preschool

Registration

2025-2026

Thank you for choosing Stepping Stone Preschool! Our philosophy is to provide children with a safe, nurturing and stimulating environment, in which to learn, play and grow. We offer a quality educational program that promotes the social, emotional, physical and cognitive development of the child using Rhode Island Early Learning and Developmental Standards. We believe that early childhood is a time for exploring, making discoveries and sharing new experiences with friends. We celebrate the diversity of each child with respect to their individual developmental stage and unique learning style. We look forward to being the first stop on your child's educational journey!

Registration Information

When: *February 10, 2025@ 9am for SK residents only
*February 18, 2025@ 9am for Non-Residents

Where: Online!

Please visit <https://secure.rec1.com/town-of-south-kingstown-ri/catalog>

Who:

- *To enter Pre-K class children must turn 4 by Sept. 1, 2025.
- *To enter 3-Year-Old class in September children must turn 3 by Sept. 1, 2025. All others may register following their third birthday, space providing.

What to bring:

- *Completed/notarized application packet
- *birth certificate
- *Proof of Residency
- *First month tuition payment
- *\$60 non- refundable registration fee

***Physical form with required immunizations must be submitted *before* the first day of school for children to attend.**

Please submit registration packets and related payments within 10 business days to guarantee your child's spot in a program.



SOUTH KINGSTOWN PARKS AND RECREATION
STEPPING STONE PRESCHOOL



Child Information

Child's Full Name: _____

Date of Birth (MM/DD/YYYY): _____ Sex: Male / Female

Primary Language: _____

Secondary Language: _____

Primary Address

Number and Street: _____

City/Town _____ State _____ Zip _____

School Information (*School age, developmental preschool, early intervention, services etc.*)

School/Program Name: _____

Number and Street: _____

City/Town: _____ State _____ Zip _____

Parent/Guardian 1 Information

Parent/Guardian Full Name: _____

Parent/ Guardian Role: Mother Father Step mother Step Father Foster Parent Other _____

Contact Information

Primary Phone: () - Mobile Work Home

Secondary Phone: () - Mobile Work Home

Email: _____

Home Address _____ same as child _____

Number and Street: _____

City/ Town: _____ State _____ Zip: _____

Employer Information

Employer Name: _____

Address: _____

City/Town: _____ State _____ Zip _____

Typical Schedule _____

Parent/Guardian 2 Information

Parent/Guardian Full Name: _____

Parent/ Guardian Role: Mother Father Step Mother Step Father Foster Parent Other _____

Contact Information

Primary Phone: () - _____ Mobile Work Home

Secondary Phone: () - _____ Mobile Work Home

Email: _____

Home Address _____ same as child _____

Number and Street: _____

City/ Town: _____ State _____ Zip: _____

Employer Information

Employer Name: _____

Address: _____

City/Town: _____ State _____ Zip _____

Typical Schedule _____

Additional Members of Child's Household

Full Name _____ Relationship _____

Full Name _____ Relationship _____

Full Name _____ Relationship _____

Full Name _____ Relationship _____

Full Name _____ Relationship _____

Parental Access Restrictions

If there are temporary or permanent restrictions on a person's access to their child, please read and complete this section thoroughly. Please note: If the restricted person (s) are a child's biological parent (s), in order to abide by the permissions stated below, programs MUST have received a copy of any /all court documentations regarding restraining orders, physical/legal custody, joint custody, etc. Without court documentation, programs/providers are unable to withhold a child from their biological parent.

Restricted Person's Name: _____ Relation to Child _____

The above stated person has permission to see the child on the following days:

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Restricted Person's Name: _____ Relation to Child _____

The above stated person has permission to see the child on the following days:

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Restricted Person's Name: _____ Relation to Child _____

The above stated person has permission to see the child on the following days:

Sunday Monday Tuesday Wednesday Thursday Friday Saturday

Acknowledgement

By signing this form, I acknowledge that the information contained in this document is true and accurate. I understand that it is my responsibility to update the program/provider in the event of any changes or updates to the information in this form.

Parent/Guardian Name (Print)

Relation to Child

Parent/Guardian Signature

Date



SOUTH KINGSTOWN PARKS AND RECREATION
STEPPING STONE PRESCHOOL



To assist us in meeting the health and educational needs of your child, please answer the following questions listed below. If you answer "YES" to any of the following questions please use the space below to provide additional information.

