Wilco Area Career Center Preschool

WILCO PRESCHOOL has been established in conjunction with the WILCO Area Career Center. The purpose of the career center is to offer high school students the training necessary for employment upon completion of a selected program. Our program, Early Childhood Education, is designed to train high school students in observing and learning about the environment of early childhood education. With the assistance and supervision of the preschool director and other teachers, the students will plan activities and lessons to promote the intellectual, physical, social-emotional, and language development of your child.

WILCO PRESCHOOL offers various morning as well as an all-day program. A registration fee and tuition are charged. The fees are used for school and snack supplies, equipment, and various activities throughout the year. Students in the All-Day Programs will need to bring a boxed lunch and sleeping bag.

REGISTRATION FEE Due by: All program choices require a $100 registration fee due by May 15th to reserve your spot.

PROGRAM CHOICES:

- **Monday, Tuesday, Wednesday, Thursday & Friday-Mornings** 8:00-11:00 a.m. = $1,440.00/school year including registration fee* Tuition may be paid in (9) monthly payments of $160 each or paid in full on or before the first day of school, in which the tuition would be $1,340.00.
- **Monday, Wednesday, Friday Mornings** 8:00-11:00 a.m. = $900.00/school year including registration fee*Tuition may be paid in (9) monthly payments of $100.00 each or paid in full on or before the first day of school, in which the tuition would be $800.00.
- **Tuesday, Thursday-Mornings** 8:00-11:00 a.m. = $675.00/school year including registration fee* Tuition may be paid in (9) monthly payments of $75.00 each or paid in full on or before the first day of school, in which tuition would be $575.00.
- **Monday, Tuesday, Wednesday, Thursday & Friday-Full Day** 8:00-2:00 p.m. = $3,150.00/school year including registration fee* Tuition may be paid in (9) monthly payments of $350 each or paid in full on or before the first day of school, in which the tuition would be $3,050.00.
- **Monday, Wednesday, Friday-Full Day** 8:00-2:00 p.m. = $1,900.00/school year including registration fee*Tuition may be paid in (9) monthly payments of $211.11 each or paid in full on or before the first day of school, in which the tuition would be $1,800.00.
- **Tuesday, Thursday-Full Day** 8:00-2:00 p.m. = $1,350.00/school year including registration fee* Tuition may be paid in (9) monthly payments of $150.00 each or paid in full on or before the first day of school, in which tuition would be $1,250.00.

LATE PICK UP FEE: Late pick up fee of $37.00 will be charged if the child is picked up more than 15 minutes late.

LATE PAYMENT FEE: Wilco will charge a $25.00/month late payment fee for payments received after the 15th of month.

AGES: 3, 4 and 5 years old (must be potty trained)

PRE-K INSTRUCTOR: Mrs. Stephanie Perella

E-MAIL: sperella@wilcoacc.org

SCAN QR TO REGISTER

LOCATION: 500 WILCO BOULEVARD · ROMEOVILLE, IL 60446-9529 815-838-6941 FAX: 815-838-1163

Preschool Student Registration Checklist

The following items are required for Preschool Registration:

1. ☐ Completed registration packet and $100.00 registration fee.

2. ☐ Any existing legal custody, divorce decree, or guardianship documents
   - If there are any legal documents pertaining to the custody of the student, you must provide a copy.

3. ☐ Physical must be dated on or after January 1, 2026.

4. ☐ Current immunizations must be noted on the physical. (see Health Examination and Immunization Requirements)
   - Students without a physical examination who have a list of *currently required immunizations* will not be allowed to start on the first day of school.

5. ☐ Payment of Fees
   - Either payment in full at time of registration or confirmation of payment plan through Wilco Area Career Center Business Services Office.

Enrollment Form

Directions: Carefully read and complete each of the following sections. You are required to provide custodial information.

Person with Legal Custody of the Student

As initial proof of the person with legal custody of the student and with whom the student lives a copy of the student's Birth Certificate or court documents will be required for enrollment.

