

Good Shepherd Lutheran Preschool

Child Application Form

Child's Name: _____ Nickname: _____
Birthdate: _____ Male/Female
Address: _____

Mother/Guardian Name: _____
Address: _____
Home Phone#: _____ Pager/cell Phone: _____
Place of Employment: _____
Address: _____
Work Phone#: _____ Work hours: _____

Father/Guardian Name: _____
Address: _____
Home Phone#: _____ Pager/Cell Phone: _____
Place of Employment: _____
Address: _____
Work#: _____ Work hours: _____
Custody/Visiting Arrangements (if any):

Persons who may pick up your child on a regular basis:

Name: _____ Relationship: _____
Address: _____ Work Phone#: _____
Home Phone#: _____

Name: _____ Relationship: _____
Address: _____ Work Phone#: _____
Home Phone#: _____

Name: _____ Relationship: _____
Address: _____ Work Phone#: _____
Home Phone#: _____

Persons who may pick up your child occasionally:

Name: _____ Relationship: _____
Address: _____ Work Phone#: _____
Home Phone#: _____
When is this person allowed to pick up? _____

Name: _____ Relationship: _____
Address: _____ Work Phone#: _____
Home Phone#: _____
When is this person allowed to pick up? _____

Name: _____ Relationship: _____
Address: _____ Work Phone#: _____
Home Phone#: _____
When is this person allowed to pick up? _____

Persons to notify in case of an emergency:

Name: _____ Relationship: _____
Address: _____
Work Phone#: _____ Home Phone#: _____

Name : _____ Relationship: _____
Address: _____
Work Phone#: _____ Home Phone#: _____

Name: _____ Relationship: _____
Address: _____
Work Phone#: _____ Home Phone#: _____



Doctor's Name: _____ Phone#: _____
Address: _____

Certified Licensed Practitioner's Name: _____
Address: _____ Phone#: _____

Parent/Guardian Signature: _____ Date: _____

To be filled out by preschool

Enrollment Date: _____

Discharge Date: _____

AM(9:00 - 11:30) PM(12:30 - 3:00)

MWF TR

Child Development Information

Child's Name: _____ Nickname: _____

Household members:

Name: _____	Relationship _____	Age: _____
Name: _____	Relationship _____	Age: _____
Name: _____	Relationship _____	Age: _____
Name: _____	Relationship _____	Age: _____
Name: _____	Relationship _____	Age: _____
Name: _____	Relationship _____	Age: _____

Pets: _____

Favorite Play Material: _____

Favorite Activity _____ Special Interest _____

What opportunities does your child have to play with children the same age? _____

Eating Habits

Is child allergic to any food? _____

What kind of an eater is your child? Good ___ Fair ___ Poor ___

Are there any foods your child does not like? _____

Are there any difficulties with eating? _____

Sleeping Habits

Child's usual bedtime? _____ a.m. wake-up time _____

Does your child nap? _____ When? _____ How long? _____

What is the child's routine in preparing for rest? _____

Does your child ever have nightmares? _____

Does your child tire easily? _____

How does he or she show this? _____

Dressing

Does your child need help with:

pants _____ shirt/dress _____ socks _____ shoes _____ coats _____
mittens _____ boots _____

Fears

Is child afraid of: storms _____ dark _____ animals _____
bathroom _____ being alone _____
loud noises _____
others, please list _____

Health

Is your child allergic to anything? _____

Does your child take medication regularly? _____

Does your child have any health problem or special needs? _____

Restroom Habits

Is your child toilet trained? _____

Does your child use the restroom facilities by himself? _____

Tells an adult? _____ Needs reminding _____

What words does your child use to indicate restroom? _____

Other

1. What do you like best about your child? _____

2. Do you have any concerns about your child? _____

3. What other information would help us to know your child better? _____

Signature of Parent/Guardian _____ Date: _____

Trips, Excursions, and Public Park Facilities

Child's Name: _____

I/We authorize Good Shepherd Lutheran Preschool to take my/our child on walking trips, special excursions, and to nearby park facilities. I/we also authorize the child to ride as a passenger in a vehicle leased by Good Shepherd Lutheran Preschool. I/we understand that all trips will be under the direct supervision of staff members and that all health and safety precautions will be in compliance with DCFS standards for licensure.

Parent Signature: _____ Date: _____

First Aid Consent

Child's Name: _____

I/we authorize staff members of Good Shepherd Lutheran Preschool to administer first aid to my/our child in the event of a minor injury. Such first aid may include the use of cold packs, band aids, etc.

