Chancellor William McGill
School of Success

3025 Fir Street, San Diego CA, 92102
(P) 619-629-0770 (F) 619-239-1318

Returning Student

Enrollment Packet
2022-2023

Student's Name: _____

Last Name: First Name:

All applications must complete **ALL** documents in the package:

- ☐ Attendance and Engagement Agreement
- ☐ Student Emergency Information Form
- ☐ Student Health Information
- ☐ Photography and Media Release
- ☐ Record of Programs and Services

The Following form must be completed by your doctor:

- ☐ Epipen Authorization Form (Must be given by Health Aide)
- ☐ Asthma Authorization Form (Medication must be given be Health Aide)
- ☐ Medication Authorization Form (Medication must be given by Health Aide)
- ☐ Over the Counter-Medication we must have doctor authorization

Please check with you child's doctor to see if they may need the following:

- ☐ Immunizations
- ☐ Physical
- ☐ TB

The following is due every six months:

- ☐ Dental Exam

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Attendance and Engagement Agreement

2022-2023

At **McGill School of Success**, we believe each and every student can be successful when students, parents and the school work together to increase students' school attendance.

This agreement outlines the responsibilities of students, parents and the staff at this school in setting students up for successful learning.

By signing this agreement, students, parents and the school are making a commitment to each other that they will fulfil their roles and responsibilities for achieving the best possible learning outcomes for students.

Student's Agreement

I want to learn new things every day and do my best at school.

In signing this agreement, I agree to:

- Arrive at school on time (8:15 am)
- Be ready to learn
- Be a good friend. Be kind to others. Treat others with respect.
- Have a positive attitude
- Always do my best
- Follow school rules
- Ask for help when I need it
- Establish a good study routine so that I can complete schoolwork on time
- Do my homework
- Work with my teachers and parents to achieve my goals.

Student Signature_____ Date: _____

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Parent's Agreement

I want to help my child to learn each and every day and to achieve success.

In signing this agreement, I agree to:

- Send my child to school every day, unless he/she is sick.
- Make sure my child arrives at school on time (school starts at 8:15 am)
- Make sure my child arrives at school ready to learn
- Encourage and support my child's learning at home
- Help my child to establish a good study routine so that he/she can complete schoolwork on time
- Talk with teachers about any problems that may affect my child's learning
- Be open and responsive to communication from my child's teachers or other school staff
- Encourage my child to do his/her homework and to ask for help at school if needed
- Reinforce the importance of education and that school is a place for learning.

I have thoroughly read and understood the information contained in this agreement and will abide by it.

Print Parent's/Guardian's name(s): _____

Parents/Guardians signature(s): _____ Date:_____

School's Agreement

The staff at McGill School of Success want to help each student to learn each and every day and to achieve the very best results that she/he can.

In signing this agreement, I agree that the staff at this school will:

- Provide quality teaching that is based on principles of effective learning and teaching
- Prioritise resources in the most effective way to advance each student's achievement
- Implement fair and supportive behaviour management strategies in line with school policy
- Inform parents about their child's progress and behaviour
- Be available to talk with parents and be open and receptive to their issues and ideas
- Communicate both positive and negative feedback to parents about their child

I have thoroughly read and understood the information contained in this agreement and will abide by it.

Principal's signature: _____ Date: 2022-2023

McGill School of Success
2022-2023 Emergency Form

I. STUDENT INFORMATION

Last Name (LEGAL NAME ONLY)	First	Middle	Suffix (Jr,II,III)

Peferred/Actual Name:	Former legal names(s) (optional):	Birthdate:	Gender ☐ Female ☐ Male

Is student Hispanic or Latino? Yes ☐ No ☐	Race (check all boxes that apply)				
	☐American Indian or Alaskan Native	*Asian /Indochinese*			*Pacific Islander*
	☐Black or African American	☐ Asian Indian	☐ Cambodian	☐ Chinese	☐ Guamanian ☐ Hawaiian
	☐Filipino	☐ Hmong	☐ Japanese	☐ Korean	☐ Samoan ☐ Tahitian
	☐White	☐ Laotian	☐ Vietnamese	☐ Other Asian	☐ Other Pacific Islander

