

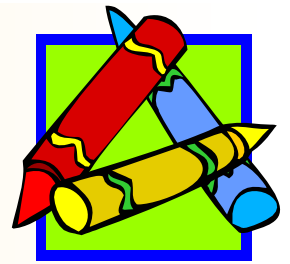
TLC PRESCHOOL AND BEFORE & AFTERSCHOOL PROGRAM

11008 N. CHURCH STREET HUNTLEY, ILLINOIS 60142

847-669-5781 FAX 847-669-5978

TLCHUNTLEY@SBCGLOBAL.NET

HTTP://TLC.TRINITYHUNTLEY.ORG



BEFORE & AFTER SCHOOL PROGRAM REGISTRATION 2011/2012

Welcome! Please bring this form with your child's **original** birth certificate to register your child.
We will copy the birth certificate and return it to you immediately.

Get $\frac{1}{2}$ off your registration and tuition for each additional sibling!

Annual Non-Refundable Registration Fee: \$50

Before School Tuition	\$160/month
After School Tuition	\$210/month
Full Days off of School	\$40/day
Before School Drop In	\$15/day
After School Drop In	\$20/day

Before & After School Tuition \$320/month

(Includes full days off of school during the school year, excluding Christmas & Spring Break).

You will be billed 9 equal payments, which includes the additional days in August & June.

WE ARE CLOSED DURING THANKSGIVING, CHRISTMAS VACATION & SPRING BREAK

Student's Name: _____ Date of Birth: _____

Parent's Names: _____ Email: _____

Home Phone: _____ Cell Phone: _____

Address: _____ City: _____ Zip code: _____

Entering Grade: _____ School: _____ (Reed Road & Leggee Campuses)

New Students: How did you hear about us?

Referral: _____ Advertisement: _____ Other: _____

We would like to register our child for:

_____ Before School Care Only

_____ After School Care Only

_____ Before & After School Care with full days off included

Total Due at Registration (Non-Refundable): \$ _____

OFFICE USE ONLY: Date Received: _____ Paid by Cash or Check# _____ Approved by: _____

**TLC BEFORE & AFTER SCHOOL PROGRAM
NEW STUDENT ENROLLMENT 2011/2012**

Child's Full Name: _____ Gender: ___ M ___ F

Nick Name: _____ Birth date: _____

Street Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Primary E-mail: _____

Child lives with: ___ both parents ___ mom ___ dad other: _____

Father's Name: _____ Cell Phone: _____

Home Address (If different than child): _____

Place of Employment: _____ Work Phone: _____

Occupation: _____ Work Hours: _____

Work Address: _____

Mother's Name: _____ Cell Phone: _____

Home Address (If different than child): _____

Place of Employment: _____ Work Phone: _____

Occupation: _____ Work Hours: _____

Work Address: _____

EMERGENCY CONTACTS: In case of illness or emergency, if the parents cannot be contacted, the following people are authorized to pick up my child. **DCFS requires 2 names.**

1) Name: _____ Relationship: _____
Phone: _____ Address: _____

2) Name: _____ Relationship: _____
Phone: _____ Address: _____

THE FOLLOWING PEOPLE ARE ALSO AUTHORIZED TO PICK UP MY CHILD:

You can use the same people as above if you choose. **DCFS requires 2 names.**

1) Name: _____ Relationship: _____
Phone: _____ Address: _____

2) Name: _____ Relationship: _____
Phone: _____ Address: _____

TLC BEFORE & AFTER SCHOOL PROGRAM

TUITION/FEEES AGREEMENT

2011/2012

Registration Fee: \$50 Non-Refundable (paid at registration)

Tuition for your second child is half price for all programs listed below.

Before & After School: \$320/month

(Includes full days off school during the school year, excluding Christmas and Spring Break)

Before School: \$160/month

After School: \$210/month

Full Days off of School: \$40/day

(Includes breakfast, lunch and snack)

Drop-In days are subject to availability.

