

I _____ hereby certify that I have paid an annual, **NON-REFUNDABLE** registration fee of \$70 to Trinity Lutheran Preschool for (child's name) _____ for the 2025-2026 school year.

Signature of payer

Date

**TRINITY LUTHERAN
PRESCHOOL**
508 North Cedar Road
New Lenox, IL 60451
APPLICATION OF ADMISSION
2025/2026
Director: Taylor Miller
SCHOOL PHONE: 815-485-6973
or email tlcsecretary508@gmail.com

FOR OFFICE USE ONLY

___ 3 year old ___ 4 year old
___ MWF AM ___ sessions/week
___ MWF PM
___ T/TH AM

Child's Name _____ Phone _____

Nickname, if preferred _____ Email: _____

Address _____ City _____ Zip _____

Date of Birth _____ Place of Birth _____

Father/Guardian's Name _____ Phone _____

Address _____ City _____ Zip _____

Employer's Name and Address _____ Hours _____

Work Phone _____ Cell Phone _____ Pager _____

Mother's/Guardian's Name _____ Phone _____

Address _____ City _____ Zip _____

Employer's Name and Address _____ Hours _____

Work Phone _____ Cell Phone _____ Pager _____

Marital Status of Parents _____

Child's Physician's Name _____

Physician's Address _____ Phone _____

PERSONAL AND DEVELOPMENTAL HISTORY

My child is ___ right handed ___ left handed ___ not yet determined

Age at which child talked _____ walked _____

Toilet habits: Trained at what age? _____

Dressing habits: Partly _____ Entirely _____

List any fears: _____

Sleeping habits: Sleeps alone _____ Sleeps with _____
Naps, bedtime, etc. _____

Has your child had any serious injuries or illnesses? _____

Explain _____

What was the child's reaction to this? _____

What methods of discipline have you found to be the most effective?

Names and ages of other children in the home: _____

What activities does the child enjoy with Mom? _____

Dad? _____ Siblings? _____

Does the child play with others? ___ yes ___ No. If so what are the ages? _____

What type of play would you describe as your child's favorite? _____

Does your child attend church or Sunday school more than twice per month? _____

Where? _____

Does your child have any fears about God? _____

How did you learn about our preschool? _____

What do you hope your child learns in preschool? _____

TRINITY LUTHERAN PRESCHOOL DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGIN. OR SEX.

Signature of parent(s) _____

Date _____

Permission/Consent Forms – Trinity Lutheran Preschool

Child's Name _____

* Signatures of both custodial parents are required.

Photographs

I/we authorize Trinity Lutheran Preschool to take photographs of our child _____ that may be used for publicity purposes.

Date

Signature of Mother

Signature of Father

Emergency First Aid

I/we understand that the following first aid measures will be taken at Trinity Lutheran Preschool and that if further care is needed I will be notified.

Slight head injury: Apply ice, notify parent upon arrival.

Serious head injury: Apply ice, notify parent immediately.

Splinter: Wash with soap and water, remove if surface, bandage, and notify parent if deep.

Nose bleed: Apply cold compress, gently apply pressure to nose.

Cut or scratch, bites: Wash with soap and water, apply band-aid, report to parent.

Bruised, sprained, strained limbs: Parents will be notified if child indicates discomfort or inability to use limb.

Date

Signature of Mother

Signature of Father

Emergency Medical Care

This authorizes Trinity Lutheran Preschool to secure EMERGENCY medical care for

_____ when I/we cannot be immediately reached at the time of the emergency.
I/we will be responsible for the emergency medical charge upon receipt of the statement.

Date

Signature of Mother

Signature of Father

I/we authorize Trinity Lutheran Preschool to administer prescribed medicine to my child as specified in written instructions.

Date

Signature of Mother

Signature of Father

I/we understand that the tuition is due each month on the first day of class for which our child is registered unless written notification of withdrawal is in the hands of the director at least 2 weeks before payment is due.

