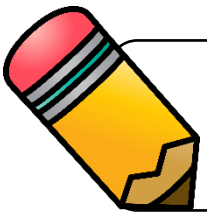
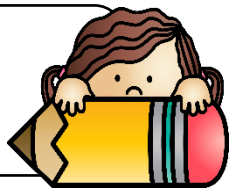
Enrollment Date: _____

Information Update Only: _____



1st Step Learning Center



407 Edwardsville Road

Troy, IL 62294

618-667-6241 lisa@troymc.org

Registration Form

Child:_____ Age on Sept.1, 2024: _____ Birthdate: __/__/__

Sex: M__ F__

Child's Address: _____

Full name of Mother:_____ Email _____

Mother's Address:☐ Same _____

Home Phone:_____ Work Phone:_____ ext. ____ Cell Phone:_____

Place of employment:_____Contact 1st ☐

Church Affiliation:_____

Full name of Father:_____ Email _____

Father's Address: ☐ Same _____

Home Phone:_____ Work Phone:_____ ext. _____ Cell Phone:_____

Place of employment:_____Contact 1st ☐

Please list the names and ages of siblings:_____

_____

Parent Marital status_____

Emergency Contacts

Minimum 2 contacts, other than parents, to contact in case of emergency/authorized to pick up child:

1. Name:_____ 2. Name:_____

Relationship to child:_____ Relationship to child:_____

Home Phone:_____ Home Phone:_____

Cell or Work Phone:_____ Cell or Work Phone:_____

Other Person(s) Authorized to pick up child:

Name:_____ Relationship_____ Phone:_____

Name:_____ Relationship_____ Phone:_____

Name:_____ Relationship_____ Phone:_____

Session Preference

- 2's Tuesday/Wednesday/Thursday 8:25-11:45 Monthly fee of $190
- 3's Tuesday/Wednesday/Thursday 8:25-11:45 Monthly fee of $180
- 4's Tuesday/Wednesday/Thursday 8:25-11:45 Monthly fee of $180

We consider it a privilege to have your child in our preschool program. To ensure that your child is registered, the attached forms must be completed in their entirety. **To reserve your child's position in class, complete the initial registration form and turn it in to the Director's office along with the $100.00 registration fee**. The other forms may be completed and turned in prior to or on the first day of school. This provides us with all the necessary information to ensure that your child will have a safe and enjoyable learning experience at 1st Step.

Child's Health Information and History

Child's Doctor:_____ Phone:_____

Are your Child's immunizations up to date? Yes ( ) No ( )

Note: attach a copy of immunization record if not enrolled in public school yet.

If not up to date, please explain: _____

Does child have any known health problems? Yes ( ) No ( ) (If yes attach documentation)

Does your child get colds/flu often?_____

Please list any serious prior injuries:_____

Check (√) any of the following illnesses the child has had:

☐Asthma ☐Earaches ☐Mumps ☐Whooping Cough ☐Bronchitis

☐Eczema ☐Pneumonia ☐Polio ☐Chicken Pox ☐Frequent Colds

☐Croup ☐Convulsions ☐Measles ☐Influenza ☐Rheumatic Fever

☐Diphtheria ☐Tonsillitis ☐Other:_____

Does your child have any known allergies? Yes ( ) No ( ) If yes, what are they and what are your child's reactions:

_____

Does your child take any medication on a regular basis? Yes ( ) No ( ) If yes please list the name of the medication(s) and the medical condition for which it is taken:

_____

Does your child have any speech, hearing or visual problems? Yes ( ) No ( )

_____

Has your child ever been tested for the above? Yes ( ) No ( )

_____
_____

Please comment on any other medical information/or special need the preschool should be aware of:

_____

_____

Medication and Emergency Care Authorization

I authorize 1st Step Learning Center to administer the medications authorized below as deemed necessary by staff for the comfort and well-being of my child. Medications will be administered in the dosages recommended for my child's age and weight. This authorization is in effect my child is enrolled, unless revoked by me and I understand that I will be notified when I pick up my child if any medications were given.

