

## St. Paul Lutheran School Registration Payment Agreement - 2023-2024

Parent Name(s) \_\_\_\_\_ Date \_\_\_\_\_

Billing Address \_\_\_\_\_

Father SS Number \_\_\_\_\_ Mother SS Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_ Email Address \_\_\_\_\_

Church Affiliation \_\_\_\_\_

### Preschool Tuition\*

	NAME	BIRTHDATE	AMOUNT
<input type="checkbox"/>	PS 3 AM - \$750	_____	_____
<input type="checkbox"/>	PS3 PM - \$750	_____	_____
<input type="checkbox"/>	PS4 AM - \$1,100	_____	_____
<input type="checkbox"/>	PS4 PM - \$1,100	_____	_____
<input type="checkbox"/>	PS Full Day - \$1,700	_____	_____
<input type="checkbox"/>	Registration - \$75	_____	_____
	<i>(Registration Fee Non-Refundable)</i>		
		<b>Preschool Subtotal</b>	_____

### K-8 Tuition\*

	NAME	GRADE	BIRTHDATE	AMOUNT
<input type="checkbox"/>	Member - \$1,422	_____	_____	_____
<input type="checkbox"/>	Child #2 - \$1,137	_____	_____	_____
<input type="checkbox"/>	Child #3 - \$829	_____	_____	_____
<input type="checkbox"/>	Child #4 - \$829	_____	_____	_____
<input type="checkbox"/>	Non-Member - \$2,841	_____	_____	_____
<input type="checkbox"/>	Child #2 - \$2,558	_____	_____	_____
<input type="checkbox"/>	Child #3 - \$2,273	_____	_____	_____
<input type="checkbox"/>	Child #4 - \$2,273	_____	_____	_____
				<b>K-8 Tuition Subtotal</b>

### K-8 Fees (non-refundable)

<input type="checkbox"/>	Registration - \$300 . . . . .	_____
<input type="checkbox"/>	Technology Fee - \$100 . . . . .	_____
<input type="checkbox"/>	Assembly Fee - \$10 . . . . .	_____
<input type="checkbox"/>	Payment Plan Fee - \$60 . . . . .	_____
<input type="checkbox"/>	Scholastic News (Kdg) - \$9 . . . . .	_____
<input type="checkbox"/>	Scholastic News (Grades 1-2) - \$8 . . . . .	_____
<input type="checkbox"/>	Band Book (Grades 5-6) - \$10 . . . . .	_____
<input type="checkbox"/>	Catechism (Grades 7-8) - \$20 . . . . .	_____
<input type="checkbox"/>	Athletic Fee - \$50 . . . . .	_____
	<i>Fees are assessed per each student enrolled.</i>	
		<b>Fees Subtotal</b>

Notes and/or Comments:

<b>TOTAL</b>	_____
(-) Gifts	_____
(-) Payments	_____
<b>GRAND TOTAL (balance due)</b>	_____

\* Tuition is pro-rated if child is withdrawn.

**Payment Plans (initial preferred option)**

- Option 1:** Pay in full via any payment method.
- Option 2:** Pay over 10 months (August through May) - ACH or credit card on file.
  - \* Requires monthly installments of \$ \_\_\_\_\_ per month.
  - \* We will charge your credit card or debit ACH bank draft on the 10th of each month regardless if the 10th falls on a weekend or holiday.
  - \* Late fees of 3% or bank fee of \$25 apply if credit card is declined or bank returns check.

**Certification (initial each box)**

- I understand and agree that I am responsible for all tuition and fees assessed per this schedule as indicated above.
- I understand and agree that I am responsible for all fees incurred due to declined credit cards or checks returned from the bank. Minimum charge is \$25.
- I understand and agree that I am responsible for additional fees should this account go to collections due to non-payment of account.

~Notice~  
Accounts are forwarded to the collection agency on May 11, 2024 (Option 2) if not paid in full.  
\*\*Accounts in PRIOR Collections MUST use Option 1 upon registration\*\*

\_\_\_\_\_  
Parent or Guardian - *Signature*

\_\_\_\_\_  
Parent or Guardian - *Signature*

\_\_\_\_\_  
Parent or Guardian - *Printed*

\_\_\_\_\_  
Parent or Guardian - *Printed*

# PHOTO PERMISSON FORM PRESCHOOL

Dear Parents/Guardians,

From time to time we would like to take photos of students participating in a variety of activities. We would like to feel free to publish them in the school or church newsletter or display them around school. If you would be willing to allow us to do this, please sign the permission slip below. If you do not I give your child permission, they will need to be left out of photographs.