Household address:	City,State:	Zip Code:

House phone: ( )	Parent/Guardian / Email	Parent/Guardian / Email

City, State, Country of birth:	First enrolled in a CA school TK-5): Date:	First enrolled in a US school TK-5): Date:

Current Caregiver (check one): ☐ **Parent/Legal guardian** ☐ **Other adult (not legal guardian requires Caregiver Affidavit**

☐Foster Living Situation:
Check one if applicable:
☐Family Home (FFH) ☐Group Home (FGF) (FFA)
☐Forrmal Kinship Care Including NREFM

Homeless Living Situation (temporary residence due to financial hardship
Check all that apply:
☐ Living with someone/Doubling up ☐Unaccompanied Youth
☐ Hotel/motel ☐Sheltered ☐ Unsheltered ☐ Runaway Youth

Other Living Situation: ☐

Complete and include siblings who are currently in TK--5th Grade (only if applicable).

Sibling 1 Full name: _____	Grade: _____	School name: _____
Sibling 2 Full name: _____	Grade: _____	School name: _____
Sibling 3 Full name:	Grade:	School name:

II. CONTACT INFORMATION Provide at least three contacts

	Parent/Guardian/Contact	Parent/Guardian Contact	Emergency Contact (other than parent)
Full Name			**Full Name:** _____
Relationship to student			
Lives with student?	☐ Yes ☐ No If no, provide address here:	☐ Yes ☐ No If no, provide address here:	**Relationship to student:**
			Home Number ( )
			Work Number ( )
Home Phone	( ) _____	( ) _____	Cell Phone ( )
Work Phone	( ) _____	( ) _____	☐ Interpreter required
Cell Phone	( ) _____	( ) _____	☐ OK to release student
Employer			**Emergency Contact (other than parent)**
Military (check all that apply)	☐ Active Duty ☐ DOD Employee ☐ Reserves ☐ National Guard ☐Full Time	☐ Active Duty ☐ DOD Employee ☐ Reserves ☐ National Guard	**Full Name:** _____ **Relationship to student:** _____
Education Level (Select one)	☐ Not a High School Graduate ☐High School Graduate ☐ Some College/AA Degree ☐College Graduate ☐Graduate School/Post-Graduate ☐ Decline to state	☐ Not a High School Graduate ☐High School Graduate ☐ Some College/AA Degree ☐College Graduate ☐Graduate School/Post-Graduate ☐ Decline to state	Home Number ( ) Work Number ( ) Cell Phone ( ) ☐ Interpreter required ☐ OK to release student

Additional Information	☐ Report card ☐Progress report provided ☐ Interpreter required ☐ Access to student info online	☐ Report card ☐Progress report provided ☐ Interpreter required ☐ Access to student info online	

Signature Required on Reverse

III. Question s for Parent/Guardian

The following questions provide important information for the school staff. Parents must answer the following questions. Check "Yes" or "No" for each question where appropriate.

Has your student ever received Special Education services? Yes ___ No ___ Does your student has a **504 Plan?** Yes ___ No ___	Has one of the parents/guardians engaged in migrant work (moved and worked seasonally in jobs related to agruculture , lumber or fishery) in the past three years? Yes ___ No ___

Name, city, and state/county of last school attended:

_____

_____

_____

Last grade level completed: _____

(For students born outside the U.S.) Was this student born in a foreign country to diplomatic, military personnel or other U.S. citizenship?

