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

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

Returning Student Registration

Dear Preschool Parents,

We are excited and grateful that you have chosen to enroll your child in Lampstand Preschool again this year! We look forward to continuing our partnership with you in preparing your child for kindergarten and beyond.

To ensure we have the most up to date information regarding your child, please complete and return this registration packet by either emailing it to Preschool@LampstandPC.org or dropping this by our office M-F between 8:30 & 11:30.
The registration fee can be paid by cash, check or through the link on our website.
This system charges a small processing fee. If you choose to pay via this method, we require this fee to be covered by checking the box within the payment that states, "Cover Fees".
Once we have received this packet along with the $75 registration fee, we will reserve your child's place in the class that best fits his/her needs.

NOTE: Enrollment will open to the public on March 4th. To ensure your child's place we suggest completing and returning this packet & registration fee prior to this date.

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 age 3 or 4 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: _____

EMERGENCY 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: _____ Phone: (_____) _____ - _____

Address:_____

Name: _____ 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.

Is there any medically diagnoses condition(s) we need to be made aware of? _☐_Yes _☐_No

If yes, is your child on daily medication we should be made aware of? _☐_ Yes _☐_ No

If yes, please list below:

_____

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?

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) _____

(Please use additional paper if necessary)

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** ☐

PLEASE RETURN THIS FORM WITH REGISTRATION

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 | ex chool | 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 _____ Dental ☐ Braces ☐ Bridge ☐ Plate Other

Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Ear/Hearing problems? Yes No

Bone/Joint problem/injury/scoliosis? Yes No

Information may be shared with appropriate personnel for health and educational purposes.

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** **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** ☐ **M[illegible]** ☐ **I** **DIASTIC S** **Yes** ☐ **No** ☐ **Modified** ☐

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

Address **Phone**