Hillsboro PreK Screening & Enrollment Process

Coffeen Early Childhood Center • 200 School Street • Coffeen, IL 62017 • (217)532-7822 • www.hillsboroschools.net/coffeenprek

Thank you for your interest in Hillsboro PreK! Please read through the requirements for PreK Screening & Enrollment, and fully complete and submit *all* required documents and forms prior to your child's screening appointment.

Required NOW for Screening & Enrollment

1. ASQ Cognition screening online @ **www.asqonline.com/family/510c9a** ONLINE
2. ASQ Social Emotional Screening @ **https://www.asqonline.com/family/33794b** ONLINE
3. **Enrollment Packet** (paper OR online)
4. **Verification of Family Income** (please *EMAIL a* picture of **1** of below or turn in a photocopy)
    - Proof of public benefits: WIC, SNAP, TANF, SSI, CCAP, or Medical Card (in parent's name)
    - DCFS Authorization Form
    - W2s (both parents if living in same home)
    - Tax Return (1st page of 1040...showing total gross income)
    - Pay stubs (2 most recent paystubs...from BOTH parents if living in same house)

*(Proof of income is now ***required*** by the Illinois State Board of Education for enrollment in Preschool For All classrooms. Students without income verification at screening will be placed on a waiting list & not eligible for enrollment until proof of income has been received.)

Required Documents before 1st day of student attendance *(please bring to screening if you have them!!)*

5. Copy of **Physical**
6. Copy of **Immunization Records**
7. Copy of **Lead Screening Results**
8. Copy of **Birth Certificate** *(from courthouse...NOT hospital footprints) or* **DCFS Authorization Form**

Screening will be held in person at COFFEEN SCHOOL. **Please bring the required & completed paperwork with you to screening.** Please arrive 5-10 minutes prior to your child's scheduled appointment time. Your appointment will last approximately 45 min to 1 hour. You will remain with your child throughout the entire screening process. They will be in a classroom with 2-3 other children to play and be observed. We ask that you not bring additional siblings/children to the screening please.

Drop-off or Mail To: Sarah VanMiddendorp; Coffeen Early Childhood Center; 200 School St.; Coffeen, IL 62017

Email: svanmiddendorp@hillsboroschools.net

Phone: 217-532-7822

Sincerely,

Sarah VanMiddendorp

Sarah VanMiddendorp
Hillsboro Early Childhood Program
Instructional Leader

Marci Gutierrez, Early Childhood Director
mgutierrez@hillsboroschools.net

Sarah VanMiddendorp, Instructional Leader
svanmiddendorp@hillsboroschools.net

Hillsboro PreK HCUSD#3 PreK Student Enrollment Form

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The information you provide on this form is strictly ***confidential***. It is important for placement & enrollment decisions.

Child's FULL Name:_____Preferred Name: _____ **Birthdate:** _____
First Middle Last

Child's Address: _____ **Gender:** M F
Street PO Box # City Zip Code

Mother/Guardian 1 Email address (required)**:** _____

Father/Guardian 2 Email address (required): _____

Has this child ever attended another school? Yes No ***If yes*, where:** _____

Active Duty Military? Yes_____ No_____ **Does this child have an Individualized Education Plan** (IEP)? Yes No

Mother's Name: _____**Age:** _____ **Highest Grade Completed or GED:** _____

Address if different than child:_____ Age when *1st* Child was born: _____

Employer: _____ Occupation: _____

Home Phone _____Cell Phone: _____Work Phone: _____

Father's name: _____**Age:**_____ **Highest Grade Completed or GED:**_____

Address if different than child:_____ Age when *1st* Child was born: _____

Employer:_____ Occupation:_____

Home Phone _____Cell Phone: _____Work Phone: _____

Please Circle Race: American Indian Asian Black Hispanic White Multi-Racial Other:_____

Are any other languages spoken in your home? Yes No If yes, which language _____

Is your child's primary language English? Yes No If no, primary language _____

Child Lives With:(circle one): Both Parents Father Mother Joint Custody Foster Parents Grandparents Other*

***LEGAL Guardian(s) if not parent:** _____

Emergency Contact Information: In order to safeguard your child in case of early dismissal, illness, or accident: If you do not have a phone or cannot be reached, whom shall we contact and where shall we send your child? ***(REQUIRED)***