Daily Drop-In Before School: \$15/day

Daily Drop-In After School: \$20/day

TLC is closed for Labor Day, Thanksgiving Break, Christmas Break, Good Friday, Spring Break, and Memorial Day. Full Day Care is offered on these dates: Oct. 7th & 10th, Nov. 2nd - 4th, Jan. 16th, Feb. 17th & 20th.

A tuition statement will be given to you each month. Please make your payment to the school at the beginning of each month. If extenuating circumstances arise and you are not able to pay your tuition, please contact the Director immediately to make other arrangements.

We agree to give notice 2 weeks prior to withdrawing our child from the program.

Our child _____ is enrolled in TLC for 2011/2012, and we agree to pay our tuition on the first class day of each month. I understand there will be a **late charge of \$10 if the tuition is not paid by the 10th day of the month, and checks returned for insufficient funds will be subject to a \$15 fee.**

signature of parent/guardian

date

signature of parent/guardian

date

STUDENT RACIAL NONDISCRIMINATION POLICY

TLC Programs admits students of any race, color, national and ethnic origin to all the rights, privileges, programs, and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, national and ethnic origin in administration of its educational policies, admissions policies, scholarship and loan programs, and other school administered programs.

TLC PROGRAMS has my/our permission for the following:

PHOTOGRAPHS, VIDEOTAPES, and ART PROJECTS: Permission is granted to the TLC staff to take photographs and/or videotape of my child during school hours. My consent is given for those photographs and videotapes to be used in publications, shown at meetings, in settings where development of children is being studied, or used in publicity for the school, including the church/school website. My child’s art work or projects may be used in ways deemed appropriate by the staff, including, but not limited to displays in the community, newsletters, t-shirts, fliers and the like, or in publicity for the school.

NAME/ADDRESS/PHONE: TLC has my permission to place my name, address, and phone number on the class list and in the school directory, which will be given to parents for the purpose of car-pooling and general information.

RELIGIOUS INSTRUCTION: It is my understanding that TLC includes the teaching of Christian values. Bible stories will be told and songs will be sung about Jesus and God, and Christian holidays will be celebrated. Prayers will be offered before snacks. I understand that this will be done with a non-denominational approach.

FIELD TRIPS & SPECIAL VISITORS: I also understand that there will be occasional visitors in the school to give presentations to the children, such as the fire department, police department, doctors, pilots, and more. The children will always be under direct staff supervision when visitors come.

My child has permission to go on neighborhood walking excursions (such as to the post office or to Ol’ Timers Park).

I HAVE READ AND AGREE TO THE ABOVE RELEASES:

_____	_____
signature of parent/guardian	date
_____	_____
signature of parent/guardian	date

TLC Arrival & Departure of Children Agreement

1) TLC dismisses children individually at the classroom door at the following times:

Morning Preschool Classes @ 11:30am

Afternoon Preschool Classes @ 3:00pm

After School Program @ 6:00pm

- a) We will charge a late pick up fee of \$5.00 for every 15 minutes, beginning 15 minutes after the end of each class session.
 - b) We will attempt to contact the parent(s) after waiting 15 minutes. If we are unable to contact the parent(s) after two attempts, we will attempt to reach the child's emergency pick up contacts.
 - c) If we are unable to contact the parents or anyone on the child's emergency list after 30 minutes, we will contact the Huntley Police Department to try to locate the child's parents and/or contacts. After one hour, we will contact DCFS.
- 2) It is very important to have up-to-date emergency contact numbers on file. Please let the director know when any emergency contact phone numbers have been changed.
- 3) TLC Preschool and the TLC Before & After School Program acknowledge that we are responsible for the child's protection and well-being until the parent, designated emergency contact person, or outside authorities arrive.
- 4) The TLC staff shall not hold the child responsible for the situation, and discussion of this issue will only be with the parent or guardian, and never with the child.

_____ We have read the above, and agree to the terms.

Child's Name: _____

signature of parent/guardian

date

signature of parent/guardian

date

TLC Programs Guidance and Discipline Policy, Receipt of Parent Handbook and Summary of DCFS Licensing Standards

Our philosophy is to work to avoid situations where discipline is needed by providing the type of environment and activities that encourage children to work together and to become self-directed. All children will make mistakes, and we believe that mistaken behaviors are part of learning!

