1205 6TH STREET, HUDSON, WI
715.386.9349

TRINITY ACADEMY

PRESCHOOL REGISTRATION

2021/22

Child's Name ______________________________ ☐Male ☐Female DOB __________
Last First

Parent or Guardian's Name ______________________________

Address ______________________________ Phone __________

City __________ Zip __________ E-Mail ______________________________

Has your child attended preschool before? ____Y____N Trinity Preschool ? ___Y___N Class Name __________

Three Year Old Classes – ***Must be 3 by September 1st*** ☐ *$80.00 Registration*

______Red Class	M., W., F.	8:45-11:30 a.m.	$204.00/month
______Yellow Class	Tu., Th.	8:45-11:30 a.m.	$163.00/month

Three/Four Year Old Class – ***Must be 4 by January 1st*** ☐ *$80.00 Registration*

______Blue Class	T., W., Th.	12:30-3:15 p.m.	$204.00/month

Four Year Old Classes (Hudson residents) — ***Must be 4 by September 1st*** *Class times are subject to change due to busing*

** A.M. Late Pickup @11:30 a.m. & Early P.M. Drop-off @12:35 p.m. includes faith based activities for HSD4K classes*

Little Warriors HSD4K Class ☐ *1st Choice* ☐ *2nd Choice* ☐ *3rd Choice*

______HSD Resident	M. – F. HSD4K	8:35–11:15 a.m.	Fee Waived
			☐ *$80.00 Registration*
______HSD Resident	M. – F. Ext. Day	11:30-3:30 p.m.	$398.00/month
______HSD Resident	M.— F. Ext. Day w/unlimited Wrap	11:30-3:30 p.m.	$627.00/month

**Unlimited Wrap Care for Little Warriors excludes care for any Trinity holiday breaks or spring break*

Purple HSD4K Class ☐ *1st Choice* ☐ *2nd Choice* ☐ *3rd Choice*

______HSD Resident	M. – F. HSD4K	8:35–11:15 a.m.	Fee Waived

Orange HSD4K Class ☐ *1st Choice* ☐ *2nd Choice* ☐ *3rd Choice*

______HSD Resident	M. – F. HSD4K	12:50-3:30 p.m.	Fee Waived

Four Year Old Classes (non Hudson resident) - ***Must be 4 by September 1st*** ☐ *$80.00 Registration*

______Purple	M. – F.	8:35–11:30 p.m.	$335.00/month
______Orange	M. – F.	12:35–3:30 p.m.	$335.00/month
______Little Warriors	M. – F.	8:35-3:30 p.m.	$575.00/month
______LW w/unlimited Wrap care	M. – F.	8:35-3:30 p.m.	$790.00/month

**Unlimited Wrap Care for Little Warriors excludes care for any Trinity holiday breaks or spring break*

Members of Trinity Lutheran Church? YES / NO We currently **Do / Do Not** have a church home.

Our family pastor is ______________________ at ______________________ church.

How did you hear about Trinity Academy?______________

Referred by a Trinity school family? YES / NO

If Yes, Family Name______________

Do you plan to use Trinity Wrap Around care? YES / NO *If yes, Wrap Around Care Registration Form must be completed with $40.00 fee.*

A **$20.00 supply fee** will be collected upon Enrollment Day in August for all classes. In addition to the supply fee, **Little Warriors** will be charged a **$15.00 rest mat fee**. If any fees are a hardship for your family, please contact our school office staff.

Trinity Academy admits students of any race, color, or national or ethnic origin to all the rights privileges, programs and activities generally accorded or made available to students at the academy. It does not discriminate on the basis of race, color, or national or ethnic origin.

Trinity Academy preschool classes are accredited by the Wisconsin Religious and Independent Schools Accreditation

School Office Use Only: **Date Received:**______________ **Time:**________

Registration Fee: $____________ via: Check#________ Cash Vanco-Online ____Coupon/New Families

Preschool Class with HSD4K
Consent and Transportation/Care Form

If you are a Hudson School District resident or have open enrolled to HSD4K and have a child enrolled in the Purple, Little Warriors, or Orange Class with HSD4K at Trinity Academy Preschool, please read and sign the following form. This form must be completed and on file with the school office prior to the first day of attendance.