(Please cross off any item you would prefer not to be used)

☐Yes ☐No I authorize use of typical first aid supplies including but not limited to Neosporin, anti-bacterial spray, cortisone, sunburn treatments, band-aids, and liquid Band-Aids.

☐Yes ☐No I authorize use of preventative supplies, such as sunblock, bug repellant, hand lotion, diaper rash cream, etc.

NOTE: If you would like your child to take a specific brand of medication, please provide it. Medications will be labeled with your child's name and kept locked. Prescription medications will require separate authorizations for each occurrence and must be sent to school in original prescription bottle.

Signature of parent:_____

Madison County Health Department
Vision & Hearing Screening Assessment Form

For your child to be screened, this form must be completed and returned to your child's facility.
PLEASE PRINT. Use BLACK or BLUE ink. SIGN the form

Child's Name: _____DOB: _____ Sex: _____
Last (legal name, no nicknames) First MI
Race (Choose all that apply): ☐ American Indian ☐ Asian ☐ African American ☐ Declined to Specify ☐ Pacific Islander ☐ White Ethnicity: ☐ Non-Hispanic ☐ Hispanic

Address: _____City: _____Zip: _____

County: _____Phone Number: _____

Physician:_____

Parents or Guardians: _____Relationship to client: _____

Street Address (if different from child): _____

Name of Facility (Day Care or Pre-school): 1st Step Learning Center

*This vision screen cannot be used as the Kindergarten eye exam.
*If your child fails a screening, you will be contacted by phone or letter within 10 days.

I hereby give my consent for hearing and vision screening assessment for my child. I give my consent to Madison County Health Department (MCHD) to release information to physicians, social workers, other health departments, pre-schools, day care and school personnel as necessary.

CONSENT and ACKNOWLEDGEMENT
Receipt of Joint Notice of Privacy Practices

I understand that the Madison County Health Department is authorized to use information gained during screening to bill any potential source of reimbursement, such as Illinois Public Assistance or government programs in which I am enrolled or qualify for services. I also hereby acknowledge a copy of the "Joint Notice of Privacy Practices," is available at Madison County Health Department. A copy is available to view at the health department's website www.madisonchd.org.

_____ _____
Date Signature of Parent or Legal Guardian
Child's Medicaid Recipient ID Number: _____

For Health Department Staff Use Only

Date of Screening: _____

_____
Screening Technician's Signature

Hearing Results: _____

Vision Results: _____

Key: P=Pass F=Fail U=unable to complete test R=Refused test

Madison County Health Department
101 E. Edwardsville Rd.
Wood River, IL 62095
618-692-8954 x2
www.madisonchd.org

Cell phones and texting

We are asking that you provide us with a cell phone number that has texting capabilities if you would like to receive important messages from the school. Some of the ways that we will use this number are as follows:

- to inform you of school closing or delays
- to inform you of an early school closing
- to remind you of a specific event that is happening that day
- to let you know that we will be at the overhang for drop off for inclement weather

When we have extremely cold weather or heavy rains, we will be receiving children at the overhang in the upstairs drive. We would ask that you pull in and one of the staff will be there to help your child out of the car as quickly as possible.
If you choose to participate, please fill out the bottom of this form and return it to school as soon as possible.

Thank you!

_ _

I would like to give my cell phone number to 1st Step Learning Center and allow them to use it to text me with important school information.

_____ _____

Parent's Name 10 digit cell phone number

ANDERSON HOSPITAL
Illinois Rt. 162 & Old Edwardsville Rd.
MARYVILLE, ILLINOIS 62062
Phone (618) 288-5711

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD AT ANY MEDICAL FACILITY AT ANY MEDICAL FACILITY (THIS FORM MUST BE NOTARIZED!!)

