205 6TH STREET, HUDSON, WI
715.386.9349

TRINITY ACADEMY

4K 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 _____

Are you a Hudson Resident? _____Y _____N

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

** Choices are always considered, but not guaranteed.*

Little Warriors 4K Class ☐*1st Choice* ☐ *2nd Choice* ☐ *3rd Choice*

_____M. – F. Ext. Day 8:30-3:30 p.m.

_____M.— F. Ext. Day w/unlimited Wrap 8:30-3:30 p.m..
**Unlimited Wrap Care for Little Warriors excludes care for any Trinity holiday breaks or spring break*

Purple 4K Class ☐*1st Choice* ☐ *2nd Choice* ☐ *3rd Choice*
_____ M.—F. 8:30–11:30 a.m.

Orange 4K Class ☐*1st Choice* ☐*2nd Choice* ☐ *3rd Choice*
_____M. – F. 12:40-3:35 p.m.

Four Year Old Class Resident and Non Resident Pricing

_____ *Registration Fee*	*Little Warriors and Non Resident $80.00*
_____Purple	Resident-Fee waived Non-Resident $362.50/month
_____Orange	Resident Fee waived Non-Resident $362.50/month
_____Little Warriors	Resident Fee $447.00/month Non Resident $622.00/month
_____LW w/unlimited Wrap care	Resident Fee $703.00/month Non Resident $852.00/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_____

**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 collected upon Enrollment Day in August for all classes. In addition to the supply fee, **Little Warriors** will be charged a **$25.00 rest mat fee**. If any fees are a hardship for your family, please contact our school office staff.

School Office Use Only: **Date Received:**_____**Time:**_____

Registration Fee: $_____via: **Check#**_____ Cash _____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 Answer all three questions:

I am authorizing my child in 4K to participate in Trinity Academy's Faith Formation classes (including music, chapel & classroom lessons) for up to 70 minutes per week. Per the **Hudson School District policy #322,** these times will be identified on the monthly calendars for Little Warriors, Purple & Orange classes. HSD4K time is 2 hours /40 minutes each day.

YES NO

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

YES NO

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 $362.50/$622.00

YES NO

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 11:30–5:30 p.m.)
_____before and after HSD4K (between the hours of 6:30–5:30 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.

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:_____

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 4K PRESCHOOL TUITION POLICY

School Year: 2024–25

REGISTRATION FEE

If you are enrolled in the Little Warriors Extended Day Class or a Non-Hudson Resident in one of our Half-Day 4K classes, an $80.00 fee per child will be collected. 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.*

☐ 4K Purple or Orange 5- ½ day sessions per week	$362.50/month (Fee waived for HSD4K)

All Day Little Warriors

☐ Extended Day (11:30-3:30 p.m.)	$447.00/month (ext. HSD4K)
☐ Extended Day w/Wrap Care (11:30-3:30 p.m.)	$703.00/month (ext. HSD4K w/unlimited Wrap Care)
☐ Non HSD Resident (8:30-3:30 p.m.)	$622.00/month
☐ Non HSD Resident w/Wrap Care (8:30-3:30pm)	$852.00/month (w/unlimited Wrap Care)

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

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/20)

STATE OF WISCONSIN
Wis. Stat. § 252.04

CHILD CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO CHILD CARE CENTER. State law requires all children in child care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the child care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the child care center. See "Waivers" below. If you have any questions about immunizations, or how to complete this form, please contact your child's child care provider or your local health department.

STEP 1 **PERSONAL DATA** **PLEASE PRINT**

Child's Name(Last, First, Middle Initial)	Date of Birth (Month/Day/Year)	Area Code/Telephone Number
Name of Parent/Guardian/Legal Custodian (Last, First, Middle Initial)	Address (Street, Apartment number, City, State, Zip)	

STEP 2 **IMMUNIZATION HISTORY**

List the MONTH, DAY AND YEAR the child received each of the following immunizations. DO NOT USE A (√) OR (**X**) except to indicate whether the child has had chickenpox. If you do not have an immunization record for this child, contact your doctor or local public health department to obtain the records.

TYPE OF VACCINE	First Dose Month/Day/Year	Second Dose Month/Day/Year	Third Dose Month/Day/Year	Fourth Dose Month/Day/Year	Fifth Dose Month/Day/Year
Diphtheria-Tetanus-Pertussis (Specify DTP, DTaP, or DT)					
Polio					
Hib (Haemophilus *Influenzae* Type B)					
Pneumococcal Conjugate Vaccine (PCV)					
Hepatitis B					
Measles-Mumps-Rubella (MMR)					
Varicella (chickenpox) vaccine Vaccine is required only if the child has not had chickenpox disease.					

Has the child had Varicella (chickenpox) disease? Check the appropriate box and provide the year if known.

☐ Yes year _____ (Vaccine is not required)

☐ No or Unsure (Vaccine is required)

STEP 3 **REQUIREMENTS**

The following are the minimum **required** immunizations for the child's age/grade at entry. All children within the range must meet these requirements at child care entrance. Children who reach a new age/grade level while attending this child care must have their records updated with dates of additional required doses.

AGE LEVELS	NUMBER OF DOSES						
5 months through 15 months	2 DTP/DTaP/DT	2 Polio	2 Hib	2 PCV	2 Hep B		
16 months through 23 months	3 DTP/DTaP/DT	2 Polio	3 Hib[1]	3 PCV[2]	2 Hep B	1 MMR[3]	
2 years through 4 years	4 DTP/DTaP/DT	3 Polio	3 Hib[1]	3 PCV[2]	3 Hep B	1 MMR[3]	1 Varicella
At Kindergarten entrance	4 DTP/DTaP/DT[4]	4 Polio			3 Hep B	2 MMR[3]	2 Varicella

[1]If the child began the Hib series at 12-14 months of age, only two doses are required. If the child received one dose of Hib at 15 months of age or after, no additional doses are required. Minimum of one dose must be received after 12 months of age (Note: a dose four days or less before the first birthday is also acceptable).

[2]If the child began the PCV series at 12-23 months of age, only two doses are required. If the child received the first dose of PCV at 24 months of age or after, no additional doses are required.

[3]MMR vaccine must have been received on or after the first birthday (Note: a dose four days or less before the first birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the fourth birthday (either the third, fourth or fifth) to be compliant (Note: a dose 4 days or less before the fourth birthday is also acceptable).

STEP 4 **COMPLIANCE DATA AND WAIVERS**

IF THE CHILD MEETS ALL REQUIREMENTS (sign at STEP 5 and return this form to the child care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to child care center).

☐ Although the child has not received all required doses of vaccine for his or her age group, at least the first dose of each vaccine has been received. I, understand that it is my responsibility to obtain the remaining required doses of vaccines for this child **WITHIN ONE YEAR** and to notify the child care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the child care center may result in court action against the parents and a fine of $25.00 per day of violation.

☐ For health reasons this child should not receive the following immunizations _____(List in STEP 2 any immunizations already received)

_____
Physician's Signature Required

☐ For religious reasons this child should not be immunized. (List in STEP 2 any immunizations already received)

☐ For personal conviction reasons this child should not be immunized. (List in STEP 2 any immunizations already received):

STEP 5 **SIGNATURE**

To the best of my knowledge, this form is complete and accurate.

_____ _____
SIGNATURE - Parent, Guardian or Legal Custodian Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

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