Identifying Information: *(To be completed by the person with legal custody of the student. Please print.)*

Your name			
Phone number(s)	Home:	Cell:	Work:
Current address	Address: City: State: Zip Code: Subdivision:		
Future Address (if under contract)	Address: City: State: Zip Code: Subdivision:		
Student's name		Student's Age	Re-enrollment? Yes ☐ No ☐
Relation to student	☐Mother ☐Father ☐Step-Mother ☐Step-Father ☐Aunt ☐Uncle ☐Guardian ☐Other:		

Student Registration – Contact Information

Student Information		
School District Student Resides:		
Student's Legal Name: (as listed on birth certificate-First, Middle, Last) First:	Middle:	Last:
Name Student Goes By:		
Date of Birth:	Gender: ☐Male ☐Female	Age:
Birthplace:	City:	State/Country:
Street Address:		
City:	State:	Zip Code:
Subdivision:	Home Phone #:	

Student Resides With (at address above): Contact #1	
Relationship ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father to Student: ☐ Aunt ☐ Uncle ☐ Guardian ☐ Other:	Legal Custody: ☐Yes ☐ No
Contact's Legal Name: (Legal First, Middle Initial, Last) First:	Middle: Last:
Home Phone Number:	Cell Phone Number:
Employer Name:	
Work Phone Number:	E-mail Address:
Preferred Language for School Written & Electronic Communication: ☐English ☐Spanish ☐Other:	

Student Resides With (at address above): Contact #2	
Relationship ☐ Mother ☐ Father ☐ Step-Mother ☐ Step-Father to Student: ☐ Aunt ☐ Uncle ☐ Guardian ☐ Other:	Legal Custody: ☐Yes ☐ No
Contact's Legal Name: (Legal First, Middle Initial, Last) First:	Middle: Last:
Home Phone Number:	Cell Phone Number:
Employer Name:	
Work Phone Number:	E-mail Address:
Preferred Language for School Written & Electronic Communication: ☐English ☐Spanish Other:	

Other Custodial Parent – Student Does Not Reside With	
Relationship ☐ Mother ☐Father ☐Step-Mother ☐Step-Father to Student: ☐Aunt ☐Uncle ☐Guardian Other:	Legal Custody: ☐Yes ☐ No
Contact's Legal Name: (Legal First, Middle Initial, Last) First: Middle: Last:	
Home Phone Number:	Cell Phone Number:
Employer Name:	
Work Phone Number:	E-mail Address:
Preferred Language for School Written & Electronic Communication: ☐English ☐Spanish Other:	

Emergency Contact #1			
Contact's Legal Name: (Legal First, Middle Initial, Last) First: Middle: Last:			
Relationship ☐ Mother ☐Father ☐Step-Mother ☐Step-Father to Student: ☐Aunt ☐Uncle ☐Guardian Other:			Legal Custody: ☐Yes ☐ No
Street Address:	City:	State:	Zip Code:
Home Phone Number:	Cell Phone Number:		
Emergency Contact #2			
Contact's Legal Name: (Legal First, Middle Initial, Last) First: Middle: Last:			
Relationship ☐ Mother ☐Father ☐Step-Mother ☐Step-Father to Student: ☐Aunt ☐Uncle ☐Guardian Other:			Legal Custody: ☐Yes ☐ No
Street Address:	City:	State:	Zip Code:
Home Phone Number:	Cell Phone Number:		
Emergency Contact #3			
Contact's Legal Name: (Legal First, Middle Initial, Last) First: Middle: Last:			
Relationship ☐ Mother ☐Father ☐Step-Mother ☐Step-Father to Student: ☐Aunt ☐Uncle ☐Guardian Other:			Legal Custody: ☐Yes ☐ No
Street Address:	City:	State:	Zip Code:
Home Phone Number:	Cell Phone Number:		

Phone Information Form

The Primary Contact Number will be used to call you every time we send a School Messenger call, regardless of the urgency of the message.