Date_____

Authorization is hereby given to 1st Step Learning Center to consent to emergency treatment for my child

_____
Name of Child

and to proceed with such treatment that may be necessary in that we the parents are not available at the time of the injury or illness.

Authorization is also given for admission to the hospital, if at the time of injury or illness, in our absence, admission to the hospital is advised by our private physician or a consulting physician of his choice.

Child's Birth Date:_____

Date of Child's Last Tetanus Immunization injection:_____

Child's Allergies and Chronic illness:_____

_____

Full Name of Private Physician: _____

Telephone Number of Physician: _____

Address & Telephone Number where Parents might be reached:

_____

As Parents, we promise to pay, whatever costs are not covered by:

_____
Name of Insurance Number on Card

1st Step Learning Center _____
Signature of Responsible Party during Parent's absence as named above

_____ _____
Signature of Child's Father Signature of Child's Mother

Subscribed and Sworn to before me
this_____ day of _____,
20___. Witness my hand and official seal.
Notary Public_____
My Commission Expires: _____

Transportation Authorization

I _____,hereby authorize the following people to transport my child from 1st Step. Should this change at any time I will notify 1st Step personnel in writing.

(*list people eligible to pick up child on lines below)*

_____

_____

_____

_____ _____

Parent Signature Date

Photo Authorization

Photographs and videos are taken on many occasions such as birthdays, holidays, outings, special occasions as well as in the normal course of our day. We use these pictures/videos for teaching, sharing information about their day, arts & crafts, albums, class books, picture CD's and various other things. Photos which may include my child may be given to families who also attend this program or may appear online unless otherwise noted by you.

Please mark the appropriate box(s):

☐ I give permission to 1st Step Learning Center to take photographs/videos of the above named child(ren). Photos used in classroom only or give to parents as a remembrance of their child's year (including other families in the program).

In Addition:

☐ I give permission for photos/videos to be posted on our Facebook or Blog (to share your child's day).

☐ I give permission for my child's photo to be used on printed marketing materials (pamphlets, flyers, etc.)

OR

☐ I do NOT want any photos/videos taken of my child.

Ages and Stages

At 1st Step Learning Center we use a developmental screening tool called Ages and Stages. The Ages and Stages Questionnaire is a nationally recognized developmental evaluation tool that will enable us to track your child's development while they attend 1st Step. The questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving and personal/social skills.

The questionnaire will be administered by your child's teacher. We use this tool in all of our classrooms and have a goal each year of evaluating all of the children by the end of November. If the questionnaire shows that your child is developing without concerns, then we will simply add the questionnaire to your child's portfolio for you to examine at the parent/teacher conferences in January. If the questionnaire shows some possible area(s) of concern for your child, we will send a copy of the same questionnaire home for you to complete with your child. We will then schedule a conference to review the results of both the teacher and the parent assessment. Together, we will discuss if it is appropriate to monitor your child or refer your child for a more involved assessment from your pediatrician. No information will be shared outside of 1st Step without written consent from the student's parents.

We believe that this screening tool validates our belief that parents know the most about their children. A typically developing child will be able to do some of the skills asked about on the questionnaire, but usually not all of them. This is NOT a test, but a tool that can tell us when a child is developing typically, when a child needs more practice in a certain area or when a child should have their development assessed by a specialist.

The first five years of life are very important for your child because this time sets the stage for success in school as well as later in life. During early childhood, your child will gain many experiences and learn life-long skills. The Ages and Stages Developmental Screening Tool can help us to ensure that each child's development proceeds well. If you have any questions or would like to see a sample questionnaire, please contact me at the preschool office.

Sincerely,

Lisa Rayle

Please read the text below and mark the desired space to indicate whether you would like your child to participate in the Ages and Stages screening/monitoring program.

____ I wish to have my child participate in the screening/monitoring program.
____ I do not wish to have my child participate in the screening/monitoring program.

Parent or Guardian Signature _____

Date _____

Child's Name _____

Child's Date of Birth_____