Enrollment Procedures

We consider it a privilege to enroll your child in our preschool program.

We offer 2 or 3 day options for our Owl Class (2 & 3 year olds)

And

3 or 4 day options for our Frog Class (4 & 5 year olds)

Monday, Tuesday, Wednesday, & Thursday.

To ensure that registration is complete, please follow the instructions given below.

On the day of registration:

- Complete Registration Information Form (Salmon)
- Complete Student Info Card (Blue Card)
- Pay $75 non-refundable registration fee

At your convenience, before the first day of school, please complete and turn in the following:

- Certificate of Child Health Examination Form
- Parent Volunteer Form (Green)
- Photography/Video Taping Permission Waiver Form (Purple)

Note:

The first day of school is Tuesday, September 3rd, 2019. This summer you will receive a school calendar, a supply list, and other important information about the beginning of school. Have a great summer and we will see you in September! If you have any questions, please feel free to contact the preschool at (618)632-6913 or vikki@shiloh-umc.org.

Registration Form

Child's Information

Child's full name: _____

Name child goes by: _____ Date of birth: _____ Sex: M/F

Child's home address: _____

Child's home phone number: _____

Parent or Guardian Information

Parent's name: _____ Phone: _____

Parent's address (if different from above)_____

Parent's occupation and place of employment: _____

Work phone and/or cellular phone number: _____

Parent's name: _____ Phone: _____

Parent's address (if different from above): _____

Parent's occupation and place of employment: _____

Work phone and/or cellular phone number:_____

Primary E-mail Address:_____

Parents' marital status: _____

Class Selection

I wish for my child to be enrolled in the following class:

_____ Two-Year Olds (Must be 2 by September 1, 2019)

_____ Three-Year Olds (Must be 3 by September 1, 2019)

_____ Four & Five-Year Olds (Must be 4 by September 1, 2019)

*We will offer a 2 or 3 day option for our Two and Three year olds and a 3 or 4 day option for our Four and Five year olds. Please mark the # of attendance days below and circle which days you will be bringing your child.

Two & Three Year Olds

_____2 days per week (2 and 3 year olds only) M T W

_____3 days per week M T W

Four and Five Year Olds

_____3 days per week M T W TH

_____4 days per week M T W TH

Family Information

Brothers and/or sisters (please indicate ages and whether they live with the child):

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Church you attend: _____

Emergency Contacts and Medical Permission

Name of adult who will assume responsibility if parents cannot be located:

(At least one contact needs to be local)

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Family Physician:

Name: _____ Address: _____

Phone: _____

Permission to seek medical help:

If you and the physician of your choice as indicated above cannot be reached in an emergency, and if, in the judgment of Three Springs staff, immediate medical and/or hospital attention is needed, do you authorize responsible Three Springs staff to send your child (properly accompanied) to an available hospital or physician, being aware that you are responsible for any charges incurred?

Yes _____ No _____ Hospital of choice: _____

Parent Signature: _____ Date: _____

Pick Up Permission

Please list the names (and relationship to child) of anyone who may pick up your child from preschool.

relationship:

relationship:

relationship:

relationship:

*If at any time someone other than the people listed above is picking up your child from preschool, we must receive written notice signed by the parent or guardian.

Personal Information

Has your child had any experience in preschool or group interaction?

If so, where and when?

Does your child have any allergies? What are they? Are there symptoms we should note?

Are there any past or current medical problems that we need to be aware of? Past surgeries?

List any special food or eating instructions:

Photography/Video Taping Permission Waiver Form

Name of Child Participant_____

Parent(s) and/or legal guardian of child participant_____

Address_____

Home Phone_____Age of Child_____Birthdate_____

On occasion, Three Springs Preschool takes photographs or makes an audio or videotape recording of children and/or adults involved in preschool activities. Such photographs or video records may be used by staff and participants to remember the activities and participants. In addition, such photographs and audio/video recordings may be used in Three Springs Preschool publications or advertising materials to let others know about our ministry. Furthermore, local news organizations may be invited or allowed, upon request, to photograph or record our events. **We will also use these photos/videos on our website.**

I consent to the use of any such audio or visual record of my child to be used, distributed, or displayed as agents of Three Springs Preschool see fit.

Signature of Parent or Legal Guardian_____

Print Name of Parent or Legal Guardian_____

Date_____

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name Last First Middle	**Birth Date** Month/Day/ Year	**Sex**	**School**	**Grade Level /ID#**
Address Street City ZIP code	Parent/ Guardian		Telephone # Home Work	

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)				Comments		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23
Check specific type (PCV7, PPV23)						
Other (Specify hepatitis A, meningococcal, etc.)						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Hepatitis B** ☐ **Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab report, if available.)**

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																						
Age/Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/ Contacts

Printed by Authority of the State of Illinois

(Complete Both Sides)

Student's Name (Last First Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)

MEDICATION (List all prescribed or taken on a regular basis.)

Diagnosis of asthma? Child wakes during the night coughing	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐Braces ☐Bridge ☐Plate Other Other concerns?			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes	No					

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **BMI>85% age/sex** Yes ☐ No ☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes ☐ No ☐
Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Blood Test Indicated? Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** **mm**

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in **(If No or Modified,please attach explanation.)**
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)

Three Springs Preschool
Supply List
2019-2020

Mrs. Cody's Class- The Owls	Mrs. Harms' Class - The Frogs
Change of Clothes	Change of Clothes
1 container baby wipes	1 container baby wipes
2 boxes 5oz dixie cups	2 boxes 5oz dixie cups
1 container of Clorox wipes	1 container of Clorox wipes
1 box sandwich ziploc bags	1 box sandwich ziploc bags

2019-2020 School Calendar

August 29	Classroom Open House 6:00 p.m.
September 3	First Day of School
October 14	Columbus Day-No School
October	Fall Field Trip to Braeutigam's (Date to be Determined)
November 7	P/T Conferences - No School
November 11	Veteran's Day - No School
November 10-17	Scholastic Fall Book Fair
November 13	Family Fun Night - Scholastic Book Fair
November 20	Lifetouch School Picture Day
November 25-28	Thanksgiving Break-No School
December 18	Happy Birthday Jesus Parties
December 19 - January 2 (inclusive)	Christmas Vacation
January 6	Classes Resume
January 20	MLK Day-No School
February 12	Valentine's Day Parties
February 17	President's Day-No School
March 2	Casmir Pulaski Day-No School
March 7	*Spring Fundraiser Event*
April 8	Teacher In-Service Day - No School
April 9 - April 13	Easter Break-No School
May 3 - 10	Scholastic Spring Book Fair
May 7	Family Fun Morning
May 16	Last Day of School & Graduation