Preschool News

PRE-SCHOOL REQUIREMENTS

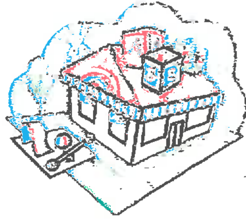
2018-19

All **3** year old pre-school students must have a current physical with up-to-date immunizations.

There must be a copy of the student's birth certificate on file in the office.

All **4** year old pre-school students must have a physical on file with up-to-date immunizations. All physicals are good for one year.

There must be a copy of the student's birth certificate on file in the office.



PRE-SCHOOL COST INFORMATION:

Thank you for your interest in the Wallace Pre-School program. We are very proud of the success the graduates have had.

Tuition is due by the 15th of each month starting with August 15th and ending on April 15th. If a payment is not made by the 1st day of the next month, the child will not be allowed to attend.

All applicants must include a $50 non-refundable supply fee that is due at the time of registration.

Tuition is $125.00 per month for the three year old/two day a week program and $150.00 per month for the four year old/three day a week program.

If paid in **FULL** by August 15th , the three year old full year tuition is $1,000 and the four year old is $1,250. If paid in **two** payments – due August 15th and January 15th – the rate for three year olds is $525 and rate for 4 year olds is $650.

Thank you for your interest in our program. If you need any other information, please call 815-433-2986.

WALLACE GRADE SCHOOL DIST. 195

PRE-SCHOOL REGISTRATION

CHILD'S NAME ______________________________

BIRTHDATE (month/day/year) ______________________

PARENTS/GUARDIAN __________________________

ADDRESS ________________________________

PHONE _________________________________

PLEASE CHECK YOUR PREFERENCE:

Tues./Thur.(3 Yr. olds) ____ 8:30-11AM ____ 12:00-2:30PM

Mon./Wed./Fri. (4 Yr. olds) ____ 8:30-11AM ____ 12:00-2:30PM

*Preferences will be honored on a first come, first serve basis. Once registration fee and forms are turned in, they will be numbered in the order in which they were received.

____ Date/Time Received ______________________

____ Deposit Received

REGISTRATION INFORMATION SHEET
COMPLETE BOTH SIDES OF THIS SHEET
2018-19

GRADE _____ SEX_____ BIRTH CERTIFICATE___

Legal Name of Child: ____________________
Name to be called, if different than above: ____________________
Address: ____________________ **Phone Number:** ____________
Date of Birth: ____________ **Place of Birth:** ____________
Social Security Number: ____________________

Race/Ethnic Background – CIRCLE – White, Hispanic or Latino, American Indian or Alaska Native, Asian, Black or African America, Native Hawaiian or other Pacific Islander

Family Information
Father ____________ Employer ____________ Phone # ____________
Mother ____________ Employer ____________ Phone # ____________
Mother's Maiden Name ____________________

Legal Guardian
Both Parents _____ Father Only _____ Mother Only _____ Foster Parents _____ Other _____
Child lives with _____ Both Parents _____ Father Only _____ Mother Only _____ Other _____

Family Data
Other Family Members - #/ages Brothers older _____ #/ages Brothers younger _____
#/ages Sisters older _____ #/ages Sisters younger _____

Please complete information on back sides. Please provide all information it's important for record keeping purposes.

FIELD TRIP PERMISSION FORM

Each year students at Wallace Grade School participate in several field trips. In order to faciliate planning these trips, we are asking that parents sign a permission slip to allow their child to participate in these school-related events at the beginning of the year. Details of each trip will be sent home with the students as the trips are scheduled.

Please sign this form and return to school with registration information.

I will allow my child ,____ to participate in ALL field trips for the 2018-19 school year. I understand that in order to participate, my child's work must be up to date and of good quality.

____

Parent/Guardian Signature

____

Date

English

Home Language Survey

The State requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students that need to be assessed for English language proficiency.

Please answer the questions below and return this survey to your child's school.

Student's Name: ____

1. " Is a language other than English spoken in your home?"

   Yes ___________

   What language? ___________________________

   No___________

2. " Does your child speak a language other than English?"

   Yes ___________

   What language? ___________________________

   No ___________

If the answer to either is yes, the law requires the school to assess your Child's English language proficiency.

________________________________   _______________

Parent/Guardian Signature   Date

Illinois State Board of Education

New U.S. Department of Education Race and Ethnicity Data Standards

Note: The student's parents or guardians should respond to both questions (Part A and Part B). If the parents or guardians decline to respond to either question (Part A or Part B), school district staff are required to provide the missing information by observer identification.

Student's Name: ______________________________ (pre-printed by school district)

SIS ID: ______________ (pre-printed by school district)

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, and both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) **Choose only one.**

☐ **No, not Hispanic/Latino**

☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.

Part B. What is the student's race? Choose one or more.

☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)

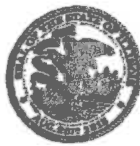
☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)

☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Note: Data collected on this form must be maintained by the school district for three years. However, when there is litigation, a claim, an audit, or another action involving this record, the original responses must be retained until the completion of the action.



State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian		Telephone # Home	Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT		
Polio (Check specific type)	☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										Comments:								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies 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**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps** ☐Rubella ☐Varicella **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: ____________________
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Printed by Authority of the State of Illinois

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)	Yes No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	List:
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		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		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	Yes No		Parent/Guardian Signature		Date

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if <2-3 years old HEIGHT WEIGHT BMI B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) 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 required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ Test performed ☐ Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm ______
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

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 Yes ☐ No ☐ Modified ☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

Health Information for 2018-19

Student name: ____________________________ Date of Birth: ____________________

Medication Allergies: ____

Food/Insect/or other Allergies:____

Does your child have an Epi-pen? Yes_____ No_____

Does your child have Asthma? Yes_____ No_____

Does your child have Diabetes? Yes_____ No_____

Does your child have a Seizure Disorder? Yes_____ No_____

Does your child have ADD/ADHD? Yes_____ No_____

Primary Care Physician's name______________________ Phone#________________

Please list any other health conditions that you feel could impact your child while at school:

____

____

____

Please list any medications (prescription or non-prescription) that your child takes regularly: (Please include inhalers/nebulizers)

Medication Dosage Time(s) Taken Reason for taking

____

____

____

____

Has your child been prescribed Eyeglasses? Yes________ No_______

Do they wear the eyeglasses full-time?________ Reading only?_________