I hereby give permission to St. Paul Lutheran School to photograph my child(ren) and to use that photograph in school or church publications, in a local and area newspapers, or in school promotional projects during the \_\_\_\_\_ school year as deemed appropriate by St. Paul Staff. This includes still photography as well as video.

Child(ren)'s Name \_\_\_\_\_

Parent

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Preschool Field Trip Permission Form

Parents and Guardians,

During the \_\_\_\_\_ school year, each week, we will be doing walking trips to the Church sanctuary for Chapel, St. Paul school library to check out books, or to other classrooms in the building.

\_\_\_\_\_ has my permission to

(Child's Name)

participate in local field trips with His Little Lambs  
Preschool

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

# HEALTH APPRAISAL

Dear Parent or Guardian: The following information is requested so that the school can work with the parent to meet the physical, intellectual and emotional needs of the child. Fill out the information requested in Section I. Section III may be certified by the transcription of information from the certificate of immunization. The remaining sections are to be completed by a doctor, nurse and dentist. **(BE SURE TO BRING YOUR CHILD'S IMMUNIZATION RECORDS TO THE EXAMINATION.)**

## PERSONAL

CHILD'S NAME (Last, First, Middle)	DATE OF BIRTH (mm/dd/yy) / /
ADDRESS (Number & Street) (City) (ZIP Code) MI	TODAY'S DATE (mm/dd/yy) / /
PARENT/GUARDIAN (Last, First, Middle)	HOME TELEPHONE NUMBER ( )
ADDRESS (Number & Street) (City) (ZIP Code) MI	WORK TELEPHONE NUMBER ( )

## SECTION I - HEALTH HISTORY

<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 10%; text-align: center;">Yes</td> <td style="width: 10%; text-align: center;">No</td> <td style="width: 10%; text-align: center;">Resolved</td> <td style="width: 70%;"><b># Is your child having any of the problems listed below?</b></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>1 Allergies or Reactions (for example, food, medication or other)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>2 Hay Fever, Asthma, or Wheezing</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>3 Eczema or Frequent Skin Rashes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>4 Convulsions/Seizures</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>5 Heart Trouble</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>6 Diabetes</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>7 Frequent Colds, Sore Throats, Earaches (4 or more per year)</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>8 Trouble with Passing Urine or Bowel Movements</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>9 Shortness of Breath</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>10 Speech Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>11 Menstrual Problems</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>12 Dental Problems: Date of Last Exam / /</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Other (please describe): _____</td> </tr> <tr> <td colspan="4" style="padding-top: 10px;"><input type="checkbox"/> <input type="checkbox"/> Does your child take any medication(s) regularly?</td> </tr> <tr> <td colspan="4">Reason for Medication _____</td> </tr> <tr> <td colspan="4" style="text-align: center;">/ /</td> </tr> <tr> <td colspan="3" style="text-align: center;"><i>Parent/Guardian Signature</i></td> <td style="text-align: center;">Date</td> </tr> </table>	Yes	No	Resolved	<b># Is your child having any of the problems listed below?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1 Allergies or Reactions (for example, food, medication or other)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2 Hay Fever, Asthma, or Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3 Eczema or Frequent Skin Rashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4 Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	5 Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	7 Frequent Colds, Sore Throats, Earaches (4 or more per year)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8 Trouble with Passing Urine or Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	9 Shortness of Breath	<input type="checkbox"/>	<input 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Reason for Medication _____				/ /				<i>Parent/Guardian Signature</i>			Date	<p><b>Birth History:</b></p> <p>Are there any current or past diagnosis(es) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please describe:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>If yes, list medications:</p> <p>_____</p> <p>_____</p> <p>Was the health history reviewed by a health professional? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Examiner's Initials:</i> _____</p>
Yes	No	Resolved	<b># Is your child having any of the problems listed below?</b>																																																																						
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## SECTION II - PHYSICAL EXAMINATION, INSPECTION, TESTS AND MEASUREMENTS