Relative/Friend #1: _____ Relationship: _____ Phone:_____

Relative/Friend #2: _____ Relationship: _____ Phone:_____

Child's Doctor: _____ Doctor's Phone:_____

Hospital: _____ Hospital's Phone: _____

Does your child have insurance? (circle one) Medical Card Parent Work Insurance KidCare No Insurance

Have you noticed or reported to a doctor any of the following? (circle all that apply)

Asthma Epilepsy (chronic seizures) Heart trouble ADHD/Hyperactivity Diabetes Glasses Hearing Aid	Underweight/Overweight Frequent Headaches Nightmares Frequent stomach aches Diarrhea Thumb Sucking/Nail Biting Overtired	Rashes Nose bleeds Frequent ear infections Frequent sore throats Frequent fever Dental concerns/cavities	**Allergies:** (food/medicine/other) List/Explain:

Please list all medications being taken regularly:

1. Reason:

2. Reason:

3. Reason:

Does child have siblings **NOT** living in your home? No Yes Names/Ages:_____

Please list the name, age and relationship to your child of <u>ALL</u> people living in the child's home:

Name (First, Last)	Age	Relationship	Name (First, Last)	Age	Relationship
1.			4.		
2.			5.		
3.			6.		

<u>ANNUAL</u> family income. _____ /year **How many adults & children live on this income?** _____

<u>DOCUMENTATION of income providing today:</u>

W2 tax return 2 consecutive paychecks TANF SNAP CCAP WIC SSI Medical Card

Has anyone in your family ever been enrolled in Speech, Reading/Math, or other Special Education Services?

Please Circle: Yes No **If yes, who?** Sibling Half-Sibling Father Mother **Which Services?_____**

Birth Weight: _____ Was this child **premature** (circle one) Yes No If yes, how early? _____

Were there complications during birth? Yes No If yes, explain _____

Is it possible that this child was exposed to drugs or alcohol before birth? Yes No

Did the child's mother smoke during pregnancy? Yes No Are you currently pregnant? Yes No Due Date:_____

Has child had any serious illnesses, diseases, injuries or hospital stays? Yes No Please explain if yes: _____

_____

Has this child had a hearing exam? Yes No Where and results? _____

At what age did he/she begin to walk? (Give approximate age) _____

At what age did he/she begin to speak? (Give approximate age) First words_____ Sentences _____

Do you have any concerns about his/her speech? Yes No Explain _____

Does the child's family receive support or services from any of the following agencies:

_____EI/Early Intervention (Child & Family Connections)
_____ PI/Prevention Initiative (0-3/First Steps Program)
_____ Learning Express (ROE 0-3 program)
_____ Salvation Army or Food Pantry Assistance
_____ Foster Care: Past current
_____ DCFS - Department of Child & Family Services
Circle: Past Open Case

____ Medical Card
____ TANF (Temporary Assistance for Needy Families)
____ CCAP (Child Care Assistance Program)
____ SNAP (Supplemental Nutrition Assistance Program)
____ WIC (Women, Infants, & Children)
____ SSI (Social Security Insurance)

Has anything happened that may influence your child's social, emotional or physical development? _____

_____

Is your family currently experiencing any of the following:

____Crime Involvement/Prison/Probation ____Drug/Alcohol Use

____Mental Health Issues
____Death of parent or sibling of the child
____Marital or Domestic Problems
____Homelessness or living with friend/relative to support basic needs
____Serious Health Concerns of a parent or sibling
____Difficulty getting basic needs (food, housing, transportation, etc.)
____Permanent or long term separation from parent or sibling
____Unemployment

Do you feel your child learns slowly or is developing differently than other children his/her age? Yes No _____

_____

Please briefly describe your child and any **concerns** you might have about or for him/her.