Consent and Acknowledgement:

Please check all that apply:

☐ I certify that I am a **Hudson School District resident.**

☐ I request that my child be allowed to participate in Trinity Academy's Faith Formation classes (including music & chapel for up to 70 minutes per week). This would excuse them from the **HSD4K Purple, Orange, or Little Warrior Classes** as per **Hudson School District policy #322. Times will be identified on the monthly class calendar.** Parents are welcome to attend chapel services.

☐ I welcome faith based and/or church literature and publications to periodically be sent home with our child or via email.

☐ I am a **non-Hudson School District resident** and have started the **open enrollment process or have been approved for HSD4K**.. I understand that if my open enrollment is **not approved or my status with the district changes**, I will relinquish my child's reserved spot or I will be responsible for monthly tuition of $325.00/$560.00

☐ I request that my son or daughter **only** attend HSD4K with **no faith based activities or instruction. By doing so, I under stand and acknowledge that although there will be no intentional faith based activities or instruction during this time, the Purple, Orange & Little Warrior Classes with HSD4K are housed in a Christian environment.**

Transportation and Wrap Around Care:

Please check an option below that best describes your transportation or childcare plans for your child. We understand that your schedules may vary or change prior to the start of school. You will be asked to provide a schedule to your preschool teacher (and Wrap Care Director) if your schedule will vary from day to day or week to week. Thank you.

☐ **My child will ride the bus to and from Trinity. It is my responsibility to determine eligibility of my child's bus transportation with the HSD. All bus routes and times are determined by Safeway Bus Transportation and the HSD. Therefore, start /end times for HSD4K are subject to change.**

☐ **My child will be using Trinity Academy's Wrap Around Care program**: *(student must be preregistered)*

_______before HSD4K (between the hours of 6:30 a.m.–class start time)
_______after HSD4K (between the hours of 11:30–6:00 p.m.)
_______before and after HSD4K (between the hours of 6:30–6:00 p.m.)

☐ **My child will be dropped off and picked up by a parent or caregiver.** Parents will be asked to supply contact information/ transportation schedule for any adults, other than parents, to the preschool teacher, wrap-care, and office staff.

I am signing this form as consent to the items marked above, acknowledgment of Trinity Academy Preschool's faith-based environment. I have checked the option above that best describes the plans for transportation and care of my child while at Trinity Academy Preschool.

Parent Signature:_________________________________ Date: ______________

Parent Signature:_________________________________ Date: ______________

EMERGENCY STUDENT INFORMATION
PRESCHOOL and WRAP AROUND CARE

Trinity Academy
Enrolled in:
Preschool ____
Wrap Around Care ____

Student Name______________________________ Preferred Name______________ Class______

DOB_________ Male / Female Address____

Mothers Name ______________________Address_______________Email________________

Home #______________________Cell #____________________Contact you 1st? ____Y____N

Place of Employment_________________________________Work #__________________

Fathers Name ______________________Address_______________Email________________

Home #______________________Cell #____________________Contact you 1st? ____Y____N

Place of Employment_________________________________Work #__________________

Guardian(s) Name_______________Address_______________Email________________

Home #______________________Cell #____________________Contact you 1st? ____Y____N

Place of Employment_________________________________Work #__________________

If unable to reach parent/guardian in an emergency the following people may be contacted **AND** are authorized to pick up this child due to sickness, injury, inclement weather, early dismissal or a school emergency:

Name______________Relationship________ Phone#:______________Phone#2:______________

Name ______________Relationship________Phone#:______________Phone#2:______________

Name ______________Relationship________Phone#______________Phone#2:______________

<u>IN THE CASE OF AN EMERGENCY OR EARLY DISMISSAL, MY CHILD WILL:</u>

______Parent will pick up or a person listed above
______Go to Wrap-Around Care (Student must be preregistered)

List any person(s) who should <u>NOT</u> pick up your child: ______________________________
(If applicable, please provide the school office with copies of any legal/ custody documents and/ or photos pertaining to the above to be filed confidentially in the office.)