Yes____ No ____

_____ _____

Parent/Guardian/Contact signature (required) ***Date***

Comments:

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Student Health Information Form

Student Name: _____ DOB: _____

Parent/Guardian: _____ Relationship to Student: _____

Phone: (Best # during school day): _____ (alt. #): _____

Parent/Guardian: _____ Relationship to Student _____

Phone: (Best # during school day): _____ (alt. #): _____

Alternate contacts to call in case of an emergency and parents/guardians cannot be reached:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Physician Name: _____ Phone: _____

Preferred Hospital: _____ Student's Health Insurance: _____

Indicate if your child has any of the following health conditions:

- ☐ ADD/ADHD
- ☐ Allergy: Food**
- ☐ Allergy: Insect Bite/Sting
- ☐ Allergy: Other
- ☐ Asthma
- ☐ Other _____
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Hearing Condition
- ☐ Heart Condition
- ☐ Other _____
- ☐ Migraine Headaches
- ☐ Muscular/Orthopedic Disorder
- ☐ Psychiatric/Psychological Disorder
- ☐ Special Needs
- ☐ Vision Loss-not corrected with glasses/contacts
- ☐ Other _____

** Parents must provide health office with a note from the doctor for any special dietary considerations regarding school lunches.

If you checked any of the boxes above, or if your child has medical conditions not listed, please explain (including **specific food, medication or other serious allergies and reactions**): _____

_____

Past history of injuries/illnesses/hospitalizations/surgeries: _____

_____

Please list all medications your child is currently taking:

Medication Name _____ Dose _____ Reason _____
Medication Name _____ Dose _____ Reason _____
Medication Name _____ Dose _____ Reason _____

PERMISSION FOR OVER-THE-COUNTER MEDICATIONS

Please initial if you permit the school health aide, after assessment, to provide the following over-the-counter medications, if needed: Advil, Motrin, Pepto Bismol, Benadryl Cream, Neosporin Ointment, Hydrocortisone Cream, Antiseptic Spray, Cough Drops or Tylenol to your child's as appropriate. Initial Yes _____ Initial No _____

I, the undersigned, do hereby authorize officials of the McGill to contact alternative adults and physicians listed. I authorize the school health aide, or trained personnel, to render treatment deemed necessary in case of an emergency. I authorize medical information to be shared with appropriate personnel.

_____ _____

Signature of Parent/Guardian Date

McGILL SCHOOL of SUCCESS
Planting the Seeds of Knowledge

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Formulario de información de salud del estudiante

Nombre del estudiante: _____ Fecha de nacimiento: _____
Padre / Tutor: _____ Relación con el estudiante: _____
Teléfono: (Mejor # durante el día escolar): _____ (alt. #): _____
Padre / Tutor: _____ Relación con el estudiante _____
Teléfono: (Mejor # durante el día escolar): _____ (# alt.): _____
Contactos alternativos para llamar en caso de emergencia y no se puede contactar a los padres / tutores:

Nombre: _____ Relación: _____ Teléfono: _____
Nombre: _____ Relación: _____ Teléfono: _____
Nombre: _____ Relación: _____ Teléfono: _____

Nombre del médico: _____ Teléfono: _____
Hospital preferido: _____ Seguro de salud del estudiante: _____
Indique si su hijo tiene alguna de las siguientes condiciones de salud:

- ▫ AGREGAR / TDAH
- ▫ Alergia: alimentos **
- ▫ Alergia: picadura de insecto / picadura
- ▫ Alergia: Otro
- ▫ Asma ▫ Condición cardíaca
- ▫ Otro _____
- ▫ Diabetes
- ▫ Trastorno de la alimentación
- ▫ Epilepsia / convulsiones
- ▫ Condición auditiva
- ▫ Pérdida de la visión: no se corrige con anteojos / lentes de contacto
- ▫ Otro _____
- ▫ Dolores de cabeza por migraña
- ▫ Trastorno muscular / ortopédico
- ▫ Trastorno psiquiátrico / psicológico
- ▫ Necesidades especiales
- ▫ Otro _____

** Los padres deben proporcionar a la oficina de salud una nota del médico para cualquier consideración dietética especial con respecto a los almuerzos escolares.