The Secondary Contact Number will be called at the same time as the Primary Number on calls where the message we are sending is of a more urgent or time sensitive nature to ensure that we get the call to you as soon as possible.

Please consider these numbers carefully and make an effort to keep us informed as soon as possible if either number changes for any reason.

Child 1: Last Name:_____ First Name:_____

Primary Contact Number: _____

Primary E-mail Contact: _____

Secondary Contact Number: _____

Secondary E-mail Contact: _____

Child 2: Last Name:_____ First Name:_____

Primary Contact Number: _____

Primary E-mail Contact: _____

Secondary Contact Number: _____

Secondary E-mail Contact: _____

Child 3: Last Name:_____ First Name:_____

Primary Contact Number: _____

Primary E-mail Contact: _____

Secondary Contact Number: _____

Secondary E-mail Contact: _____

Thank you for your assistance and please be sure to return this form as soon as possible.

Parent Agreement

I give my permission for the enrollment of my child, _____, in the Wilco Area Career Center Preschool and I agree the Wilco Preschool will not be responsible in case of sickness or injury of my child while in attendance at the preschool. I further understand that I am fully responsible for providing transportation for my child to and from the center.

I give my permission for my child to be photographed for school projects and activities that the preschool and/or the career center may conduct. This includes Wilco publications, displays, videos, Wilco's website, or articles placed in the newspaper.

I give my permission for my child to participate in the daily snack which is provided by the preschool, high school students, and/or parents. I will notify the preschool of any food allergies my child has.

I also understand the Wilco Preschool is not responsible for loss or damage to my child's belongings or property.

I agree to pay a monthly fee at the beginning of each month and will carry out the rules and regulations of the Wilco Area Career Center Preschool.

I further agree that in case of an accident or injury to my child, in the preschool or on the school grounds, emergency medical care may be given in the event that I cannot be contacted immediately.

Date

X _____

Parent/Guardian Signature

CHILD'S PERSONAL RECORD

What does your child say when he/she wishes to use the washroom?

Who has cared for your child other than the parents?

Does he/she need help in:

Dressing?

Washing hands?

Undressing?

Eating?

Toilet?

How does your child interact with:

Parents?

Brothers and Sisters?

Other children?

Other Adults?

Describe child's play experiences: (outdoors, with friends, favorite games and toys, etc.)

Has he/she had group play experiences?

Has he/she attended another preschool or day care?

Where?

What do you expect your child to gain from attending classes at Wilco Preschool?

Special Information: Please list any health, hearing, or vision issues, glasses, allergies, fears, etc.

Has your child completed any type of preschool screening or testing?

Does your child receive any special services, such as speech, therapy, etc.

If so, where?

Medication Authorization Form

1. Authorized Wilco Area Career Center personnel will administer medication during the school day only when it is absolutely necessary for a student's critical health and well-being. All medications, which include both PRESCRIPTION DRUGS and OVER-THE-COUNTER, to be taken during the school day will only be administered after the parent/guardian, and physician, Advanced Practice Nurse, or Physician Assistant completes the Wilco Area Career Center "Medication Authorization Form". The form is available from the building administration team in the Main Office. This form must be filled out at the beginning of each school year or when a new medication is to be given.

2. The first dosage of medication should not be given at school in case the student suffers an allergic or other adverse reaction.

3. Prescription Medication must be brought to school by a parent/guardian and must be in the original pharmaceutical container labeled with the student's name, name of medication, the exact dosage and all pertinent instructions. Over-the-Counter medication must be brought to school by a parent/guardian in its original unopened / sealed container with the student's name affixed to the container. If it is absolutely impossible for parents to bring the medication to school, we ask that students, upon their immediate arrival to school, turn the medication into the health office in a sealed envelope. Unused medication should be picked up by parent/guardian at the end of each school year. If the parent/guardian does not pick up the medication by the last day of school, the building administrative team will dispose of and document that medications were discarded. Medications will be discarded in the presence of a witness.