Required for Child Care and Head Start / Early Head Start

### Tests and Measurements

No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care	No	Yes	Was child tested for:	Test results:	Normal	Referred	Under Care
<input type="checkbox"/>	<input type="checkbox"/>	VISION Date: / /	Visual Acuity				<input type="checkbox"/>	<input type="checkbox"/>	HEIGHT & WEIGHT	Height			
			Muscle Imbalance							Weight			
			Other:							Other:			
<input type="checkbox"/>	<input type="checkbox"/>	HEARING Date: / /	Audiometer				<input type="checkbox"/>	<input type="checkbox"/>	HEMOGLOBIN / HEMATOCRIT	Reading: →			
			Other:							Other:			
<input type="checkbox"/>	<input type="checkbox"/>	URINALYSIS Date: / /	Sugar				<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULIN Date: / /	Type:			
			Albumin							Neg. <input type="checkbox"/> Pcs.: <input type="checkbox"/>			
			Microscopic							mm			
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD LEAD LEVEL Date: / /	Level _____ ug/dl				<b>NOTE:</b> Blood lead level required for all children enrolled in Medicaid must be tested at one and two years of age, or once between three and six years of age if not previously tested. All children under age six living in high-risk areas should be tested at the same intervals as listed above.						
			Other:										

### Examinations and/or Inspections

Essential Findings Deviating from Normal:	

**SECTION III - IMMUNIZATIONS**

Statements such as "UP-TO-DATE" or "COMPLETE" will not be accepted. Admission to school may be denied on the basis of this information.\*

VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY		VACCINES (Circle Type)	DATE ADMINISTERED MM/DD/YYYY	
Hepatitis B (HepB)	1	3	Hepatitis A (HepA)	1	2
	2		Influenza (IIV/LAIV)	1	3
				2	4
DTaP/DTP/DT/Td	1	4	Meningococcal (MCV4 / MPSV4)	1	2
	2	5	Human Papillomavirus (HPV9/HPV4/HPV2)	1	3
	3	6		2	
Tdap	1		OTHER Vaccines Specify Date & Type	Type of Vaccine(s)	Date of Vaccine(s)
Haemophilus Influenzae type b (HIB)	1	3		1	
	2	4		2	
Polio (IPV/OPV)	1	3		3	
	2	4	<i>Indicate and attach physician diagnosis or laboratory evidence of immunity as applicable</i>		
Pneumococcal Conjugate (PCV7/PCV13)	1	3	*NOTE: According to Public Act 368 of 1978, any child enrolling in a Michigan school for the first time must be adequately immunized, vision tested and hearing tested. Exemptions to these requirements are granted for medical, religious and other objections, provided that the waiver forms are properly prepared, signed and delivered to school administrators. Forms for these exemptions are available at your provider office for medical waiver forms and through your local health department for nonmedical waiver forms.		
	2	4			
Rotavirus (RV1/RV5)	1	3	Parent/Guardian refused immunizations: <input type="checkbox"/>		
	2				
Measles, Mumps, Rubella (MMR)	1	2			
Varicella (Chickenpox)	1	2			
History of Chickenpox Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date: _____					
I certify that the immunization dates are true to the best of my knowledge					
_____ Health Professional's Signature			_____ Title		_____ Date

		<b>SECTION IV - RECOMMENDATIONS</b> (Required for Child Care and Head Start/Early Head Start)
No	Yes	Is there any defect of vision, hearing or other condition for which the school could help by seating or other actions? If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Should the child's activity be restricted because of any physical defect or illness? If yes, check and explain degree of restriction(s): <input type="checkbox"/> Classroom <input type="checkbox"/> Playground <input type="checkbox"/> Gymnasium <input type="checkbox"/> Swimming Pool <input type="checkbox"/> Competitive Sports <input type="checkbox"/> Other
<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Recommendations _____ _____		

<b>SECTION V - DENTAL EXAMINATION AND RECOMMENDATIONS (OPTIONAL)</b>
I have examined _____'s teeth. As a result of this examination, my recommendation for treatment is: _____ child's name
_____ Dentist's Signature
_____ Date

<b>PHYSICIAN'S SIGNATURE</b>			
_____ Examiner's Signature	_____ Date	_____ Examiner's Name (Print or Type)	_____ Degree or License
_____ Number & Street	_____ City	_____ MI	_____ ZIP Code (_____) Telephone

Information required for:

**Early On** - Hearing and Vision Status; Diagnosis; Health Status

**Child Care Licensing** - Physical Exam, Restrictions, Immunizations

**Head Start/Early Head Start** - Determination that child is up-to-date on a schedule of age-appropriate preventive and primary health care, including medical, dental, and mental health. The schedule must incorporate the well-child care visit required by EPSDT and the latest immunizations schedule recommended by the Centers for Disease Control and Prevention, State, tribal, and local authorities. An EPSDT well-child exam includes height, weight, and blood tests for anemia at regular intervals based on age.