Si marcó alguna de las casillas anteriores, o si su hijo tiene afecciones médicas que no figuran en la lista, explique (incluyendo alimentos, medicamentos u otras alergias y reacciones graves específicas): _____
_____
Historial pasado de lesiones / enfermedades / hospitalizaciones / cirugías:
_____
Enumere todos los medicamentos que su hijo está tomando actualmente:

Nombre del medicamento _____ Dosis _____ Motivo _____
Nombre del medicamento _____ Dosis _____ Motivo _____
Nombre del medicamento _____ Dosis _____ Motivo _____

PERMISO PARA MEDICAMENTOS DE VENTA LIBRE

Inicialice si permite que la asistente de salud escolar, después de la evaluación, proporcione los siguientes medicamentos de venta libre, si es necesario: Advil, Motrin, Pepto Bismol, Benadryl Cream, Neosporin Ointment, Hydrocortisone Cream, Antiseptic Spray, Cough Drops o Tylenol para su hijo según corresponda. Inicial Sí _____ Inicial No _____

Yo, el abajo firmante, autorizo a los funcionarios de McGill a contactar a los adultos y médicos alternativos enumerados. Autorizo al asistente de salud escolar, o al personal capacitado, a brindar el tratamiento que se considere necesario en caso de emergencia. Autorizo que la información médica se comparta con el personal apropiado.

_____ _____
Firma del padre tutor Fecha

McGill School of Success

PHOTOGRAPHY/VIDEO/MEDIA RELEASE

Student's Name: (Last, First Middle) **Start Date**

_____ _____

During the school year, schools host events where representatives of the news media may be on campus to gather photographs and/or video footage.

In addition, parents and students may take photos of events in classrooms or around schools. These photos may be posted on the internet or otherwise distributed without the permission of the school. Your child's participation in these events is valued, and parent permission is needed to include him or her in events where photography may take place.

Parents/Guardians who prefer that their child not be photographed or video recorded must notify their school by using this form. Schools make every effort to ensure the wishes of the parent/guardian. Please be aware that photographing and video recording by devices such as cell phones may take place without the knowledge of the teacher, principal or staff.

PARENTS OR GUARDIANS: Indicate your level of permission OR use the last circle to opt-out completely.

_____ **I give my permission** (please initial):

- to have my student interviewed, photographed, and/or video recorded by news media
- to have my student photographed and/or video recorded by the school. Photos and videos may be used on school websites, brochures, etc.
- to have my child's name published in order to credit his or her work.

_____ **I *DO NOT* want my child s name, photo, or video published publicly.** (please initial)

Parent's Signature: _____ Date: _____

McGill School of Success

FOTOGRAFÍA / VIDEO / COMUNICADO

_____ _____

Nombre del estudiante: (Apellido, primer nombre) **Fecha de inicio**

Durante el año escolar, las escuelas organizan eventos donde los representantes de los medios de comunicación pueden estar en el campus para recopilar fotografías y / o vídeos.

Además, los padres y los estudiantes pueden tomar fotos de eventos en las aulas o alrededor de las escuelas. Estas fotos pueden publicarse en Internet o distribuirse de otro modo sin el permiso de la escuela. Se valora la participación de su hijo en estos eventos, y se necesita el permiso de los padres para incluirlo en los eventos en los que se pueden tomar fotografías.

Los padres / tutores que prefieran que su hijo no sea fotografiado o grabado en vídeo debe notificar a su escuela mediante este formulario. Las escuelas hacen todo lo posible para garantizar los deseos de los padres / tutores. Tenga en cuenta que la fotografía y la grabación de video por dispositivos como teléfonos celulares pueden realizarse sin el conocimiento del maestro, el director o el personal.

PADRES O TUTORES: Indique su nivel de permiso o use el último círculo para darse de baja por completo.

_____ **Doy mi permiso** (inicial)

- hacer que mi estudiante sea entrevistado, fotografiado y / o grabado en video por los medios de comunicación
- que la escuela fotografíe y / o grabe a mi estudiante. Fotos y videos puede usarse en sitios web de la escuela, folletos, etc.
- para que se publique el nombre de mi hijo para acreditar su trabajo.

_____ **NO** quiero que el nombre, la foto o el video de mi hijo se publiquen públicamente. (por favor inicial)

Firma del padre: _____ Fecha: _____

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Record of Programs and Services

It is important that we be informed of any special help he/xshe may have received or programs he/she has participated in at their previous(s) school. Please give us the following information to help us expedite your child's placement.

