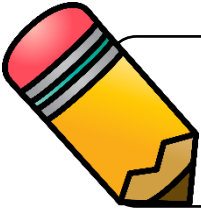


Enrollment Date: \_\_\_\_\_

Information Update Only: \_\_\_\_\_



# 1<sup>st</sup> Step Learning Center



407 Edwardsville Road

Troy, IL 62294

618-667-7748 [1stStep@troymc.org](mailto:1stStep@troymc.org)

## Registration Form

Child: \_\_\_\_\_ Age on Sept.1, 2025: \_\_\_\_\_ Birthdate: \_\_/\_\_/\_\_

Sex: M\_\_ F\_\_

Child's Address: \_\_\_\_\_

Full name of Mother: \_\_\_\_\_ Email \_\_\_\_\_

Mother's Address: ☐ Same \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Contact 1<sup>st</sup> ☐

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

Full name of Father: \_\_\_\_\_ Email \_\_\_\_\_

Father's Address: ☐ Same \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Place of employment: \_\_\_\_\_ Contact 1<sup>st</sup> ☐

Please list the names and ages of siblings: \_\_\_\_\_

\_\_\_\_\_

Parent Marital status \_\_\_\_\_

## Emergency Contacts

Minimum 2 contacts, other than parents, to contact in case of emergency/authorized to pick up child:

1. Name: \_\_\_\_\_ 2. Name: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

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

Cell or Work Phone: \_\_\_\_\_ Cell or Work Phone: \_\_\_\_\_

Other Person(s) Authorized to pick up child:

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

## Session Preference

- 2's Tuesday/Wednesday/Thursday 8:25-11:45      Monthly fee of \$195  
Your child must be 2 before March 1<sup>st</sup>
- 3's Tuesday/Wednesday/Thursday 8:25-11:45      Monthly fee of \$185
- 4's Tuesday/Wednesday/Thursday 8:25-11:45      Monthly fee of \$185

We consider it a privilege to have your child in our preschool program. To ensure that your child is registered, the attached forms must be completed in their entirety. **To reserve your child's position in class, complete the initial registration form and turn it into the Director's office along with the \$100.00 registration fee.** The other forms may be completed and turned in prior to or on the first day of school. This provides us with all the necessary information to ensure that your child will have a safe and enjoyable learning experience at 1<sup>st</sup> Step.

## Child's Health Information and History

Child's Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Are your Child's immunizations up to date? Yes ( ) No ( )

Note: attach a copy of immunization record if not enrolled in public school yet.

If not up to date, please explain: \_\_\_\_\_

Does child have any known health problems? Yes ( ) No ( ) (If yes attach documentation)

Does your child get colds/flu often? \_\_\_\_\_

Please list any serious prior injuries: \_\_\_\_\_

Check (√) any of the following illnesses the child has had:

- |                                     |                                      |                                       |   |  |
|-------------------------------------|--------------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> Asthma     | <input type="checkbox"/> Earaches    | <input type="checkbox"/> Mumps        | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Bronchitis      |
| <input type="checkbox"/> Eczema     | <input type="checkbox"/> Pneumonia   | <input type="checkbox"/> Polio        | <input type="checkbox"/> Chicken Pox    | <input type="checkbox"/> Frequent Colds  |
| <input type="checkbox"/> Croup      | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Measles      | <input type="checkbox"/> Influenza      | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Other: _____ |   |  |

Does your child have any known allergies? Yes ( ) No ( ) If yes, what are they and what are your child's reactions:

\_\_\_\_\_

Does your child take any medication on a regular basis? Yes ( ) No ( ) If yes please list the name of the medication(s) and the medical condition for which it is taken:

\_\_\_\_\_

Does your child have any speech, hearing or visual problems? Yes ( ) No ( )

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Has your child ever been tested for the above? Yes ( ) No ( )

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Please comment on any other medical information/or special need the preschool should be aware of:

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## Medication and Emergency Care Authorization

I authorize 1<sup>st</sup> Step Learning Center to administer the medications authorized below as deemed necessary by staff for the comfort and well-being of my child. Medications will be administered in the dosages recommended for my child's age and weight. This authorization is in effect my child is enrolled, unless revoked by me and I understand that I will be notified when I pick up my child if any medications were given.

