



# 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 15<sup>th</sup> 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 15<sup>th</sup> of month.

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

**PRE-K INSTRUCTOR:** Mrs. Stephanie Perella

**E-MAIL:** [sperella@wilcoacc.org](mailto:sperella@wilcoacc.org)



**SCAN QR TO REGISTER**

# 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.

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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age: [ ]
Birthplace: [ ]	City: [ ]	State/Country: [ ]
Street Address: [ ]		
City: [ ]	State: [ ]	Zip Code: [ ]
Subdivision: [ ]	Home Phone #: [ ]	
Student Resides With (at address above): Contact #1		
Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father to Student: <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Guardian <input type="checkbox"/>		Legal Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other: [ ]		
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:		
<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: [ ]		
Student Resides With (at address above): Contact #2		
Relationship <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Step-Father to Student: <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Guardian <input type="checkbox"/>		Legal Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other: [ ]		
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:		
<input type="checkbox"/> English <input type="checkbox"/> Spanish Other: [ ]		

## 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.*

## 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?

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: <input style="width: 90%;" type="text"/>	DOB: <input style="width: 90%;" type="text"/>	
Parent Phone Numbers		
Home Phone: <input style="width: 90%;" type="text"/>	Work Phone: <input style="width: 90%;" type="text"/>	Emergency Phone: <input style="width: 90%;" type="text"/>
<b>PARENT'S REQUEST FOR MEDICATION ADMINISTRATION</b> I hereby request that Wilco Area Career Center administer to my child during school hours, the drug(s) order by <input style="width: 150px;" type="text"/>		
Physician's Phone <b>REQUIRED</b> : <input style="width: 100%;" type="text"/>		

**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	<i>Only enter one of these</i>
Drug: <input style="width: 90%;" type="text"/>	Dosage: <input style="width: 90%;" type="text"/>
Side effects: <input style="width: 90%;" type="text"/>	Time given or Frequency: <input style="width: 90%;" type="text"/>
Diagnosis: <input style="width: 90%;" type="text"/>	Start Date: <input style="width: 90%;" type="text"/> End Date: <input style="width: 90%;" type="text"/>
Physician's Signature: <input style="width: 90%;" type="text"/>	

LICENSED PRESCRIBER'S ORDER FOR MEDICATION #2	<i>Only enter one of these</i>
Drug: <input style="width: 90%;" type="text"/>	Dosage: <input style="width: 90%;" type="text"/>
Side effects: <input style="width: 90%;" type="text"/>	Time given or Frequency: <input style="width: 90%;" type="text"/>
Diagnosis: <input style="width: 90%;" type="text"/>	Start Date: <input style="width: 90%;" type="text"/> End Date: <input style="width: 90%;" type="text"/>
Physician's Signature: <input style="width: 90%;" type="text"/>	

LICENSED PRESCRIBER'S ORDER FOR MEDICATION #3	<i>Only enter one of these</i>
Drug: <input style="width: 90%;" type="text"/>	Dosage: <input style="width: 90%;" type="text"/>
Side effects: <input style="width: 90%;" type="text"/>	Time given or Frequency: <input style="width: 90%;" type="text"/>
Diagnosis: <input style="width: 90%;" type="text"/>	Start Date: <input style="width: 90%;" type="text"/> End Date: <input style="width: 90%;" type="text"/>
Physician's Signature: <input style="width: 90%;" type="text"/>	

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

X  
 \_\_\_\_\_  
 Signature Parent/Guardian

X  
 \_\_\_\_\_  
 Received by Nurse

# 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 2<sup>nd</sup> Birthday

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

**Measles/Mumps/Rubella (MMR)** – One (1) dose on or after the 1<sup>st</sup> 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.

Last	First	Middle	Birth Date Month/Day/Year	Sex	School	Grade Level/ ID
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> <input type="checkbox"/> Yes <input type="checkbox"/> No List: <small>(Food, drug, insect, other)</small>	<b>MEDICATION</b> <input type="checkbox"/> Yes <input type="checkbox"/> No List: <small>(List all prescribed or taken on a regular basis.)</small>
Diagnosis of asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of function of one of paired organs? (eye/ear/kidney/testicle) <input type="checkbox"/> Yes <input type="checkbox"/> No
Child wakes during night coughing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalizations? When? What for? <input type="checkbox"/> Yes <input type="checkbox"/> No
Birth defects? <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery? (List all.) When? What for? <input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental delay? <input type="checkbox"/> Yes <input type="checkbox"/> No	Serious injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain. <input type="checkbox"/> Yes <input type="checkbox"/> No	TB skin test positive (past/present)? * <input type="checkbox"/> Yes <input type="checkbox"/> No *If yes, refer to local health department.
Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No	TB disease (past or present)? * <input type="checkbox"/> Yes <input type="checkbox"/> No
Head injury/Concussion/Passed out? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco use (type, frequency)? <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures? What are they like? <input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol/Drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problem/Shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family history of sudden death before age 50? (Cause?) <input type="checkbox"/> Yes <input type="checkbox"/> No
Heart murmur/High blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No	Eye/Vision problems? <input type="checkbox"/> No <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Last exam by eye doctor
Dizziness or chest pain with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Information may be shared with appropriate personnel for health and educational purposes.
Ear/Hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No	Parent/Guardian
Bone/Joint problem/injury/scoliosis? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		And any two of the following: Family History <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ethnic Minority <input type="checkbox"/> Yes <input type="checkbox"/> No		Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) <input type="checkbox"/> Yes <input type="checkbox"/> No At Risk <input type="checkbox"/> Yes <input type="checkbox"/> 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. [http://www.cdc.gov/tb/publications/factsheets/testing/TB\\_testing.htm](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

<b>SYSTEM REVIEW</b>	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		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> 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)

## 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.