

Dear Families,

Welcome to the Little Explorers Preschool. I am so excited for the upcoming year and to be able to share this time with your child. I have a heart for little ones and seeing them grow in God's love and learn in their own unique ways. To be best prepared to welcome your child, please answer the following questions and return them with the enclosed registration materials. Together WE make a team. I am looking forward to a great year!

Sincerely,

Ms. Cortnee



Student's name _____

Parent's name _____

Describe your child's personality.

What are your expectations for your child this year?

How does your child feel about school?

What are your child's strengths?

What area would you like to see the most improvement for your child?

What are your child's hobbies and interests?

Please include any other information you would like for me to know about your child.



2018 - 2019 School Calendar

School Opens -Fall Semester Begins.....	September 4
Thanksgiving Break No Classes	November 21-23
Christmas Break No Classes.....	Dec. 24- Jan. 1
Easter Break	March 29- April 1
Memorial Day Observed No Classes	May 27
Last Day of Classes	May 31

Little Explorers Preschool will follow public school closings due to severe weather conditions.

Teacher Contact Information

Little Explorers Preschool

715-479-2173

Director: Wendy Reese

715-479-6942

reesefamily@frontier.com

Head Teacher: Cortnee Pinski

307-371-3722

cortpinski@gmail.com



Registration Form

Student

Name of Child: _____ Preferred Name: _____

Date of Birth: _____ Sex: M _____ F _____

Address: _____ Phone: _____

City / State: _____ ZIP: _____

Email: _____

Parents/Guardians

Name: _____

Address: _____ City: _____

Home Phone: _____ Cell/Text: _____

Work Phone: _____ Email: _____

Name: _____

Address: _____ City: _____

Home Phone: _____ Cell/Text: _____

Work Phone: _____ Email: _____

How did you learn of Little Explorers Preschool? _____

Emergency Contact Information

Name: _____

Name: _____

Relationship to Child: _____

Relationship to Child: _____

Address: _____

Address: _____

Cell or Daytime Phone: _____

Cell or Daytime Phone: _____

Physician Information

Preferred Medical Clinic: _____

City

Physician's Name: _____ Phone: _____

Allergies / Medical Concerns: _____

Other People Authorized to Pick Up Your Child

Name: _____
Address: _____
Phone: _____ Email: _____

Name: _____
Address: _____
Phone: _____ Email: _____

Programs

\$25 Nonrefundable enrollment fee due on receipt of application

Student must be 3 years old by September 1st of the current school year to be enrolled in the Prek 3 class, or the Student must be 4 years old by September 1st of the current school year to be enrolled in the Prek 4 class. Classroom placement priority is given in order in which application forms are received.

Pre K3 Tues/Thurs 9am-12pm _____ Pre K4 Mon/Wed/Fr 9am-12pm _____

Tuition

Set tuition regardless of absences or missed days. Checks made payable to **Saint Germain Ev. Free Church**

Payment Options (circle one):

	<u>Pre K3</u>	<u>Pre K4</u>
Paid in Full	\$1,125	\$1,350
Two installments Sept. 1 & Feb.1	\$500/\$625	\$600/\$750
Monthly	\$125	\$150

Authorizations

- Yes No I release Little Explorers Preschool and St. Germain Evangelical Free Church from any liability associated with activities my child will be involved in while attending.
- Yes No I hereby give my consent for emergency medical care of treatment to be used only if I cannot be reached immediately.
- Yes No I grant permission to Little Explorers Preschool, to take and use: photographs and/or digital images of my child for use in news releases and/or educational materials as follows: printed publications or materials, electronic publications, or Web sites. I agree that my child's name and identity: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints, digital reproductions and shall be the property of Little

parent/guardian signature

date

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks)** of admission to the child care center. These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

PERSONAL DATA

PLEASE PRINT

STEP 1	Child's Name (Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
	Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

IMMUNIZATION HISTORY

STEP 2 List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (✓) OR (X) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus- <i>Peritussis</i> (Specify DTP, DTaP, or DT)					
Polio					
Hib (<i>Haemophilus influenzae</i> Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

- Yes year _____ (Vaccine is not required)
 No or Unsure (Vaccine is required)

REQUIREMENTS

STEP 3 The following are the minimum required immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES					
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B	
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib ¹	3 PCV ²	2 Hep B	1 MMR ³
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib ¹	3 PCV ²	3 Hep B	1 MMR ³ 1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT ⁴	4 Polio			3 Hep B	2 MMR ³ 2 Varicella

¹If the child began the Hib series at 12-14 months of age, only 2 doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose 4 days or less before the first birthday is also acceptable).

²If the child began the PCV series at 12-23 months of age, only 2 doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

³MMR vaccine must have been received on or after the first birthday (Note: a dose 4 days or less before the 1st birthday is also acceptable).

⁴Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th birthday is also acceptable).

COMPLIANCE DATA AND WAIVERS

STEP 4 IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD DOES NOT MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

- Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of up to \$25.00 per day of violation.

- For health reasons this child should not receive the following immunizations _____ (List in STEP 2 any immunizations already received)

Physician's Signature Required

- For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)
 For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

SIGNATURE

STEP 5 To the best of my knowledge, this form is complete and accurate.

SIGNATURE - Parent, Guardian or Legal Custodian	Date Signed
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HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(K)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION

Provide information where the parent(s) / guardian(s) may be reached while the child is in care.			
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number
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SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to apply sunscreen to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to allow my child to self-apply sunscreen.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to apply repellent to my child.	Brand Name	Ingredient Strength
<input type="checkbox"/> Yes <input type="checkbox"/> No	I authorize the center to allow my child to self-apply repellent.		

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.

- No specific medical condition
- Asthma
- Cerebral palsy / motor disorder
- Other condition(s) requiring special care – Specify.
- Diabetes
- Gastrointestinal or feeding concerns including special diet and supplements
- Epilepsy / seizure disorder
- Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism

Milk allergy: If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.

Food allergies – Specify food(s).

Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.

- a.
- b.
- c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian

Date Signed (mm/dd/yyyy)

Review dates: