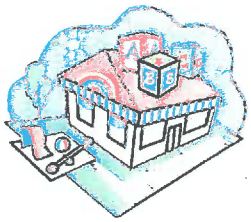

PRE-SCHOOL COST INFORMATION:

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.

Preschool News

PRE-SCHOOL REQUIREMENTS

2017-18

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.

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
2017-18

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 side, also. Please provide all information it's important for record keeping purposes.

Please list any special circumstances the school should be made aware of:

_____

_____

_____

Please provide us with your e-mail address: _____

_____

I give permission for my child to:

Y	N	Be included in photos/videos (including newsletter, web pages, newspapers, etc.) during the 2017-18 school year.
Y	N	Be included in a student directory (name, address, phone #) that you could be associated with organizations related to school.
Y	N	In the event of a school bus accident, Emergency Medical Service (EMS) personnel must determine which passengers have significant injuries and must be transported to an appropriate hospital. If your child is on a bus during an accident, but in the judgment of the EMS personnel, has not been injured and does not require transfer to a hospital, you, as parent, must indicate here whether you still want your child transported to the hospital or not. If you mark **YES**, you agree to incur all expenses associated with the transport. If you mark **NO**, your uninjured child will not be transported to the hospital.
Y	N	Would you like to purchase supplementary insurance for your child? If you are interested; please contact the school for an appropriate form. Students having accidents/injuries at school are **NOT** covered by the district insurance.

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 2017-18 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

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.

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

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 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 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.

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?	Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Child wakes during night coughing?	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. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No						

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**