After preschool my student will:
______Picked up by a parent
______Picked up by someone other than a parent (listed above) Name:_______________________
______Go to **Wrap-Around Care** (student must be preregistered)
______My student will have a varied schedule that I will provide to teachers and wrap-care. Please indicate below.
    ______Weekly
    ______Monthly

Comments:____
____
____
____

Continue to back side…

Student Name:______________________________

HEALTH INFORMATION

Diagnosed Allergies____
Emergency Action Required: ______Y_____N (examples: nut, bee stings, asthma)
Allergy Emergency Action Plan filled out by Doctor needs to be on file in the school office along with emergency medications.

Medical Concerns____Action Plan_____Y____N
****If checked (Yes), a current Action Plan is attached for school records*** ______Y______N

Daily Medications____
During the school day, Authorization to Administer Medication Form needs to be filled out and on file in the office.

Doctor / Office: ____Phone #_______________

Dentist / Office: ____Phone #_______________

Health Insurance Co.:____Phone #_______________

For a major emergency 911 will be called.
For a minor injury requiring medical attention, the parent, guardian or emergency person will be called. Any expenses incurred by the above will be the responsibility of the child's family.

I GIVE MY CONSENT TO:

Please check one:	Yes	No
Emergency medical treatment if I cannot be reached immediately:		
To give Tylenol or Ibuprofen for headaches or minor aches/pain: ***Not applicable if your child attends Wrap-Around Care; a separate authorization form must be signed*		
To apply anti-biotic ointment minor cuts/scrapes: ***Not applicable if your child attends Wrap-Around Care; a separate authorization form must be signed*		
To attend in-house fieldtrips: *(Examples: to the church sanctuary, gym or outdoor classroom)*		
Use my child's photograph in publications and on the school website:		
To publish the following in the School Directory:		
Home Phone:		
Cell Phone:		
Address:		
Email Address:		

Signature of Parent/Guardian____Date__________

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-04020L (Rev. 6/2018)

STATE OF WISCONSIN
Wis. Stat. §§ 252.04 and 120.12 (16)

STUDENT IMMUNIZATION RECORD

INSTRUCTIONS TO PARENT: COMPLETE AND RETURN TO SCHOOL WITHIN 30 DAYS AFTER ADMISSION. State law requires all public and private school students to present written evidence of immunization against certain diseases **within 30 school days of admission**. The current age/grade specific requirements are available from schools and local health departments. These requirements can only be waived if a properly signed health, religious or personal conviction waiver is filed with the school. The purpose of this form is to measure compliance with the law and will be used for that purpose only. If you have questions regarding immunizations, or how to complete this form, contact your child's school or local health department.

PERSONAL DATA **PLEASE PRINT**

Step 1

Student's Name	Birthdate (MM/DD/YYYY)	Gender	School	Grade	School Year

Name of Parent/Guardian/Legal Custodian	Address (Street, City, State, Zip)	Telephone Number
		( )

IMMUNIZATION HISTORY

Step 2

List the MONTH, DAY, AND YEAR your child received each of the following immunizations. DO NOT USE A (√) OR (X) except to answer the question about chickenpox, Tdap, or Td. If you do not have an immunization record for this student at home, contact your doctor or public health department to obtain it.

TYPE OF VACCINE*	FIRST DOSE MM/DD/YYYY	SECOND DOSE MM/DD/YYYY	THIRD DOSE MM/DD/YYYY	FOURTH DOSE MM/DD/YYYY	FIFTH DOSE MM/DD/YYYY
DTaP/DTP/DT/Td (Diphtheria, Tetanus, Pertussis)					
Adolescent booster (Check appropriate box) ☐ Tdap ☐ Td					
Polio					
Hepatitis B					
MMR (Measles, Mumps, Rubella)					
Varicella (Chickenpox) Vaccine *Vaccine is required only if your child has not had chickenpox disease. See below:*					

Has your child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known:
☐ YES ______ Year (Vaccine not required)
☐ NO or Unsure (Vaccine required)

Has your child had a blood test (titer) that shows immunity (had disease or previous vaccination) to any of the following? (Check all that apply)
☐ Varicella ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B
If YES, provide laboratory report(s)

REQUIREMENTS

Step 3

Refer to the age/grade level requirements for the current school year to determine if this student meets the requirements.

COMPLIANCE DATA

Step 4

STUDENT MEETS ALL REQUIREMENTS
Sign at Step 5 and return this form to school.

Or

STUDENT DOES NOT MEET ALL REQUIREMENTS

Check the appropriate box below, sign at Step 5, and return this form to school. PLEASE NOTE THAT INCOMPLETEY IMMUNIZED STUDENTS MAY BE EXCLUDED FROM SCHOOL IF AN OUTBREAK OF ONE OF THESE DISEASES OCCURS.

☐ Although my child has NOT received ALL the required doses of vaccine, the FIRST DOSE(S) has/have been received. I understand that the SECOND DOSE(S) must be received by the 90th school day after admission to school this year, and that the THIRD DOSE(S) and FOURTH DOSE(S) if required must be received by the 30th school day next year. I also understand that it is my responsibility to notify the school in writing each time my child receives a dose of required vaccine.

NOTE: Failure to stay on schedule may result in exclusion from school, court action and/or forfeiture penalty.

WAIVERS (List in Step 2 above, the date(s) of any immunizations your child has already received)

☐ **For health reasons** this student should not receive the following immunizations ______________________

SIGNATURE - Physician ______________________ Date Signed ______________________

☐ **For religious reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap, ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

☐ **For personal conviction reasons,** I have chosen not to vaccinate this student with the following immunizations (check all that apply)
☐ DTaP/DTP/DT/Td ☐ Tdap ☐ Polio ☐ Hepatitis B ☐ MMR (Measles, Mumps, Rubella) ☐ Varicella

SIGNATURE

Step 5

This form is complete and accurate to the best of my knowledge. Check one: (I do ☐ I do not ☐) give permission to share my child's current immunization records and as they are updated in the future with the Wisconsin Immunization Registry (WIR). I understand that I may revoke this consent at any time by sending written notification to the school district. Following the date of revocation, the school district will provide no new records or updates to the WIR.

SIGNATURE - Parent/Guardian/Legal Custodian or Adult Student ______________________ Date Signed ______________________

CHILD HEALTH REPORT

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: ______________ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

TRINITY ACADEMY: PRESCHOOL
WRAP AROUND CHILDCARE REGISTRATION

TRINITY ACADEMY, 1205 6TH STREET, HUDSON, WI 54016, 715.386.9349

Child's Full Name____Child's DOB_____________
Last First Middle

Parent or Guardian's Name___________________________________Home Phone__________________

Address____Cell Phone______________

City________________________Zip________________ E-Mail_________________________________

WRAP AROUND CHILDCARE FEES

Registration fees: $40 or $60/family. Non-refundable fee must accompany this form at the time of registration.

Preschool: **$18.00** for ½ day (up to 5 hours)
$36.00 for Full day (5 - 10 hours)

Wrap Around hours are from 6:30am – 6:00 pm. Fees will be billed on a weekly basis.

REGISTRATION INFORMATION

My child will be attending the following class:

______Red (3's) ______ Yellow (3's) ______Blue (3/4's)
______Purple w/HSD4K(4's) ______Orange w/HSD4K(4's) ______Little Warriors w/HSD4K(4's)

Wrap Around needs: (Please circle)

Monday Tuesday Wednesday Thursday Friday

Start Date: ___________________

Approximate hours needed for care:____________________

Arrival time:______ **Departure time:**__________

Trinity Academy admits students of any race, color, or national or ethnic origin to all the rights privileges, programs and activities generally accorded or made available to students at the academy. It does not discriminate on the basis of race, color, or national or ethnic origin.

Trinity Wrap-Around Care program is licensed with the Wisconsin Department of Health and Family Services.

Rev. 12/2020

School Office Use Only: Registration Fee: Date__________ $____________Check#__________ $___________Cash $_____________Vanco

_____Coupon/New Families