_____

Consent of Parent/Guardian: I agree to the release of health information on my child to appropriate school or health authorities and to Medicaid as needed for reimbursement

Name of Person Completing Interview (**print**): _____Relationship to Child: _____

Signature of Person Completing Interview: _____ Date: _____

HILLSBORO COMMUNITY UNIT SCHOOL DISTRICT #3

McKinney-Vento Act

Student/Family Questionnaire

Your child may be eligible for additional services through the McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

1. Presently, are you and/or your family in any of the following situations? **CIRCLE YES OR NO**

YES / NO Living with relatives or others due to lack of housing (doubled-up)
YES / NO Staying in a shelter
YES / NO Temporarily living in a Motel/hotel due to loss of housing, economic hardship or similar reason
YES / NO Living in a car, park, campground, abandoned building or similar substandard housing
YES / NO Unknown nightly residence (non-permanent)

IF YOU ANSWERED NO TO ALL OF THE ABOVE, DO NOT COMPLETE THE REMAINDER OF THIS FORM

Fill in the names of the students that the above information pertains to:

Student First Name	Student Last Name	D.O.B.	Grade	School Name

I certify that according to information provided above, the student(s) listed meet the definition of "Homeless" as stated in the McKinney-Vento Homeless Assistance Act.

Print Parent/Guardian Name Signature Date

Hillsboro PreK Screening Interview

1. Has your child been **hospitalized** for anything since birth?
2. Does your child have asthma or any ongoing **medical conditions**?
3. Does your child have any **food allergies**?
4. Is your child **potty trained**?
   (*Students do **NOT** have to be potty trained to be enrolled in our PreK)
5. Does your child have a regular **bedtime**?
6. Do you have any concerns about your child's **sleep**?
7. Do you have any concerns about your child's **nutrition**?
   (picky eater, picky about textures, fruits, vegetables, etc.?)
8. Are there any concerns with your child's **dental health** at this time? (cavities, pain, dental surgeries, etc.)
9. Do you **brush your child's teeth** 2x/day?
10. Does your child currently use a **pacifier or bottle**?
11. Is it a challenge to take your child out in **public places** like the grocery store or restaurant?
12. Is your child able to **use sentences** to tell you about a story about something that happened when they weren't with you?
13. Are friends/family members able to easily understand your child's **speech**?
14. Do you have any concerns about your child or their development that you want us to be aware of? If so, what?

Goals:

What are the **social and/or educational goals** you have in mind for your child's time in Pre-K?

What goals do you have for yourself as a parent or family in which we could provide support? (ex. bedtime routines, potty training, behavior strategies, healthy meals, reading with your child, making time to "play" with your child, seeking employment, finding affordable housing/transportation, meeting basic needs, etc.)

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Initials Date

Hillsboro PreK Permissions

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Screening and Testing

☐ parent initial Yes, my child may participate in the district-wide screening to identify possible developmental delays in cognition, speech/language, social-emotional, vision, or hearing. I also agree that their developmental progress in these areas can be monitored throughout the school year.

Field Trips

☐ parent initial Yes, my child may attend field trips during their enrollment in PreK. I understand that this may include riding a school bus, or walking to and from a local site to be visited. I also understand that I am giving permission for my child to attend field trips for the entire school year, and will not sign a consent each time a trip is taken.

☐ parent initial No, my child may not attend field trips. Please inform me of when trips are and I will keep him/her home from school on those days.

Lending Library

☐ parent initial Yes, my child may check out books, toys, or other age appropriate materials when available. I agree to return these items to the best of my ability.

☐ parent initial No, my child may not check out materials from the school lending library.

Internet Access

☐ parent initial Yes, I am aware that Hillsboro District #3 has internet access in the school buildings. I understand that it is available in my child's classroom as an educational tool, with the supervision of their teacher or assistant.

Photo and Video Usage

☐ parent initial Yes, I consent that photos and videos of my child taken at school or on field trips can appear in newspapers, school publications, or on the school website.

☐ parent initial **No**, photos or video of my child **cannot** be used outside of the classroom.

☐ parent initial Photos or video of my child **can** appear in newspapers, school publications, or on the school website **but ONLY WITHOUT THEIR NAME** connected to the photo or video.

I have read all of the information above, and initialed those I give consent for.