Developed in Cooperation with the Department of Health and Human Services, Education, Michigan American Association of Pediatrics, Early Childhood Investment Corporation, Child Care Licensing, Head Start, Michigan State Medical Society, Michigan Association of Osteopathic Physicians and Surgeons.

# CHILD INFORMATION RECORD

State of Michigan - Department of Licensing and Regulatory Affairs - Child Care Licensing Bureau

Instructions: Unless otherwise indicated, all requested information must be provided. If the information is not known or does not apply "unknown" or "none" is the required response. A blank field, a line through a field or "N/A" are not acceptable responses.

<b>For Provider Use Only:</b>	Date of Admission	Date of Discharge
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Name of Child (Last, First, Middle Initial)			Child's Date of Birth		
Address (Number and Street, Building/Apartment Number)			City	State	Zip Code
Parent/Legal Guardian's Name		Home Phone (    )	Parent/Legal Guardian's Name (Optional)		Home Phone (    )
Home Address (if not child's address)		Cell Phone (    )	Home Address (if not child's address)		Cell Phone (    )
City	State	Zip Code	City	State	Zip Code
Email Address (optional)			Email Address		
Employer Name		Work Phone (    )	Employer Name		Work Phone (    )
Name of Child's Physician or Health Clinic			Physician's or Health Clinic's Phone Number (    )		
Hospital Preferred for Emergency Treatment (optional)					

Allergies, Special Needs and Special Instructions (Attach additional sheets, if necessary.)

**Emergency Contact & Release of Child:** List all individuals, including parents/legal guardians, in order of preference, to be contacted in an emergency. If possible, include at least one person other than the parents/legal guardians to be contacted in an emergency and to whom the child can be released. The second phone number column can be left blank. (If more individuals, attach additional sheets.)

1.	(    )	(    )
2.	(    )	(    )
3.	(    )	(    )

**Release of Child Only:** List all individuals, other than the parents/legal guardians, to whom the child may be released. (If more individuals, attach additional sheets.)

1.	(    )	2.	(    )
3.	(    )	4.	(    )

**Parent/Legal Guardian Initials:**

\_\_\_\_\_ I give permission to \_\_\_\_\_, licensed by the Department of Licensing and Regulatory Affairs to secure emergency medical treatment for the above named minor child while in care.

I certify that I accurately completed this form and if anything changes, I will notify the provider by updating this form.

Signature of Parent or Guardian \_\_\_\_\_ Date Signed \_\_\_\_\_

Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials	Date Card Reviewed	Parent or Legal Guardian Initials

LARA is an equal opportunity employer/program.

AUTHORITY: 1973 PA 116  
COMPLETION Required  
PENALTY: Rule Violation Citation.

**WRITTEN INFORMATION PACKET DOCUMENTATION**  
Michigan Department of Licensing and Regulatory Affairs  
Child Care Licensing Bureau

Child(ren)'s Name(s) (Last, First)	Facility's Name and License Number <b>His Little Lambs</b>
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A written information packet has been provided at the time of enrollment. The packet included all the following information (R 400 3146 ; 1-2)

- Criteria for admission and withdrawal
- Schedule of operation, denoting hours, days, and holidays during which the center is open, and services are provided
- Fee policy
- Discipline policy
- Food service program
- Program philosophy
- Typical daily routine
- Parent notification plan for accidents, injuries, incidents, and illnesses
- Transportation policy, if applicable
- Medication policy
- Exclusion policy for child illnesses
- Notice of the availability of the center's licensing notebook

The center keeps a licensing notebook containing a summary sheet, all licensing inspections and special investigation reports, and related corrective action plans for the last 5 years. The licensing notebook is available to parents/guardians during regular business hours. Reports from at least the past three years are available at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare)

The center does not keep a licensing notebook, but internet is available onsite. Reports from at least the last three years are available at [www.michigan.gov/michildcare](http://www.michigan.gov/michildcare)

- Other \_\_\_\_\_

I certify that I received all of the above items

Parent/Guardian Signature	Date
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**Note:** A single CCL-340 form may be used for all children in the same family.