1. Do you have any concerns about your child's general health? (eating sleeping habits, weight, bladder/bowels) Yes ___ No ___
2. Does your child have any eye issues? (difficulty seeing, crossed eyes, frequently watery eyes) Yes ___ No ___
3. Does your child wear glasses? Yes ___ No ___
4. Does your child have any ear or hearing difficulties? (frequent earaches, difficulty hearing, tubes in ears) Yes ___ No ___
5. Do you have any speech concerns for your child? (difficulty understanding speech, delayed speech development, stuttering?) Yes ___ No ___
6. Does your child have any other illnesses, disabilities, or limiting conditions?
Yes ___ No ___ If yes, please list: _____
7. Has your child received any evaluations which would assist the teacher in planning for his/her health or educational needs? Yes ___ No ___
8. Do you have any concerns about your child's behavior or emotional well-being that the teacher should know about? Yes ___ No ___
9. Do you have any concerns about your child's social skills or developmental needs that the teacher should know about? Yes ___ No ___

*If you answered "YES" to any of the above questions, please provide additional information below:

Signature of Parent / Guardian

Date



Stepping Stone Preschool Authorized Escort List



I, _____, hereby give permission and consent for Stepping Stone Preschool to release my child/children _____ to the following people:

Name: _____	Name: _____
Phone: _____	Phone: _____
Relationship: _____	Relationship: _____
Name: _____	Name: _____
Phone: _____	Phone: _____
Relationship: _____	Relationship: _____

In the event I need to call Stepping Stone to arrange for a last minute pick-up for my child, I will provide a code word so the staff knows that it is actually me on the line. I understand that the code word is for my immediate family ONLY and **is not to be given to any other person**, including the escorts listed above.

Parents, Guardians and Escorts are required to show a driver's license to verify identity.

Code word: _____

Parent Signature: _____ Date: _____

Parent Name (please print): _____



Rhode Island Department of Health

Required immunizations.

Requirements for children entering pre-kindergarten, child care, or day care centers licensed by the Rhode Island Department of Children, Youth, and Families.

- 4 doses of DTaP (diphtheria, tetanus, pertussis) vaccine
- 1 dose of flu vaccine each year (July 1- Dec. 31, 2025)
- 3 doses of hepatitis B vaccine
- 3 doses of Hib (Haemophilus influenzae type b) vaccine
- 1 dose of MMR (measles, mumps, rubella) vaccine
- 4 doses of pneumococcal conjugate vaccine (not routinely given to healthy children 5 years of age and older)
- 3 doses of polio vaccine
- 1 dose of varicella (chickenpox) vaccine



Rhode Island Department of Human Services

Group/Family Child Care Home: Parent Authorization for Emergency Treatment

Updated 03/20/2020

Authorization Statement	
Child Care Provider/Program Name: _____	
Child's Name: _____	Date of Birth: _____
In consideration of admittance, I hereby authorize _____ <i>Child Care Provider/Program Name</i>	
located at _____ <i>Number and Street</i>	RI _____ <i>City/Town</i> _____ <i>Zip</i>
to arrange for medical examination and/or treatment of my child _____ <i>Child's Full Name</i>	
should an emergency arise while my child is in the care of the above state provider/program. It is understood that a conscientious effort will be made by the provider to contact me at the emergency numbers I have provided below before any medical action is taken.	

Preferred Hospital			
I would prefer my child be taken to the following hospital should the need arise. However, I understand that the choice of hospital may be limited by service of the local rescue.			
Name of Hospital: _____			
Number and Street: _____	State: _____	Zip: _____	

Physician and Insurance Information	
I would prefer my child be taken to the following hospital should the need arise. However, I understand that the choice of hospital may be limited by service of the local rescue.	
Name of Doctor: _____	Phone: _____
Health Insurance Carrier: _____	Policy Number: _____

Emergency Contact Information
In the event of an emergency, the child's parent/guardian(s) will be contacted first. In the event the parent/guardian cannot be reached, emergency contact and authorized persons must be listed.
Authorized Person: An authorized person can pick up a child from care with no confirmation from a parent/guardian. An authorized person may also be contacted if the program cannot get ahold of the parent.
Emergency Contact: An emergency contact can pick up a child from care ONLY if there is written and/or verbal communication from the parent. An emergency contact may also be contacted if the program cannot get ahold of the parent.
Please complete the following form listing the authorized and/or emergency contact persons in the order you wish them to be contacted (For example: The first contact listed is the first person that will be called if a parent/guardian cannot be reached).



Rhode Island Department of Human Services

Group/Family Child Care Home: Parent Authorization for Emergency Treatment

Updated 03/20/2020

Emergency Contact Information			
Full Name:			
Relationship:			<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact
Primary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home
Secondary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

Full Name:			
Relationship:			<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact
Primary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home
Secondary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

Full Name:			
Relationship:			<input type="checkbox"/> Authorized Pick Up <input type="checkbox"/> Emergency Contact
Primary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home
Secondary Phone:	()	-	<input type="checkbox"/> Mobile <input type="checkbox"/> Work <input type="checkbox"/> Home

Parent/Guardian Name (Print)

Relation to Child

Parent/Guardian Signature

Date

Notary

Subscribed and sworn to before me on this _____ day of _____

Date

Month

Year

Notary Public (Print)

Notary Public (Signature)

Commission Expiration