Our intent is to mold or change mistaken behavior using the following:

1. TLC Staff modeling loving Christian behavior;
2. Developing with the students rules that set clear limits for their behavior;
3. Redirecting to other activities if a child becomes frustrated or demonstrates difficulty in managing him/herself;
4. Reinforcing positive behavior;
5. Encouraging students to develop solutions to their mistaken behaviors;
6. Helping the student to understand the consequences of their behavior.

In extreme situations, a "Sit & Watch" procedure is used. The teacher remains with the child in the classroom, gives him/her a manipulative, and helps the child find better choices for mistaken behaviors. Occasionally we will have to "close" a center to a child, until they are able to exhibit appropriate behavior in the center. If behaviors are consistently disruptive to learning and teaching time or cause potential harm to others, the parent or guardian will be called to make an individual plan for their child with TLC.

The parent has the right to disenroll their child if desired.

TLC reserves the right to disenroll children as we deem necessary.

An exit plan would be made as required by DCFS.

_____ We have received a copy of the TLC Handbook, which includes the TLC Guidance & Discipline policy, available online at <http://tlc.trinityhuntley.org>.

_____ We have received a copy of the Summary of DCFS Standards, available online at <http://tlc.trinityhuntley.org>.

Child's Name: _____

_____ signature of parent/guardian _____ date

_____ signature of parent/guardian _____ date

(Must be signed by at least one parent)

**TLC Before & After School Program
Transportation Agreement
2011/2012**

Child's Name: _____ Primary Phone: _____

Huntley School District 158 School: _____ Grade: _____

I agree that TLC Before & After School Program staff will provide the transportation for my child to and from the District Reed Road Campus or Square Barn Campus to and from their location at 11008 N. Church Street, Huntley, IL 60142.

The Reed Road Campus route is from the District School to Reed Road to Route 47 to Algonquin Road to Church Street to TLC. The Square Barn Campus route is from the District School to Algonquin Road or Huntley/Main Street to Church Street to TLC.

The children who attend Leggee Elementary will be taking the Huntley Consolidated School District 158 School Buses.

I understand that a copy of the child's emergency information card will be in the church vehicle transporting my child. In case of an accident, we agree that the information on the emergency card is to be used to contact us.

signature of parent/guardian

date

signature of parent/guardian

date



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

NOTE TO PARENTS:
Parents are responsible for completing
Health History on back! ➡

Please Print

Student's Name			Birth Date	Sex	School	Grade Level /ID#
Last	First	Middle	Month/Day/ Year			

Address			Parent/ Guardian	Telephone #	Work
Street	City	ZIP code		Home	

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)																		
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	R		L		R		L		R		L		R		L		R		L	
Age/Grade																				
Vision																				
Hearing																				

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

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
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes No
Developmental delay?	Yes	No		Surgery? (List all.) When? What for?	Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes No
Diabetes?	Yes	No		TB skin test positive (past/present)?	Yes* No
Head injury/Concussion/Passed out?	Yes	No		TB disease (past or present)?	Yes* No
Seizures? What are they like?	Yes	No		Tobacco use (type, frequency)?	Yes No
Heart problem/Shortness of breath?	Yes	No		Alcohol/Drug use?	Yes No
Heart murmur/High blood pressure?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes No
Dizziness or chest pain with exercise?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other	
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Other concerns?
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 (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/>				
Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				

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 Indicated? Yes No **Blood Test Date** _____ **Blood Test Result** _____ (Blood test required in Chicago and other high risk zip codes.)

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. **Date Read** / / **Result** _____ **mm**

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results	Date	Results
Hemoglobin * or Hematocrit *				Sickle Cell * (as indicated)
Urinalysis				Other

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
PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited (If No or Modified, please attach explanation.)

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name _____ **Signature** _____ **Date** _____

Address _____ **Phone** _____

(Complete both sides)

Parents MUST complete this section and sign.

Doctors: Please complete physical exam including highlighted areas.