205 6TH STREET, HUDSON, WI
715.386.9349

TRINITY ACADEMY

3YR PRESCHOOL REGISTRATION

2024/25

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.	8:30-11:30 a.m.	$290.00/month
_______Red Class Ext Day	M., W., F.	8:30– 3:35 a.m.	$530.00/month
_______Yellow Class	Tu., Th.	8:30-11:30 a.m.	$195.00/month

Members of Trinity Lutheran Church? YES / NO ☐ We **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______________________

**If you plan to use Wrap Around Care, a separate Wrap Care Registration packet must be completed with $40.00 registration fee.*

A **$35.00 supply fee** will be billed to all families for all classes. If any fees are a hardship for your family, please contact our school office staff.

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

_____ Before Red & Yellow Classes (between the hours of 6:30 a.m.–8:30 a.m.)

_____After Red & Yellow Classes (between the hours of 11:30–5:30 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.

Trinity Academy admits students of any race, color, or national or ethnic origin to all the rights privileges, programs and activities generally

School Office Use Only: **Date Received:**____________________**Time:**__________

Registration Fee: $__________________via: Check#__________ Cash _____Coupon/New Families

Trinity Academy
Enrolled in:
Preschool ____
Wrap Around Care ____

EMERGENCY STUDENT INFORMATION
PRESCHOOL and 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:________________

IN THE CASE OF AN EMERGENCY OR EARLY DISMISSAL, MY CHILD WILL:

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

List any person(s) who should NOT 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.

Check any that apply:

☐ Has special physical considerations ☐ Referred for/currently operating under ____IEP _____ Birth to 3

☐ Has been referred, diagnosed or treated for _____ADD _____ADHD

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__________

TRINITY 3YR PRESCHOOL TUITION POLICY

School Year: 2024–25

Registration Fee

$80.00 per child. This is a *non-refundable fee and is due at the time you enroll your child. This fee will secure your child's placement in the preschool class. A **$35.00 supply fee** will be billed to your account and must be paid prior to the start of the school year.
**If the additional fees are a hardship please contact the school office.

Tuition

Tuition payments for all preschool programs are due on the 1st of each month.
Payments will be made online through our school Student Information System (FACTS) account or Cash or Check can be delivered to the school office.

- Payments that are more than 2 weeks late may result in the child's dismissal, unless a special payment plan has been agreed upon.
- There are no refunds for absences.
- There will be $35 service fee for any returned checks.

Termination of Enrollment

Trinity Preschool must be notified in writing one month in advance to withdraw from the program. When giving notice, the parent will be responsible for paying the next full month's tuition. Tuition for the current month and registration fee will not be refunded.

Late Pickup Fee

If a parent is late picking up their child from preschool, he or she may be taken to Wrap Care and appropriate fees will be charged.

Preschool Tuition: *Please check the appropriate box.*

- ☐ Yellow 2- ½ day sessions per week — $195.00/ month
- ☐ Red 3- ½ day sessions per week — $290.00/month
- ☐ Red 3- full day sessions per week — $530.00/month

I the parent of ________________________________ agree to the above Tuition Policy's terms and conditions.
(Please print first and last name of child)

______________________________ ______________________________

Print Parent Name Parent Signature

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.

Step 1 PERSONAL DATA — PLEASE PRINT

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 ( )

Step 2 IMMUNIZATION HISTORY

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)

Step 3 REQUIREMENTS

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

Step 4 COMPLIANCE DATA

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

Step 5 SIGNATURE

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 – Child Care Centers

Use of form: Use of this form is required unless the health examination report is on an electronic printout from a licensed physician, physician assistant, or other EPSDT provider. Completion of this form meets the requirements of DCF 202.08 (4), DCF 250.04 (6) (a) 4. and DCF 251.04 (6) (a) 8. 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. Each child 2 years of age but who is not 5 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 other EPSDT provider to be completed, signed, and dated. The licensee / operator 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 includes a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – This section should be completed by the parent or guardian

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

Child's Address (Street, City, State, Zip Code)

Parent or Guardian Name (Last, First, MI)

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

HEALTH PROFESSIONAL – This section should be completed by the health professional

Instructions for feeding and care of child with special health concerns – Specify: (attach information as necessary).

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

☐ Yes ☐ No Does this child have any food or non-food allergies? If "Yes," specify and include the treatment plan to be implemented in the event of an allergic reaction.

Date of child's 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 other EPSDT Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA, or other EPSDT Provider	Date of Examination