Students Name: _____

Date of Birth:_____ **Grade:** _____

_____ My Child **has not** participated in any special programs
_____ My child has had special testing

My child has participated in the program(s), checked below:

_____ Gate (Gate Education)
_____ Special Education
_____ SEEC
_____ Resource Specialist
_____ Counseling
_____ Other Programs:

_____ Hearing Impaired
_____ Speech Therapy
_____ Visually Handicapped
_____ Multiple Handicapped
_____ ESL English as a Second Language

_____

_____

School(s) child has been enrolled previously:

_____

_____

McGILL SCHOOL *of* SUCCESS

Planting the Seeds of Knowledge

Registro de Programas y Servicios

Es importante que se nos informe de cualquier ayuda especial que haya recibido o de los programas en los que haya participado en su (s) escuela (s) anterior (es). Por favor dénos la siguiente información para ayudarnos a acelerar la colocación de su hijo.

El nombre del estudiante: _____

Grado: _____ Fecha de nacimiento: _____

____ Mi hijo no ha participado en ningún programa especial
____ Mi hijo ha tenido exámenes especiales

Mi hijo ha participado en el programa (s), marcado a continuación:

____ Gate (Educación de Gate)
____ Educación especial
____ SEEC
____ Especialista en recursos
____ Asesoramiento
____ Otros programas:

____ Discapacidad auditiva
____ Terapia del habla
____ Discapacitados visuales
____ Discapacitados múltiples
____ ESL Inglés como segundo idioma

_____

_____

La escuela (s) niño (a) ha sido matriculada previamente.

_____

_____

_____

Oral Health Assessment Form

California law (*Education Code* Section 49452.8) states your child must have a dental check-up by May 31 of his/her first year in public school. A California licensed dental professional operating within his scope of practice must perform the check-up and fill out Section 2 of this form. If your child had a dental check-up in the 12 months before he/she started school, ask your dentist to fill out Section 2. If you are unable to get a dental check-up for your child, fill out Section 3.

Section 1: Child's Information (Filled out by parent or guardian)

Child's First Name:	Last Name:	Middle Initial:	Child's birth date:
Address:			Apt.:
City:			ZIP code:
School Name:	Teacher:	Grade:	Child's Sex: ◻ Male ◻ Female
Parent/Guardian Name:	Child's race/ethnicity: ◻ White ◻ Black/African American ◻ Hispanic/Latino ◻ Asian ◻ Native American ◻ Multi-racial ◻ Other_____ ◻ Native Hawaiian/Pacific Islander ◻ Unknown		

Section 2: Oral Health Data Collection (Filled out by a California licensed dental professional)

IMPORTANT NOTE: Consider each box separately. Mark each box.

Assessment Date:	Caries Experience (Visible decay and/or fillings present) ◻ Yes ◻ No	Visible Decay Present: ◻ Yes ◻ No	Treatment Urgency: ◻ No obvious problem found ◻ Early dental care recommended (caries without pain or infection; or child would benefit from sealants or further evaluation) ◻ Urgent care needed (pain, infection, swelling or soft tissue lesions)

_____ _____ _____

Licensed Dental Professional Signature *CA License Number* *Date*

Section 3: Waiver of Oral Health Assessment Requirement

To be filled out by parent or guardian asking to be excused from this requirement

Please excuse my child from the dental check-up because: (Check the box that best describes the reason)

◻ I am unable to find a dental office that will take my child's dental insurance plan.
My child's dental insurance plan is:

◻ Medi-Cal/Denti-Cal ◻ Healthy Families ◻ Healthy Kids ◻ Other _____ ◻ None

◻ I cannot afford a dental check-up for my child.

◻ I do not want my child to receive a dental check-up.

Optional: other reasons my child could not get a dental check-up: _____

If asking to be excused from this requirement: ▶ _____

Signature of parent or guardian *Date*

The law states schools must keep student health information private. Your child's name will not be part of any report as a result of this law. This information may only be used for purposes related to your child's health. If you have questions, please call your school.