_____ _____ _____

Child's Name | parent/guardian signature | date

Hillsboro PreK Transportation

Child's Name:

**Class session & teacher preferences are* NOT *guaranteed.*

How do you plan for your child to get to school

❑ **PT:** I plan to provide transportation

❑ **Bus:** My child will ride the bus

Teacher Preference (optional) _____

Which Site & session do you *prefer**

❑ **Coffeen Early Childhood Center**
- ❑ AM Class
- ❑ PM Class

❑ **HCCDC** (daycare site)--Full Day/No transportation

AM CLASS (8:15-10:50 a.m.)

Primary PICK-UP Before School

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Alternate PICK-UP (optional)

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Primary DROP-OFF After School:

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Alternate DROP-OFF (optional)

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

PM CLASS (11:50 a.m. - 2:30 p.m.)

Primary PICK-UP Before School

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Alternate PICK-UP (optional)

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Primary DROP-OFF After School:

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Alternate DROP-OFF (optional)

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Hillsboro PreK

Friday Class Selection

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Hillsboro PreK offers classes Monday through Friday*, with bussing offered *Monday through Thursday*. **No bussing is provided on Fridays**. Families choosing to send their child to school on Fridays must provide their own transportation to and from school. PreK is only offered on Friday **MORNINGS** (but offered to both a.m. and p.m. students). We understand that transportation may be a hardship for some families financially or due to childcare. Therefore, *enrolling for Friday Class is not required*. However, in order for us to plan, we do ask families to make a selection for their child to attend 4 days (Monday -Thursday) or 5 days (Monday - Friday). **Children signed up for Fridays will be expected to have regular attendance each week**. Please indicate your selection below. (*Bussing IS provided on Fridays for students with full IEP services.*)

*Children attending class on Fridays are likely to be in a classroom with different teachers & different classmates than they are with Monday - Thursday due to lower enrollment on Fridays & blending of classes.

Students who do NOT have an IEP (Special Education Services):

_____ **Yes,** my child will attend class on Friday Mornings, and we will provide transportation to and from school. **Drop-off at 8:15 a.m.; Pick-up at 10:50 a.m.**

_____ **NO,** my child will not be attending class on Fridays. (Please indicate reason(s) below.)

____ We are unable to provide transportation due to babysitting.

____ Providing transportation is a financial hardship for my family at this time.

____ I prefer that my child only attend school 4 days per week at this age.

Students with IEPs (Special Education Services):

____ **YES**, my child has an IEP and WILL attend class on Fridays.

____ My child **will** ride the school bus on Fridays.

____ My child ***will NOT*** ride the bus on Fridays. We will provide our own transportation.

____ **NO**, my child has an IEP, but we are choosing NOT to have them attend on Fridays this year.

Child's Name: _____ Teacher: _____

Parent Signature: _____ Date: _____

State of Illinois

Certificate of Child Health Examination

Student's Name (Last, First, Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address, City, ZIP Code	Parent/Guardian	Telephone (home/work)

HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	☐ Yes ☐ No	**List:**	**MEDICATION** (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		Hospitalization? 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 disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
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				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Ear/Hearing problems?	☐ Yes ☐ No	
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No	

☐ Dental ☐ Brace ☐ Bridge ☐ Plate ☐ Other

Additional Information:

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 MO DA YR**	**DOSE 2 MO DA YR**	**DOSE 3 MO DA YR**	**DOSE 4 MO DA YR**	**DOSE 5 MO DA YR**	**DOSE 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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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 _____

Student's Name (Last / First / Middle)	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

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) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official which 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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

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

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ 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 aged 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.

☐ 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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/
Urinalysis			Social and Emotional Screening		☐ Completed ☐ A
Sickle Cell (when indicated			Other:		N/

A

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐	Eyes		Endocrine	☐
Throat	☐	Mouth/Dental		Gastrointestinal	☐
Cardiovascular/HTN	☐	Respiratory	Screening	Genito-Urinary	☐ LMP:
Currently Prescribed	☐	Asthma	Result:	Neurological	☐
Medication:	☐		Screening	Musculoskeletal	☐
	☐		Result:	Spinal Exam	☐
	☐			Nutritional Status	☐
	☐			Mental Health	☐
	☐		☐ Diagnosis of Asthma	Other	☐

☐ Quick-relief medication (e.g., Short Acting Beta Agonist)
☐ Controller medication (e.g., inhaled corticosteroid)

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 ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone