LAMPSTAND PRESCHOOL
Preschool@Lampstandpc.org
(217) 542-5436

Internal Use Only:
Date Received ___/___/___
Amount $_____
Method of Pmnt _____
(If Check #_____)

New Student Registration

Dear Preschool Parents,

I hope you are as excited as we are for your child to shine bright at the Lampstand Preschool! However, You may have some questions. We will try to answer some of those questions right here. If you have additional questions, PLEASE do not hesitate to call 217-542-5436 The office staff will direct your question to the right person.

- **Do Parents volunteer in the Pre-K classroom?** Our preschool is designed for parents and families who would like to take an active role in their child's education AND have a desire for their child to learn and grow in an environment rooted in Christ. We understand that volunteering time in the classroom is not always an option for all parents, so we have two rates available to better fit the needs of all families. One rate is reduced for volunteering parents as there is a savings experienced by the preschool when there is not a need for an additional paid teaching assistant.
- **How do we register our child?** Please complete the attached form in its entirety. In order to reserve a spot at the preschool, there is a non-refundable $75.00 registration fee due when forms are returned. This fee includes your child's school supply fee and the cost of ONE background check. Registrations are then accepted on a first come-first served basis only. The deadline for background checks is the first day of the school year.
- **Do I have to have a background check to volunteer in the classroom?** Well, in short, the answer is YES. We, like you, take the safety of our kids very seriously. Each person that will be involved in the classroom or with volunteering is required to submit to a background check. Should you have multiple persons in your family wanting a role in the co-op (this would include any volunteering in the building), an additional $9 fee will be required for each additional background check.
- **What if my child's health exam is not until closer to the start of school, can I turn the health form in later?** Forms may be turned in without the health forms being completed. However, your child's health form MUST be submitted within 4 weeks of the first day of school. The exam must have been completed no earlier than a year (365 days) prior to the start of attendance. In addition, we will also need a copy of your child's original birth certificate within 4 weeks of the first day of school.
- **When is class tuition due?** Your first tuition payment is due on the first day class is in session. Subsequent payment information will be made available at the first Parent meeting.
- **Parent Meeting?** Oh, yes, we want our parents to be involved in all aspects of the school. This includes a Parent Orientation in August. You will be informed of the date and time. This meeting is mandatory and will answer many of your specific questions. FYI, a copy of the preschool's by-laws is available by email on request.

We look forward to partnering with you in this exciting time in your child's life!

Blessings,

Lampstand Preschool Board

CHILD'S NAME _____

Our preschool was designed and created to serve the families of this church and surrounding community who desire the opportunity for their children to learn and grow in a loving environment. Our curriculum will prepare each child with the fundamental elements associated with an early learning center through play, respecting and caring for others as well as the foundation of faith-based, Biblical teachings rooted in Christ. With this preparation, each student will be prepared for a smooth transition from the home environment to kindergarten and beyond.

Our preschool is governed by our own board. The preschool board provides a leadership role in conjunction with the teacher in handling the operation of the preschool.

The children must be 3 or 4 year of age by September 1st to be enrolled in their respective class.

Class Schedule

3's - Thursday, Friday 8:30 am -11:30 am

Tuition: Volunteer Program $110/Month Non-Volunteer Program $135/Month

4's – Monday, Tuesday, & Wednesday 8:30 am -11:30 am

Tuition: Volunteer Program $150/Month Non-Volunteer Program $185/Month

The parents must agree to help with our school in several ways.

- They are scheduled as snack helper on a rotating basis.
- They are available when needed to drive on field trips.
- They attend parent meetings if/when called.
- They complete the required health forms before the start of school.
- They keep their ill child at home, stay home themselves if they are ill and notify the teacher of this absence.
- They advise the teacher in writing when someone other than themselves will be picking up their child.

If you decide to enroll your child in our Co-op, please sign and date that you agree to the above and return along with the completed registration and fee.

Thank you!

_____ ____ / ____ / ____

Signature Date

_____

Printed Name

Please return this completed form with $75.00 Registration fee to: Lampstand Preschool.

Please indicate the class for which you are applying:
NOTE: Please read the requirements for the Volunteer Program printed in the Parent Handbook before selecting this option.)

3's Volunteer Program ☐ 3's Non-Volunteer Program ☐ 4's Volunteer Program ☐ 4's Non-Volunteer Program ☐

Child's Name: _____ Sex: M ☐ F ☐ Birthdate _____ / _____ / _____

Address: _____ Zip: _____

Home/Cell Phone: __(_____) _____-_____ Birthplace: _____

Mother's Name: _____ Employer: _____

Address (if different from above): _____

Home/Cell Phone (if different from above): (_____) _____-_____ Work:(_____) _____ - _____

Email Address: _____

Father's Name: _____ Employer: _____

Address (if different from above): _____

Home/Cell Phone (if different from above): (_____) _____-_____ Work:(_____)_____ - _____

Email Address: _____

EMERCENCY CARE INFORMATION

Preferred Physician: _____ Phone: (_____) _____ - _____

Address: _____

Preferred Hospital: _____ Phone: (_____) _____ - _____

Address: _____

TWO (2) people who should be notified in case of emergency if parents/guardians are not available:

Name: _____ Relationship to Child: _____ Phone: (____) ____ - _____

Address: _____

Name: _____ Relationship to Child: _____ Phone: (____) ____ - _____

Address: _____

Those Allowed to Pick Up Your Child

Please list (Print) all those with the authority to pick up your child.

Name: _____ Relationship to Child: _____ Phone: (____) ____ - _____

Name: _____ Relationship to Child: _____ Phone: (____) ____ - _____

Name: _____ Relationship to Child: _____ Phone: (____) ____ - _____

Name: _____ Relationship to Child: _____ Phone: (____) ____ - _____

Child Pick-Up Code Word

For the security and safety of your child, each person picking up them will need a code word. The code word to pick up your child is _____.

PLEASE RETURN THIS FOR WITH REGISTRATION

STUDENT PROFILE

PLEASE ANSWER THE QUESTIONS BELOW TO ENSURE WE HAVE THE MOST UP-TO-DATE INFORMATION REGARDING YOUR CHILD AND HIS/HER NEEDS. THANK YOU.

Child's LEGAL Name: _____ Birthdate _____ / _____ / _____

Does your child prefer to be called by a name different from this name? _____

My child is afraid of _____

My child's favorite activity is _____

THREE of My child's strengths are: _____

_____

My child is _____right-handed _____ left-handed _____ does not have a dominant hand yet.

Has your child had any experience with scissors or cutting? _____ Yes _____No

Each child receives a Lampstand Preschool T-Shirt to be worn at all Field Trips. What size shirt does your child wear? _____

Has your child had any experiences with group situations, such as preschool, playgroups, church, etc.?

_____

_____

List any pre-existing medical conditions as well as any medication(s) your child is on daily that we need to be aware of.

_____

List any medically diagnosed food-related allergies we should be aware of? _____

_____

Does your child require an EPI Pen? _____ Yes _____ No

Please relate any questions or concerns you have about your child.

_____

_____

What THREE things would you like your child to accomplish this year?

_____

_____

What THREE words best describe your child? (1) _____ (2) _____ (3) _____

HOME ENVIRONMENT

Who lives in your home? (Please use additional paper if necessary)

Name: _____ Relationship to Child _____ Age (if child) _____

Name: _____ Relationship to Child _____ Age (if child) _____

Name: _____ Relationship to Child _____ Age (if child) _____

Name: _____ Relationship to Child _____ Age (if child) _____

Who has legal custody of your child? _____

What language(s) are spoken in the home? _____

How often does your child speak English? (circle one): **Always** **Sometimes** **Never**

How did you hear about our Preschool? _____

PLEASE RETURN THIS FORM WITH REGISTRATION

Permission Slip/Medical Release/Liability Release
Lampstand Preschool

2024-2025 School Year

My child:

May participate generally in activities at Lampstand Preschool.

I hereby release and indemnify the staff, volunteers and Lampstand Preschool from any and all liability from claims of any kind or nature whatsoever from my child's participation in events sponsored by Lampstand Preschool.