LARA is an equal opportunity employer/program

## Preschool Supply List

2 rolls of paper towels

2 boxes of tissues

1 box of Gallon size bags

1 box of quart or sandwich size bags

1 pack of washable markers

1 pack of colored pencils

2 pack of dry erase markers

1 pack of Purple Elmer's glue sticks

An extra set of clothing in a Ziploc bag in their backpack (shirt, underwear, pants, socks).



Child's name \_\_\_\_\_

Date \_\_\_\_\_ Checklist completed by \_\_\_\_\_

Please place a check in the appropriate column.

Yes	No	Preschool
		Makes activity choices without help
		Eats, sleeps, toilets without fuss away from home
		Takes care of bathroom needs – wipes and flushes & remembers to wash & dry hands
		Handles sudden change with control
		Can express anger in words rather than actions
		Does not withdraw from other excessively
		Plays by self, next to others and/or with others
		Shows concern for others
		Shares things with others
		Takes turns/waits for turn without fuss
		Is able to say "I'm sorry" when something wrong has been done
		Helps others
		Runs with control over direction and speed
		Shows hand preference (which is _____ )
		Uses drawing/writing tools with some control
		Uses scissors with control
		Uses glue with some control
		Recognizes some basic geometric shapes – circle, square, triangle ...
		Recognizes colors – red, green, blue, yellow, black, white ...
		Recognizes differences in size
		Attempts to count to ten
		Attempts to count objects
		Recalls words to song or chant (example: "Jesus Loves Me")
		Speaks confidently
		Speaks clearly enough to be understood/speaks in sentences
		Takes part in conversations with others
		Asks questions & responds with proper word order
		Will ask for help when it is needed
		Knows full name
		Prints letters of first name (only 4's)
		Know some alphabet letters
		Pays attention to a short story when it is read/answers questions about the story
		Remembers simple instructions and is able to carry out task after being told once
		Is able to put together a simple puzzle
		Prays with the family at meals
		Prays with parents and/or sibling at bedtime
		Has devotions with family
		Attend worship services with family



# Parent Questionnaire

My child's name/nickname \_\_\_\_\_

Parent(s) name(s) \_\_\_\_\_

Best way to contact me: (please fill out each line, and check all boxes that apply)

Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Note sent home

Please list any allergies your child has: \_\_\_\_\_

What are some of your child's special interests, hobbies, and skills? \_\_\_\_\_

Please list the goals you have for your child this year: \_\_\_\_\_

What are your child's strengths? \_\_\_\_\_

What are some things your child needs to work on? \_\_\_\_\_

How can I help your child succeed this year? \_\_\_\_\_

Is there anything else you'd like to share? \_\_\_\_\_

I look forward to working with you to help your child have the best year ever!

# A Parent's Guide

## *to preparing your child for preschool*

Starting preschool is such an exciting and momentous occasion! When children turn 3-years-old, they are no longer toddlers. They are "big kids" who may be ready to start preschool. As parents, we can help our children prepare for this next big step by doing these 5 things.

### READ

**1** If we were only allowed to give one piece of advice to parents it would be, "Read to your child." Read every day. Have books in every room, in your purse, and in the car. Read favorite books so often that you and your child have them memorized. Visit the library often.

### TALK

**2** Developing your child's oral language skills is a crucial part of preparing her for preschool. Turn off the movie in the car and engage your child in a discussion about the world around her. Ask questions. Talk about nature, and colors, and letters, and feelings. Put down your phone and listen when your child talks to you. Encourage your child to make eye contact and greet others with a "Hello" and a "Good Bye."

### PLAY

**3** Spend time every day on the floor playing with your child. Encourage pretend play and role playing. Get messy! Laugh and have fun together. Offer your child time to play by herself, giving her the opportunity to decide what to do.

### ENCOURAGE INDEPENDENCE

**4** Children who are able to take care of some of their personal needs do better at the beginning of preschool than children who rely on adults for everything. Make sure your child has shoes that she can put on herself. Allow extra time before you need to leave the house each day so that your child can put on her own shoes. Support your child in taking care of her own bathroom needs. If she asks help with her pants, or with wiping, try talking her through it rather than doing it all for her. Teach her to wash her own hands and flush the toilet. It's not glamorous, but these are important skills in preschool!

### PRACTICE

**5** Give your child time away from you. Practice separating and giving your child a little bit of space. Invite other children over for play dates and allow your child to go on short play dates as well.