4. Medication will be stored in the school in a safe place. The student must come to the school's main office for his/her medicine. The school will strive to assist students to remember to come to the office to take his/her medication.

5. Students are prohibited from keeping any kind of medication in their possession while at school, except where a student is authorized to self-administer an epinephrine auto-injector (EpiPen®), diabetic care supplies, pancreatic enzymes, or asthma medication. Students must have the Emergency Medication Hold Harmless and Indemnity Form signed by their parents/guardian and physicians to keep their inhalers, diabetic care supplies, or epinephrine auto-injectors with them in school. In case of emergency or loss of these items, we recommend that these students also keep an additional inhaler, diabetic care supplies, or epinephrine auto-injector in the health office.

6. Acknowledging that occasionally a medication must be administered during the school day, a registered professional nurse, if available, shall administer the medication. If a nurse is unavailable, a building administrator or another staff member who volunteers may either:
    a. Supervise the self-administration of the medication; or
    b. Administer the medication himself/herself.

7. Medications will generally not be administered to students during field trips or other school-sponsored activities located away from the customary site of storage of the medication. In these situations, medication will only be administered to a student if absolutely necessary for the critical health and well-being of the student as documented in a student's individualized health care plan or Emergency Allergy Action Plan. Medication to be administered in these situations must be sent to school by a parent/guardian, in a pharmaceutical container labeled with the student's name, name of medication, dosage and all pertinent instructions. The administration protocol will be determined by the Wilco administrative staff.

Wilco Area Career Center and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration or self-administration of medication pursuant to these procedures.

Student Information		
Name:	DOB:	
Parent Phone Numbers		
Home Phone:	Work Phone:	Emergency Phone:

PARENT'S REQUEST FOR MEDICATION ADMINISTRATION

I hereby request that Wilco Area Career Center administer to my child during school hours, the drug(s) order by

Physician's Phone **REQUIRED:**

I have determined that the following medication(s) must be taken during school hours.

Enter each medication needed in a separate box below. Use an additional form if more than 4 medications are needed.

LICENSED PRESCRIBER'S ORDER FOR MEDICATION #1		*Only enter one of these*
Drug:	Dosage:	Time given or Frequency:
Side effects:	Diagnosis:	Start Date: End Date:
Physician's Signature:		

LICENSED PRESCRIBER'S ORDER FOR MEDICATION #2		*Only enter one of these*
Drug:	Dosage:	Time given or Frequency:
Side effects:	Diagnosis:	Start Date: End Date:
Physician's Signature:		

LICENSED PRESCRIBER'S ORDER FOR MEDICATION #3		*Only enter one of these*
Drug:	Dosage:	Time given or Frequency:
Side effects:	Diagnosis:	Start Date: End Date:
Physician's Signature:		

The physician's signature is **REQUIRED** on each medication listed above.
(All orders will expire on August 1st if no end date is specified)

X _____

Signature Parent/Guardian

X _____

Received by Nurse

Student Health History

Student Name:_____ Age:_____ School:_____

Sex: ☐Male ☐Female DOB:_____ Phone Number:_____

Doctor's Name:_____

(if you indicate YES for any category, please explain)

#	Concern	Yes or No	Explanation & Comments
1	Allergies	☐Yes ☐No	
	*Uses EpiPen	☐Yes ☐No	
2	Asthma	☐Yes ☐No	
	*Uses Inhaler	☐Yes ☐No	☐Rarely ☐Once daily ☐More than once daily ☐For Sports
	*Uses Inhaler at School	☐Yes ☐No	
3	Blood Disorders	☐Yes ☐No	
4	Daily Medications	☐Yes ☐No	
	*Names of Medications	At home	
	School Medications REQUIRE Medical Authorization Form	At school	
5	Diabetes	☐Yes ☐No	
6	Ear/Hearing Problems	☐Yes ☐No	
7	Glasses/Contacts	☐Yes ☐No	Last eye exam:_____
8	Eye/Vision Problems	☐Yes ☐No	
9	Heart Problems	☐Yes ☐No	
10	Hospitalizations	☐Yes ☐No	Age:_____
11	Mental Health Concerns	☐Yes ☐No	
12	Neurological Problems	☐Yes ☐No	
13	Physical Restrictions	☐Yes ☐No	
14	Seizures	☐Yes ☐No	
15	Serious Injuries	☐Yes ☐No	Age:_____
16	Surgery	☐Yes ☐No	Age:_____
17	Other	☐Yes ☐No	

I release this information to be share with appropriate school and emergency personnel for health and educational purposes.

X_____

Parent/Guardian Signature

Date:_____

HEALTH EXAMINATION & IMMUNIZATION REQUIREMENTS

Wilco Area Career Center welcomes you and your child as he/she begins preschool!

The Illinois School Code Sec 27-8 requires all incoming preschool students to have a health/physical examination with the required immunizations completed prior to the first day of school. **Incoming preschool students must use the State of Illinois Certificate of Child Health Examination form**

Immunizations must include:

Diphtheria/Pertussis/Tetanus (DPT/DTAP) – Four (4) doses, three doses by 1 year of age & one additional booster by 2nd Birthday

Polio (OPV/IPV) – Three (3) doses. Two doses by 1 year of age. One more dose by 2nd birthday

Measles/Mumps/Rubella (MMR) – One (1) dose on or after the 1st birthday

Varicella – One (1) dose on or after 1st birthday or a statement from physician verifying disease

Hemophilus influenzae type b (HIB)--per the ACIP HIB vaccination schedule

Pneumococcal Conjugate Vaccine (PCV) – per the ACIP PCV vaccination schedule

Hepatitis B – Three (3) doses. Third dose must have been administered on or after 6 months of age

Dates of ALL immunizations must be verified by a physician or healthcare provider. The Student Information (top of page 1) and Health History sections (top of page 2) must be fully completed and signed by the parent/legal guardian. The Physical Examination Requirements section (bottom of page 2) must be fully completed and signed by the physician, APN or PA, including the lead risk questionnaire and diabetes screening for all students in preschool.

If you have any questions, or your child has any specific health care needs such as diabetes, allergies, asthma, seizure disorder or medication that needs to be taken at school, please contact Mrs. Stephanie Perella (815) 838-6941 ext. 1031.

Please complete and return all original forms to Mrs. Stephanie Perella. All paperwork is due to Wilco Area Career Center by **August 1st**. Students not in compliance by the first day of school will be excluded from school until the required documentation is submitted to Mrs. Stephanie Perella.

State of Illinois
Certificate of Child Health Examination

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. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 Month	DOSE 1 Day	DOSE 1 Year	DOSE 2 Month	DOSE 2 Day	DOSE 2 Year	DOSE 3 Month	DOSE 3 Day	DOSE 3 Year	DOSE 4 Month	DOSE 4 Day	DOSE 4 Year	DOSE 5 Month	DOSE 5 Day	DOSE 5 Year	DOSE 6 Month	DOSE 6 Day	DOSE 6 Year
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																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles, Mumps, Rubella										Comments:								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify any immunizations administered and dates																		

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 (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) Month	Day	Year	**MUMPS Month	Day	Year	HEPATITIS B Month	Day	Year	VARICELLA Month	Day	Year

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies 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** _____

3. Laboratory Evidence of Immunity (check one) ☐ **Measles** * ☐ **Mumps** ** ☐ **Rubella** ☐ **Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.