I give my permission for photos to be taken and used responsibly by Staff on the Lampstand Preschool website & social media with the understanding that NO child's name will ever accompany any picture/image.

☐ **Yes** ☐ **No**

I grant the permission of First Aid to be given to my child by Staff and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. I understand I will be promptly notified in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, I understand that every effort will be made to contact the parent/guardian of the student. In the event that I cannot be reached, I hereby give permission to the physicians selected by the adult to hospitalize, secure proper treatment for and to order injections, anesthesia or surgery, if deemed necessary for my child. I agree not to hold Lampstand Preschool, its Staff, and volunteers liable for damages, losses, diseases or injuries incurred by the subject of this form.

Food Allergies? If yes, please indicate: _____

Health Ins. policy in the name of:

Insurance Company & Number:

Parent/Guardian Name (s)

Parents Phone Number: Father ( )_____ Mother ( )_____

Emergency Name/Number:

Parent/Guardian Signature:

Date:

BACKGROUND CHECK

PLEASE ATTACH A COPY OF A STATE PHOTO I.D

Child's Name: _____

Background checks shall be conducted on ALL volunteers or employees involved in the ministry of Lampstand Preschool. Background checks are provided through Christian Background Check. ONE (1) background check is provided with the Registration fee. Any additional background checks will require an additional $9/check.

Full Name: _____
First Middle Last

Maiden/Previous Name(s): _____

SSN _____ - _____ - _____ Sex: M ☐ F ☐ Date of Birth _____ / _____ / _____
M D Y

Driver's License # _____ State Issued: _____

PLEASE PROVIDE ALL RESIDENTIAL ADDRESSES FOR THE PAST SEVEN (7) YEARS

Current Address:

Street # _____ Street Name: _____

Apt. # _____ City _____ State _____ Zip _____

County _____ From: (Date) _____

Previous Address:

Street # _____ Street Name: _____

Apt. # _____ City _____ State _____ Zip _____

County _____ From: (Date) _____

CONTACT INFORMATION:

Phone: (_____) _____ – _____ Email (Required) _____

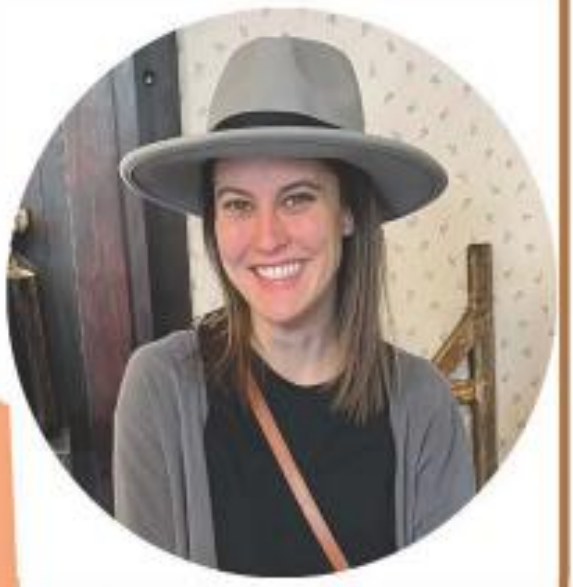
I, _____, hereby authorize Lampstand Preschool to conduct a background check through Christian Background Check regarding any record of charges or convictions, or any criminal files maintained on me. I release the church and preschool from all liability that may result from any such disclosure made in response to this request.

_____ _____ /_____ / _____

Signature of Applicant Date

PLEASE RETURN THIS FORM WITH REGISTRATION

Meet Our TEACHER



A Bit About Me...

Hello! My name is Vanessa Kelson. I am so excited to be your child's teacher this school year! I've had the privilege of teaching grades K, 2nd & 3rd in Decatur Public Schools from 2015 - 2023 when I took the call to come to Lampstand Preschool. I have my M. Ed in Foundations of Education from Antioch University. I look forward to meeting you and working alongside you to help your child grow!

My Passions

- Children
- Faith
- Family
- Friends
- All Things DIY

My Family

I live in Decatur with my husband, our adorable Yorkie-poo, Sofie Jo.

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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: * indicates invalid dose		
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? 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. **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** **BMI PERCENTILE** **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**