Greenview Christian Preschool Registration

2020-2021

Please check the class you are enrolling your child in. 3's and 4's _____PreK_____

Child's full name(no initials please)_____

Boy_____Girl_____

Child's current age_____Date of birth_____

Mother's Name_____

Father's Name_____

Child lives with_____

Address(please include city and zip code)_____

Mother's phone number_____

Father's phone number_____

Do you attend church services?_____Where_____

Has your child attended preschool before?_____Where_____

Please list any medical concerns including allergies_____

_____

Please list any concerns you may have(speech, hearing, vision, behavior)_____

_____

My child will be attending SACC (available to PreK students) Yes_____No_____

I give my permission to post pictures of my child on a secret Facebook page.

Yes_____No_____Parent Signiture_____

I give permission to post pictures of my child on the church and school websites.

Yes_____No_____Parent Signiture_____

$25 Registration Fee_____

Preschool Student Pick-Up Authorization Form

Student Name_____

I authorize the following person/persons to pick up my child from Greenview/New Horizon Christian School. I understand that my child will be released to only those listed on the form.

NAME	RELATIONSHIP	PHONE
1.		
2.		
3.		
4.		
5.		

_____

Parent/Legal Guardian

Preschool Supply List

2020-2021

Backpack (large enough for a two-pocket folder)

1 Two-pocket folder

Jumbo Crayola crayons (3's and 4's)

Twistable or any other fun crayons (optional)

Elmer's Liquid glue (small bottle please)

Glue sticks

Tissues (kid print only please)

Wet wipe refills

Disinfectant wipes

Water Color Paints (Crayola only please)

Extra clothes to keep in backpack (shirt, pants, shorts, underwear, socks)

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

DCFS

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	Race/Ethnicity	School /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 *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 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)						
MMR Combined Measles Mumps Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

COMMENTS:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature _____ Title _____ Date _____

Signature _____ 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 result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date												
Age/ Grade												
	R L	R L	R L	R L	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

Last	First	Middle	Birth Date Month/Day/Year	Sex	School	Grade Level/ ID

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 night coughing?	Yes Yes	No No		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					
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	*If yes, refer to local health department.
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? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes Parent/Guardian Signature Date			
Bone/Joint problem/injury/scoliosis?	Yes	No					

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

HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) 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. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes☐ No☐ Blood Test Indicated? Yes☐ No☐ Blood Test Date Result

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines No test needed ☐ Test performed ☐

Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

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		Amblyopia Yes☐ No☐	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

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 Yes☐ No☐ Limited☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

(Complete Both Sides)