Date

Signature of Mother

Signature of Father

Trips, Excursions, and Public Park Facilities

I/we authorize Trinity Lutheran Preschool to take _____ on walking trips, special excursions, and to nearby public park facilities. I/we understand that all such trips are under the supervision of the preschool director, that all health and safety precautions are taken in compliance with DCFS standards for licensure, and that I/we will be notified before each such outing.

Date Signature of Mother Signature of Father

Local Emergency Contacts other than Parent/Guardian:

	Name	Address	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

Persons Authorized to pick up a child:

	Name	Address	Phone
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

I/we understand that our child, _____ will not be released from preschool to anyone who has not been authorized in writing, and whose name is not on file at the preschool.

Date Signature of Mother Signature of Father

I/we understand that as a participant in the program of Trinity Lutheran Preschool our child will be included in activities of Christian instruction including Bible Stories, religious songs, and recitations.

Date Signature of Mother Signature of Father

DISCIPLINE POLICY OF TRINITY LUTHERAN PRESCHOOL

PHILOSOPHY

Discipline is the on-going process of helping children develop their controls so that they can manage their own behavior in socially approved/acceptable ways.

HOW DISCIPLINE WILL BE IMPLEMENTED BY THE STAFF

Appropriate discipline techniques used include:

Avoid problems by offering an organized, stimulating program	Modeling.
Reinforcement for positive behavior	Setting clear limits.
Redirection to a more acceptable behavior	Offering choices.
Ignoring negative behavior (when appropriate)	Acknowledging good behavior.
Time-out or removal of child from the area, for short periods of time (one minute per age of child)	
Including the child in resolution of the conflict	

The following discipline techniques are PROHIBITED:

Physical punishment	Screaming at the child, or ridiculing a child or the child's family
Withholding food	Blaming, teasing, insulting, name calling, or threatening the child
Withholding positive attention	

No child will be subjected to, under any circumstances, any form of corporal punishment. The childcare staff will never use abusive or profane language or deprive children of food, rest, or use of restrooms. Children will not be punished for toilet accidents.

HOW PARENTS WILL BE INVOLVED IN GUIDANCE PROCESS

The director will verbally notify the child's parent or a pattern of unacceptable behavior is noted.

As needed, the teacher will discuss with the parent(s) the child's behavior. If an unacceptable behavior occurs during the day or a behavior is uncharacteristic of the child, a behavior report will be completed, signed by the parent, and a copy will be retained in the child's file.

The director may request a formal conference with the parent(s).

If deemed necessary, the parent may be asked to pick up the child from the center and/or remove the child for the next business day.

HOW CHILDREN WILL BE INVOLVED IN THE PROCESS

Children will be aware of the classroom guidelines and will be reminded of the guidelines throughout the day.

Children will have a reasonable opportunity to resolve their own conflicts.

DISCHARGE POLICY

Any child who, after attempts have been made to meet the child's individual needs, demonstrates the inability to benefit from the type of care offered by the facility, or whose presence is detrimental to the group, shall be discharge from the facility.

I have read and understand the center's guidance and discipline policies.

Parent/Staff signature

Date



State of Illinois
Certificate of Child Health Examination

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



Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle	Month/Day/Year			
Address			Parent/Guardian	Telephone #	Home	Work
Street	City	Zip Code				

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)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> 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													Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade													
	R	L	R	L	R	L	R	L	R	L	R	L	
Vision													
Hearing													

Student's Name	Birth Date	Sex	School	Grade Level/ ID #
Last _____ First _____ Middle _____	Month/Day/ Year _____			

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	Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____		
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Parent/Guardian Signature _____		Date _____
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?	Yes	No			
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 <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/>				
Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
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 <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____				
Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>	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 Antagonist) <input type="checkbox"/> 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** (for one year) Yes No Limited

Print Name _____	(MD,DO, APN, PA) Signature _____	Date _____
Address _____	Phone _____	

(Complete both sides)