Return this form to the school ***no later than*** May 31 of your child's first school year.
Original to be kept in child's school record.

McGILL SCHOOL of SUCCESS
Planting the Seeds of Knowledge

Part II - Medical Evaluation
To the Health Care Provider: Please complete and sign.

_____ had a complete history and physical exam on _____

Student's Name Birthdate

Note: Mandated Screening/Testing under California Law

Findings for this student are as follows:

Screening/Test Results

Height:		BMI:	
Weight:		Postural	
Blood Pressure:		☐	Normal
Pulse:		☐	Abnormal
HCT/HGB:		Min. _____	
Urinalysis:		Slight _____	
Gross Dental:		Mod. _____	
Lead (Date Result)		Marked _____	
		☐	Referral

TB and Other Test Results (Sickle Cell, etc.)

TB: In high-risk group? ☐ Yes ☐ No

Test	Date	Results

Vision Type of Screening	Auditory/Type of Screening
With glasses R R 201 201	Pass/Fail R
Without glasses R L 201 201	L

Chronic Disease Assessment:

No	Yes		Date of onset
☐	☐	Asthma ☐ mild ☐ moderate ☐ severe	_____
☐	☐	exercise induced ☐ unclassified	_____
☐	☐	Diabetes ☐ Type I ☐ Type II	_____
☐	☐	Anaphylactic Reaction ☐ food ☐ insect ☐ latex	_____
☐	☐	Seizure Disorder	_____
☐	☐	Other: Please specify	_____

Immunization Record

To be completed by the Health Provider
(Must be completed in full to meet California law)

Other Health Information (Optional)

For the child's welfare-and with the parent's permission – it is recommended that significant health information be shared with the school. If the child needs help with medication. At school, please contact the school nurse.

- ☐ The checkup reveals no conditions of importance to the school or physical activity.
- ☐ Conditions that need further evaluation or that can affect school or physical activity are: (please explain)

Explain: _____

Medical Provider Information

Name, Address, and Telephone Number:

_____ _____

Signature of Medical Professional **Date**

This student has the following problems which may adversely affect his or her education experience: **(Please check box)**

☐ Vision ☐ Auditory ☐ Speech/Language ☐ Physical Dysfunction ☐ Emotional ☐ Behavior

The pupil has a health condition which may require emergency action at school, e.g., seizures, allergies, anaphylaxis. ***Specify below.***

The pupil is on long-term medication. ***Specify below.***

Comments and recommendations (additional information about any of the above health assessment): _____

☐This student may participate fully in the school program, including physical education activities.☐☐

☐This student may participate in the school program and physical education with the following restriction/adaption .

(Specify reason and restriction) _____

☐ Yes ☐ No Based on this comprehensive health history and physical examination, this student has maintained his/her level of well.

☐ I would like to discuss information in this report with the school nurse.

McGill School of Success

3025 Fir Street, San Diego, CA 92102
619-629-0770b 619-239-1318f

Health Assessment Record

Report of Health Checkup for School Entry

California law requires a health checkup for school entry to protect the health of all children.
Please return this report to the school. All information will be keep confidential

Name of Student (Last, First, Middle)	Birth Date	Sex

Address (Street)	Race/Ethnicity	
	☐ Black, not of Hispanic origin	☐ White, not of Hispanic orgin
	☐ Asian	☐ Hispanic/Latino
	☐ America Indian	☐ Other

Home Telephone Number:	School Name:	Grade:

Parent/Guardian Name: (Last, First, Middle)

Health Care Provider	Health Insurance Company/Number or Medicaid Number

Part I - To be completed by parent

Important: Complete Part I before your child is examined
Take this form with you to the health care provider's office.

Please check answers to the following questions in columns on the left.
(Explain all "yes" in the space provider's office.