(Please cross off any item you would prefer not to be used)

☐Yes ☐No I authorize the use typical first aid supplies including but not limited to Neosporin, anti-bacterial spray, cortisone, sunburn treatments, band-aids, and liquid Band-Aids.

☐Yes ☐No I authorize the use of preventative supplies, such as sunblock, bug repellent, hand lotion, diaper rash cream, etc.

NOTE: If you would like your child to take a specific brand of medication, please provide it. Medications will be labeled with your child's name and kept locked. Prescription medications will require separate authorizations for each occurrence and must be sent to school in original prescription bottle.

Signature of parent: \_\_\_\_\_



Madison County Health Department  
Vision & Hearing Screening Assessment Form

For your child to be screened, this form must be completed and returned to your child's facility.

PLEASE PRINT. Use BLACK or BLUE ink. SIGN the form

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: \_\_\_\_\_

Last (legal name, no nicknames) First MI

Race (Choose all that apply): ☐ American Indian ☐ Asian ☐ African American ☐ Declined to Specify ☐ Pacific Islander ☐ White Ethnicity: ☐ non-Hispanic ☐ Hispanic

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician: \_\_\_\_\_

Parents or Guardians: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Street Address (if different from child): \_\_\_\_\_

Name of Facility (Day Care or Pre-school): 1<sup>st</sup> Step Learning Center

\*This vision screen cannot be used as the kindergarten eye exam.

\*If your child fails a screening, you will be contacted by phone or letter within 10 days.

I hereby give my consent for hearing and vision screening assessment for my child. I give my consent to Madison County Health Department (MCHD) to release information to physicians, social workers, other health departments, pre-schools, day care and school personnel as necessary.

CONSENT and ACKNOWLEDGEMENT

Receipt of Joint Notice of Privacy Practices

I understand that the Madison County Health Department is authorized to use information gained during screening to bill any potential source of reimbursement, such as Illinois Public Assistance or government programs in which I am enrolled or qualify for services. I also hereby acknowledge a copy of the "Joint Notice of Privacy Practices," is available at Madison County Health Department. A copy is available to view at the health department's website [www.madisonchd.org](http://www.madisonchd.org).

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Legal Guardian

Child's Medicaid Recipient ID Number: \_\_\_\_\_

For Health Department Staff Use Only

Date of Screening: \_\_\_\_\_

\_\_\_\_\_  
Screening Technician's Signature

**Hearing Results:** \_\_\_\_\_

**Vision Results:** \_\_\_\_\_

**Key: P=Pass F=Fail U=unable to complete test  
R=Refused test**

Madison County Health Department

101 E. Edwardsville Rd.

Wood River, IL 62095

618-692-8954 x2

[www.madisonchd.org](http://www.madisonchd.org)

## **Cell phones and texting**

We are asking that you provide us with a cell phone number that has texting capabilities if you would like to receive important messages from the school. Some of the ways that we will use this number are as follows:

- to inform you of school closing or delays
- to inform you of an early school closing
- to remind you of a specific event that is happening that day
- to let you know that we will be at the overhang for drop off for inclement weather

When we have extremely cold weather or heavy rain, we will be receiving children at the overhang in the upstairs drive. We would ask that you pull in and one of the staff will be there to help your child out of the car as quickly as possible.

If you choose to participate, please fill out the bottom of this form and return it to school as soon as possible.

Thank you!

-----  
I would like to give my cell phone number to 1<sup>st</sup> Step Learning Center and allow them to use it to text me with important school information.

\_\_\_\_\_  
Parent's Name

\_\_\_\_\_  
10-digit cell phone number

ANDERSON HOSPITAL  
Illinois Rt. 162 & Old Edwardsville Rd.  
MARYVILLE, ILLINOIS 62062  
Phone (618) 288-5711

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD AT ANY MEDICAL FACILITY AT  
ANY MEDICAL FACILITY (THIS FORM MUST BE NOTARIZED!!)

Date \_\_\_\_\_

Authorization is hereby given to 1<sup>st</sup> Step Learning Center to consent to emergency treatment for my child

\_\_\_\_\_  
Name of Child

and to proceed with such treatment that may be necessary in that we the parents are not available at the time of the injury or illness.

