

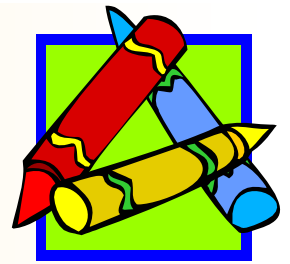
TLC PRESCHOOL AND BEFORE & AFTERSCHOOL PROGRAM

11008 N. CHURCH STREET HUNTLEY, ILLINOIS 60142

847-669-5781 FAX 847-669-5978

TLCHUNTLEY@SBCGLOBAL.NET

HTTP://TLC.TRINITYHUNTLEY.ORG



TLC PRESCHOOL REGISTRATION 2012/2013

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.

All children must be toilet trained, per DCFS regulations. No pull-ups allowed.

Annual Non-Refundable Family Registration Fee: \$50

Supply/Snack Fees noted below are due by the first day of school.

Special tuition rates for siblings attending the same school year. Please call for rates.

Same tuition rates as last year!

2 Day Programs Annual Supply/Snack Fee: \$35
Monthly Tuition: \$125

3 Day Programs Annual Supply/Snack Fee: \$65
Monthly Tuition: \$170

5 Day Program Annual Supply/Snack Fee: \$85
Monthly Tuition: \$250

Student's Name: _____ Date of Birth: _____

Parent's Names: _____ Email: _____

Address: _____ City: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

New Students: How did you hear about us?

Referral: _____ Advertisement: _____ Other: _____

When you refer a new family to our TLC Preschool Program for the 2012-13 school year we will credit you AND your friend your registration fee when you both attend in September!

Morning Classes: 9 - 11:30 a.m.

Afternoon Classes: 12:30 - 3 p.m.

3 years old by Sept. 1, 2012

4 years old by Sept. 1, 2012

___ 2 Day (TH, F) Morning

___ 3 Day (M, T, W) Morning

___ 2 Day (M, T) Afternoon

___ 3 Day (M, T, W) Afternoon

___ 3 Day (M, T, W) Afternoon

___ 5 Day (M - F) Afternoon

Teacher Request: _____ We do our very best to fill all requests! ☺

\$50 Non-Refundable Registration Fee Due at Registration with this Form

Students will not be able to start school without this form.



FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 5/2006

**NOTE TO PARENTS:
Parents o wuv completg
Health History on back!**

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#								
Address Street City ZIP code						Parent/ Guardian			Telephone # Home			Work								
IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for <i>every</i> dose administered. The day and month is required if you cannot determine if the vaccine was given <i>after</i> 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 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 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																					Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade																					
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																					
Hearing																					

Printed by Authority of the State of Illinois
(Complete Both Sides)

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

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?	Yes	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night coughing?	Yes	No			Yes	No
Birth complications/prematurity?	Yes	No	Hospitalizations? When? What for?	Serious injury or illness?	Yes	No
Developmental delay?	Yes	No			Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	Surgery? (List all.) When? What for?	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No			Yes*	No
Head injury/Concussion/Passed out?	Yes	No	TB disease (past or present)?	Tobacco use (type, frequency)?	*If yes, refer to local health department.	
Seizures? What are they like?	Yes	No				
Heart problem/Shortness of breath?	Yes	No	Alcohol/Drug use?	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No			Yes	No
Dizziness or chest pain with exercise?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other	Other concerns?		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____						
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)						
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
DIABETES SCREENING (Not required for daycare.) 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.						
Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> 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. <input type="checkbox"/> No Test Needed <input type="checkbox"/> 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"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/>	Result _____	Genito-Urinary	LMP	
	Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/>		Neurological		
Nose				Musculoskeletal		
Throat				Spinal examination		
Mouth/Dental				Nutritional status		
Cardiovascular/HTN				Mental Health		
Respiratory						
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		INTERSCHOLASTIC SPORTS (for one year)		Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>		
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.

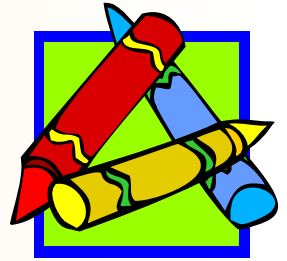
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Welcome to our TLC Preschool family!

We are looking forward to working with you and your child! There are a few things that you will need to know:

- ❖ All children must be toilet trained before entering school. Pull-ups are not allowed, per DCFS regulation.
- ❖ All students must have a current physical before they enter preschool. All vaccinations must be up to date and the physical must be completed no more than 6 months prior to their entrance to school. **Please be sure to complete the top portion of the form and the Health History section prior to your doctor visit.** This is a standard form in Illinois and your physician will be able to complete the remainder of the form for you. **Please note:** if your doctor chooses NOT to do a lead and/or tb test, they MUST mark so on the form. Otherwise, results must be put on the form.
- ❖ We must have your child's birth certificate on file. Please bring us the original and we will make a copy and return the original to you immediately. Thank you!
- ❖ We will host a "TLC Family Fun Day" in August, at which time you can pick up the remainder of your enrollment forms. On that day, we will notify you of your classroom information.
- ❖ Also in late August, we will host a "Parent Night". This will offer you an opportunity to return your completed enrollment forms.
- ❖ We will have an "Easy Start" program the week before regular classes begin in September. This is a time when you and your child can spend time together in the classroom with their teacher and a few new friends before their first day of school.
- ❖ Specific dates and details regarding all of this will be sent to you via email in July. Please be sure we have your correct email address on your registration form.

If you have any questions at all, please do not hesitate to contact us. Our office is open all summer, as we do have summer camp here at TLC! ☺ We are looking forward to a fantastic school year filled with lots of fun and learning!

Sincerely,

Linda Kranz
Director, TLC Programs