# St. Barnabas Christian Preschool

Preschool Registration for 2022-2023

Welcome to St. Barnabas Christian Preschool! The following check list may be useful when submitting the enrollment packet. Please be sure the following forms are returned with your registration with the exception of the physical form.

**This must be dated within 6 months prior to school starting.** All students must have HIB shots, TB test, Chicken Pox and Hepatitis B shots.

## Check List:

__1. Preschool Application form filled out completely
__2. All About My Child Questionnaire
__3. **School Phone Directory/Tuition Agreement Form**
__4. **Permission Form**
__5. **Student Pick Up Authorization Form**
__6. Nonrefundable Registration fee of $75
**(The fee increases to $100.00 after April 1st)**
__7. Copy of Birth Certificate (new students only)
__8. **PHYSICAL FORM COMPLETELY FILLED OUT**
**(must be dated 6 months before school start)**

If we can be of any further assistance in making the enrollment process easier, please contact us at 847-516-4171 or:

Email:
stbcpreschool@gmail.com
khedgepath8901@gmail.com
**Website: stbarnabaschristianpreschool1.org**

# St. Barnabas Christian Preschool Application
2022-2023

Child's Full Name _____

Date of Birth _____ Sex _____ Name your child will write _____

Address _____

City _____ Zip _____ Home Phone # _____

Parent(s) Email address _____

How did you hear about us/Recommended by whom? _____

Parent/Guardian Name(s) _____

Father's Cell Phone _____ Mother's Cell Phone _____

Father's Work Phone _____ Mother's Work Phone _____

***Conditions for Enrollment:** Child must be toilet trained to enter school (no-pull ups) and be age of 3 or 4 by October 31st, and 5 by December 31 for Pre-K. A copy of your child's birth certificate is required at registration for all new students.

**Check the class you wish to enroll your child in**
****A minimum number of 5 children are needed to run each class****

**3-Year Old Class**
*Two-days per week - $200/month*
*9:00-11:30 am*
- ❑ Monday/Wednesday Morning
- ❑ Tuesday/Thursday Morning

**4-Year Old Class**
*Three-days per week - $235/month*
9:00-11:30am
- ❑ Monday/Wednesday/Thursday Morning

*Four-days per week - $255/month*
- ❑ Monday-Thursday Morning 9:00-11:30am

**Pre-K**
*Four-days per week - $265/month,* 12:30-3:00pm
- ❑ Monday-Thursday Afternoon

A **$75 NON-REFUNDABLE** registration fee is required for each child enrolled, along with this application. After April 1st, registration fees for **ALL** classes will increase to $100.

_____

Parent Signature Date


# All About My Child Questionnaire

Please help us get to know your child. Please fill out this form and turn it in with your application.

Child's Name_____Class_____

1. Does your child have any physical handicaps? Explain_____
2. Is your child receiving any special services? If so please explain._____
3. Does your child have any allergies? (food, insect bites, medications)_____
4. Does your child require a special diet? Explain_____
5. List any medications your child takes regularly._____
6. Does your child wear: Glasses:_____ Orthopedic Appliances:_____
   Special clothing/shoes_____
7. Which hand preference has your child shown? Right___ Left___ No Preference____
8. Did your child attend preschool before and where? Yes____ No____
9. What school district do you live in? _____
10. Are there any circumstances or changes in your family or home that has or may have an effect on your child? (If yes please explain)_____
11. Is there any other information about your child that we should be aware of?

    _____

12. List the other children in your household:

    Name_____ Birth date_____
    Name_____ Birth date_____
    Name_____ Birth date_____
    Name_____ Birth date_____

**Thank you for enrolling at St. Barnabas Christian Preschool.**

# Preschool Phone Directory

If you would like your child included in a published class list, which would be distributed to your child's class, please indicate below when returning the registration packet.

**PLEASE PRINT CLEARLY**

_____ YES, I would like my child to be in the school phone directory.

_____ NO, I would not like my child to be in the phone directory.

Child's name_____ Parent's Name_____

Address_____City_____Zip_____

Email Address_____

Telephone number _____ Parent's signature_____

## TUITION AGREEMENT

Tuition payments are due by the first of every month unless other arrangements have been made. Tuition is considered **LATE** if received after the fifth of the month and a $25 late fee will be incurred.
If a tuition payment is delinquent after the due date, we understand that my child will not be admitted into the classroom until the overdue tuition balance, including late charges, is paid in full. Once a child is enrolled, the parents are responsible for maintaining tuition payments.