	Yes	No	
1.	☐	☐	Do you have any concerns about your child's general health (overall eating and sleeping habits, teeth, etc.)?
2.	☐	☐	Has your child been diagnosed with any chronic disease? ☐ asthma ☐ diabetes ☐ seizure disorder ☐ other _____
3.	☐	☐	Does your child have any allergies (food, insects, medication, latex, etc.)?
4.	☐	☐	Does your child take any medications (daily or occasionally)?
5.	☐	☐	Does your child have any problems with vision, hearing or speech (glasses contacts, ear tubes, hearing aids)?
6.	☐	☐	Has your child had any hospitalization, operation, major illness or injury, or significant accident? (Please specify)
7.	☐	☐	In the last 12 months, has your child experienced any difficulty with wheezing, excessive coughing or excessive night waking? (Please specify.)_____
8.	☐	☐	In the last 12 months, has your child experienced any difficulty with excessive weight loss or weight gain, or excessive thirst or urination? (Please specify.)
9.	☐	☐	Does your child have health insurance?
10.	☐	☐	Does your child have dental insurance?
11.	☐	☐	Would you like to discuss anything about your child's health with school nurse?

Please explain any "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time

_____

_____

_____

I give permission for release of information on this form for confidential use in meeting my child's health and education needs in school

_____ _____

Signature of Parent/Guardian Date

To be maintained in the student's Cumulative School Health Record

2022-2023
McGill School of Success
Extended Day Program

Before School Program

Program Hours: 6:15am - 8:15am (Monday - Friday)

Enrolled students must arrive by 7:15am every day.

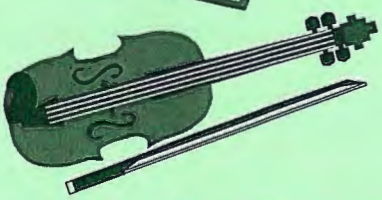
- Healthy Breakfast
- Homework/Academic Enrichment
- Physical Activity

After School Program

Program Hours: 3:00-6:00pm (Mon.-Tues., Thurs.-Fri.)/ 1:00 -6:00pm (Wed.)

Enrolled students must participate in program until 4:30 (Mon.-Tues., Thurs.-Fri.)/3:30pm (Wed.)

- Academic Enrichment
- Physical Activity
- Healthy Supper
- Classes



Please see staff in Front Office for more information or to enroll your student for the 2022-2023 school year.

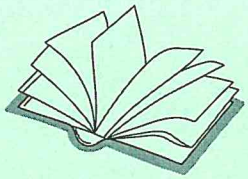
2022-2023
McGill School of Success
Extended Day Program

Programa antes de la escuela

horario del programa: 6:15am - 8:15am (lunes - viernes)

Los estudiantes inscritos deben llegar a las 7:15 am todos los días.

- Desayuno saludable
- Tarea/Enriquecimiento Académico
- Actividad física

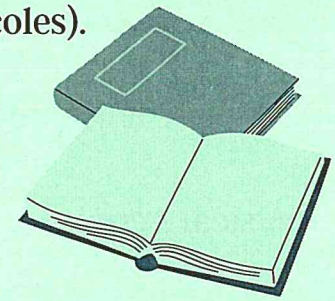


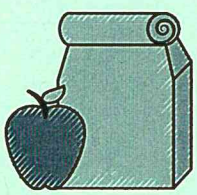
Despues del programa escolar

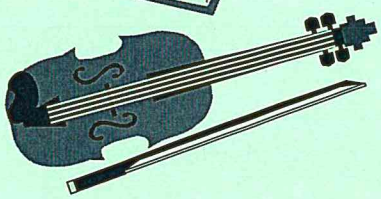
horario del programa: 3:00-6:00pm (lunes, martes, jueves y viernes)/ 1:00 -6:00pm (miércoles)

Los estudiantes inscritos deben participar en el programa hasta las 4:30 p. m. (lunes, martes, jueves y viernes)/3:30 p. m. (miércoles).

- Enriquecimiento Académico
- Actividad física
- Merienda Saludable
- Clases







Consulte al personal de la oficina principal para obtener más información o para inscribir a su estudiante.