Parent Signature: _____ Date: _____

Media Consent Form

Child's Name: _____

I authorize my/our child to be photographed and/or video taped by local media and staff members of Good Shepherd Lutheran Preschool.

Parent Signature: _____ Date: _____

Guidance and Discipline Policy

It is our policy to allow each child to develop an awareness of logical consequences in a positive and loving manner. Redirection and positive reinforcement will be the main tools used. To this end, we will use a traffic light to monitor behavior. Here is how it works:

1. At the beginning of the day there will be no names on the traffic light. If a child is misbehaving, they will be given a verbal redirection and we will discuss the choice they have made and what would be a better choice in the future.
2. After three redirections the child will be required to move their name to the green light on the stop light.
3. After three more redirections the child will be required to move their name to the yellow light.
4. After three more redirections the child will be asked to move their name to the red light. At this point the child will be given a "time out." Time outs last one minute per the child's age. For example, a three year old would receive a three minute time out and a four year old would receive a four minute time out. Before returning to their activity, staff will discuss with the child why they received a time out and what better choices they can make in the future.
5. Some behaviors, such as those intended to cause harm to someone or something, will result in an immediate time out.

If a child should receive a time out at school, the teacher will talk to the parent or send a note home at the end of the day. Children who do not go to red light will receive a sticker at the end of the day.

Staff Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Late Pick Up Policy

If a child has not been picked up 15 minutes after preschool has ended the parent or authorized pick up person will be called. If staff members are unable to reach them, emergency contact persons will be called to help locate them. Emergency contact persons will not be allowed to pick up the child unless they are on the authorized pick up list. If, despite all efforts, staff members are not able to locate the child's parent or authorized pick up person within 30 minutes of dismissal, the Frankfort Police Department will be called to assist in locating them. If they are unable to do so the child may be released into their custody. It is very important that all phone numbers be kept up to date at all times. Please let the school know of any changes in home phone numbers, work phone numbers, cell phones or pagers. Preschool staff will be responsible for the safety and well being of all children until the arrival of the parent, authorized pick up person, or outside authorities. Staff will not hold the child responsible for the situation and will only discuss the issue with the parent or guardian and never with the child.

Staff Signature _____

Date _____

Parent Signature _____

Date _____

Religious Instruction

Christian education will be an integrated part of our curriculum. The Northern Illinois District Department of Lutheran Schools- Early Childhood Education Department sponsors our curriculum. All components of our program will emphasize Christian values and morals, which focus on early childhood development. The children will learn bible verses, prayers and bible stories. All bible verses and prayers will be sent home for parents to review.

Parent Signature: _____ Date: _____

Parents Handbook Verification of Receipt

I/We (Parents Name) _____ hereby verify
the I/we have received and read Good Shepherd Lutheran Preschool's Parents handbook. I
understand the policies and procedures that have been addressed in this handbook and will
adhere to them.

Child's Name: _____

Parent's Signature: _____

Date: _____

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD _____

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES

Parent(s) or legal guardian placing the child may sign any or all of the following consents.

EMERGENCY MEDICAL CARE

This authorizes _____
to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will
be responsible for the emergency medical charges upon receipt of the statement. _____
is the preferred doctor/clinic/hospital.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize _____ to administer prescribed medicine to my/our child as
specified in the prescription's directions for administration.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

ADMINISTER PATENT MEDICINE

(Administer only in accord with the appropriate standards for licensure)

I/we authorize _____ to administer patent medicine to my/our child as
specified in written instructions.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child



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



Please Print

Student's Name Last	First	Middle	Birth Date	Sex	Grade Level	ID#
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Address Street	City	ZIP code	Parent/ Guardian	Telephone # Home	Work
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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			2			3			4			5			6			
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	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)	<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			
Check specific type (PCV7, PPV23) Date																			
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
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 #
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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	No
Birth complications/prematurity? Developmental delay?	Yes Yes	No No		Hospitalizations? When? What for?	Yes No	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
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? _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> 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	

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

PHYSICAL EXAMINATION REQUIREMENTS	HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
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DIABETES SCREENING (Not required for daycare.) **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.
Questionnaire Administered? Yes No **Blood Test Indicated?** Yes No **Blood Test Date** _____ **Blood Test Result** _____
 (If child resides in Chicago, blood test is required.)

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. No Test Needed Test performed **Date Read** / / **Result** mm

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			Gastrointestinal	
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>		Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optomtrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	

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)