Authorization is also given for admission to the hospital, if at the time of injury or illness, in our absence, admission to the hospital is advised by our private physician or a consulting physician of his choice.

Child's Birth Date: \_\_\_\_\_

Date of Child's Last Tetanus Immunization injection: \_\_\_\_\_

Child's Allergies and Chronic illness: \_\_\_\_\_

Full Name of Private Physician: \_\_\_\_\_

Telephone Number of Physician: \_\_\_\_\_

Address & Telephone Number where Parents might be reached:

As Parents, we promise to pay, whatever costs are not covered by:

\_\_\_\_\_  
Name of Insurance

\_\_\_\_\_  
Number on Card

\_\_\_\_\_  
1<sup>st</sup> Step Learning Center

\_\_\_\_\_  
Signature of Responsible Party during Parent's absence as named above

\_\_\_\_\_  
Signature of Child's Father

\_\_\_\_\_  
Signature of Child's Mother

Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_,  
20\_\_\_\_. Witness my hand and official seal.  
Notary Public \_\_\_\_\_  
My Commission Expires: \_\_\_\_\_

## Transportation Authorization

I \_\_\_\_\_, hereby authorize the following people to transport my child from 1<sup>st</sup> Step. Should this change at any time I will notify 1<sup>st</sup> Step personnel in writing.

***(list of people eligible to pick up child on lines below)***

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\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

## Photo Authorization

Photographs and videos are taken on many occasions such as birthdays, holidays, outings, special occasions as well as in the normal course of our day. We use these pictures/videos for teaching, sharing information about their day, arts & crafts, albums, class books, picture CD's and various other things. Photos which may include my child may be given to families who also attend this program or may appear online unless otherwise noted by you.

Please mark the appropriate box(s):

☐ I give permission to 1<sup>st</sup> Step Learning Center to take photographs/videos of the above named child(ren). Photos used in classroom only or give to parents as a remembrance of their child's year (including other families in the program).

### **In Addition:**

☐ I give permission for photos/videos to be posted on our Facebook or Blog (to share your child's day).

☐ I give permission for my child's photo to be used on printed marketing materials (pamphlets, flyers, etc.)

**OR**

☐ I do NOT want any photos/videos taken of my child.



## **Ages and Stages**

At 1<sup>st</sup> Step Learning Center we use a developmental screening tool called Ages and Stages. The Ages and Stages Questionnaire is a nationally recognized developmental evaluation tool that will enable us to track your child's development while they attend 1<sup>st</sup> Step. The questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving and personal/social skills.

The questionnaire will be administered by your child's teacher. We use this tool in all our classrooms and have a goal each year of evaluating all the children by the end of November. If the questionnaire shows that your child is developing without concerns, then we will simply add the questionnaire to your child's portfolio for you to examine at the parent/teacher conferences in January. If the questionnaire shows some possible area(s) of concern for your child, we will send a copy of the same questionnaire home for you to complete with your child. We will then schedule a conference to review the results of both the teacher and the parent's assessment. Together, we will discuss if it is appropriate to monitor your child or refer your child for a more involved assessment from your pediatrician. No information will be shared outside of 1<sup>st</sup> Step without written consent from the student's parents.

We believe that this screening tool validates our belief that parents know the most about their children. A typically developing child will be able to do some of the skills asked about on the questionnaire, but usually not all of them. This is NOT a test, but a tool that can tell us when a child is developing typically, when a child needs more practice in a certain area or when a child should have their development assessed by a specialist.

The first five years of life are very important for your child because this time sets the stage for success in school as well as later in life. During early childhood, your child will gain many experiences and learn life-long skills. The Ages and Stages Developmental Screening Tool can help us to ensure that each child's development proceeds well. If you have any questions or would like to see a sample questionnaire, please contact me at the preschool office.

Sincerely,

Amy Burrelsman

Please read the text below and mark the desired space to indicate whether you would like your child to participate in the Ages and Stages screening/monitoring program.

☐ I wish to have my child participate in the screening/monitoring program.

☐ I do not wish to have my child participate in the screening/monitoring program.

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Child's Name \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_