- Tuition payments total $1800.00 per year for the 2-day per week Three's program.
- Tuition payments total $2115.00 per year for the 3-day per week Four's program.
- Tuition payments total $2295.00 per year for the 4-day per week Four's program.
- Tuition payments total $2385.00 per year for the four day Pre-K.

The annual tuition is divided into nine monthly payments of either $200.00 (3's-2 day), $235.00 (4's-3 day), $255.00 (4's-4day), and $265.00 (Pre-K).

**A non-refundable registration fee of $75.00**
**($100.00 if after April 1, 2022) is due at the time of registration.**
**A Supply Fee of $50.00 will be due in September.**

By signing below, I/We agree with and will uphold the monthly tuition requirements of St. Barnabas Christian Preschool.

Parent Signature_____ Date_____
Parent Signature_____ Date_____

# St. Barnabas Christian Preschool Permission Form

**Child's Name**_____

1. I hereby grant permission for my child to use all play equipment and participate in all of the activities in school.
2. I hereby grant permission for my child to leave the school premises under the supervision of a staff member for neighborhood walks.
3. I hereby grant permission for my child to accompany his/her class and staff persons on field trips planned and authorized by the preschool when reasonable care is given to assure the child's safety.
4. I hereby grant permission for the Director/Assistant Director/Administrative Assistant to take whatever steps may be necessary to obtain emergency medical and dental treatment if warranted. These steps may include, but are not limited to the following:

    - ✓ Attempt to contact a parent or guardian
    - ✓ Contact local paramedics
    - ✓ Attempt to contact you through any of the persons listed on your child's pick up form.
    - ✓ Attempt to contact the child's physician.
    - ✓ If we cannot contact you or your child's physician we will do the following:
        a. Call another physician
        b. Have the child taken to the emergency room in the company of a staff member
        c. Call an ambulance.

5. Any expenses incurred under item 4 above will be paid by the child's family.
6. I hereby grant permission for my child to be included in pictures connected with the program. They may be used on our website or FB page but no child's name will be used. I am also aware this is a Christian Preschool and basic Christian beliefs will be taught.
7. The school will NOT assume responsibility for anything that may occur as a result of false information given at the time of enrollment.
8. The school will NOT assume responsibility for a child who has NOT been signed in when he/she arrives for the day.
9. Injury sustained at this preschool must be reported within 24 hours to the Director or acting Director.

I hereby agree with all the above and grant permission for the staff to administer first aid:

Signature of
Parent/Guardian_____Date_____

# St. Barnanbas Christian Preschool Pick-Up Form

I/We **AUTHORIZE** only the listed individuals below to pick up my child. **Please list at least two people other than the parents.**

Signature of one or both parents is required.

CHILD'S NAME_____

1. Name_____ Relationship_____
   Phone Number where this person can be reached_____
   Address_____ City_____

2. Name_____ Relationship_____
   Phone Number where this person can be reached_____
   Address_____ City_____

3. Name_____ Relationship_____
   Phone Number where this person can be reached_____
   Address_____ City_____

4. Name_____ Relationship_____
   Phone Number where this person can be reached_____
   Address_____ City_____

5. Name_____ Relationship_____
   Phone Number where this person can be reached_____
   Address_____ City_____

To the best of my knowledge, all information contained in the registration record for my child is true and correct. I understand that it is my responsibility to notify St. Barnanbas Christian Preschool if any of the information above changes.

Signature of
Parent/Guardian_____Date_____

Signature of
Parent/Guardian_____Date_____

# State of Illinois
# Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

| 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 |
| Vision | | | | | | | | | | | | | | | | | | | | |
| Hearing | | | | | | | | | | | | | | | | | | | | |

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



**(COMPLETE BOTH SIDES)**

Printed by Authority of the State of Illinois

| Student's Name (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? | Yes | No | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes | No | |
| Child wakes during the night | 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 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.
Questionnaire Administered ? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date (Blood test required if resides in Chicago.)

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

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

Address Phone

**(Complete both sides)**