**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

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) ☐ Yes ☐ No	List:		**MEDICATION** (List all prescribed or taken on a regular basis.) ☐ Yes ☐ No	List:	
Diagnosis of asthma?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ 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? ☐ No ☐ 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**		
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No		**Signature**		**Date**

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 ☐ No test needed ☐ Test performed — 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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm

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		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**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/Restriction

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** ☐ **Modified**

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

Address **Phone**

(COMPLETE BOTH PAGES)

Supply List

	Quantity	Item
☐	1 box	Kleenex Tissue
☐	1 box	Dry Erase Markers
☐	1 (4 pack)	Play dough
		Change of clothing in plastic bag to stay at school (socks, underwear, shirt, pants) *Please label all clothing with child's name and replace as the seasons change*

*Your child's teacher may have an additional list for you at the meet and greet. That list will contain other school supplies
Supplies "run out" during the school year. Please check with your child periodically to see if any need replacing

Wilco Preschool Goals

FOR THE CHILDREN'S INTELLECTUAL DEVELOPMENT:

To expand the children's basic concepts; to encourage their interest in learning with a variety of teaching methods; to increase the children's curiosity about their world; to help them solve various problems; to help them develop basic skills which will be helpful in their future school years; to improve their visual and auditory perception; to increase their imagination and verbal skills by encouraging them to tell stories and interpret pictures; to challenge their thinking with many new ideas.

FOR THE CHILDREN'S SOCIAL-EMOTIONAL DEVELOPMENT:

To help the children get along with others by developing a feeling of security in group situations; to understand themselves and to relate to others; to encourage successful social habits, self-control, consideration for others, sharing, fairness, and good manners. To provide the children with many opportunities for success; to value their ideas; to teach them to value themselves; to help them feel they belong to the group; to set reasonable limits and rules to follow; to provide many opportunities to express their feelings through art, music, talking, and moving; to promote a positive relationship with the other children and teachers; to accept their emotions with criticism; to strengthen their abilities in storytelling, painting, coloring, eye-hand coordination, perception, left to right progression, talking and movement so they feel a sense of pride; to maintain flexibility in the daily lesson that will meet the children's needs.

FOR THE CHILDREN'S PHYSICAL DEVELOPMENT:

To provide opportunities for the children to develop their bodies by using both large and small muscles; to develop the children's awareness of how their bodies move; to learn the names of their body parts; to develop coordination in hopping, skipping, galloping, jumping; to develop a sense of balance and rhythm; to promote overall good health and physical fitness.

FOR THE CHILDREN'S LANGUAGE DEVELOPMENT:

To provide opportunities to improve communication skills; to expand their vocabularies by learning new words and meanings; to use complex sentence structures; to understand correct word order; to begin to recognize written words and realize they convey meaning.

PRESCHOOL POLICIES

ILLNESS

If your child is unable to attend class, please let us know the reason so that we may keep accurate records.

Please keep your child home if he/she shows signs of illness. This will safeguard the health of your child and the health of the others.

If your child becomes ill in school, he/she will be isolated from the other children. You will be notified immediately so that you can plan for pick up as soon as possible.

If your child develops a communicable disease, please let us know at once so that we may alert the other parents.

EMERGENCY CANCELLATION OF SCHOOL

In extreme weather emergencies, notification concerning cancellation of classes, School Messenger will be utilized to notify families of school closures. Also, information will be posted on the Wilco website www.wilco.k12.il.us.

TUITION AND FEES

Registration fee is **non-refundable**.
The registration fee is not applied toward September tuition.

Tuition payments are due on the first of each month. **A $25.00 late fee will be added to a payment made after the 15th of the month. If payment is not received in full by the end of the month, the student will not be permitted to attend preschool until the payment is brought current; previous and current month's payment must be made for the student to be reinstated.**

Tuition payments will remain the same each month regardless of school cancellations, teacher institutes, family vacations or holidays.

Late Fee of $33.00 will be assessed for failure to pick up your child by 2:15 p.m.

Tuition may be paid online at www.wilco.k12.il.us Go to Online payments/Preschool. Visa or MasterCard are accepted.

Checks should be made payable to WILCO Area Career Center.