IMMANUEL LUTHERAN SCHOOL
606 S. Hanover Street
Okawville, Illinois 62271
Phone (618)243-6142 FAX 618-243-6562
Immanuel's Mission: Preparing students for life here and in eternity.

March 3, 2025

Dear Parents,

We send you greetings from Immanuel Lutheran School.

Our mission is to prepare students for life here and in eternity. With that mission in mind, we have well trained teachers who bring excellence in education to our students using a Christian emphasis in all that is taught.

Our school is accredited by one of the most stringent accreditations in the United States (National Lutheran School Accreditation) and also holds State of Illinois recognition. One of the requirements of our accreditation is improvement each year. This is something that we are very pleased to do.

We would like to invite you to enroll your child in our excellent preschool program. Registration will be held March 10th – March 14th 7:00 a.m. – 3:30 p.m. for members of Immanuel and sister congregations and those currently enrolled as students of Immanuel. Enrollment for all others will be March 17th – 21st 7:00 a.m. – 3:30 p.m. If you would like to learn more about what our preschool program can offer your child, please call the school office at 618-243-6142 or email Mrs. Hundelt at phundelt@immanuelokawville.org We would enjoy having the opportunity to meet with you.

In His Service,

Pam Hundelt,
Pre-School Teacher

PRE-SCHOOL REGISTRATION

Each child needs a record proving he/she has received the required immunizations appropriate for his/her age.

If this is your child's first year in preschool, he/she is required to have a physical examination.

If your child was enrolled this past year, his/her physical will remain current for this year as long as the physical is not more than two years old.

A TB skin test is highly recommended but not a requirement for a child entering the pre-school program.

Included in the physical is a requirement for a diabetic screening.

A lead-screening test is required by the state for all children age six and under living in the zip code area of 62214 and 62803.

Beginning in the fall of 2002, children entering into any school operated program for the first time at kindergarten level and below are required to show proof of having received one dose of the chickenpox vaccine on or after their first birthday.

The original birth certificate is required the first day of school – a copy will be made in the office and the original return.

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Okawville, Illinois 62271

SCHOOL REGISTRATION FOR 2025/2026 SCHOOL YEAR

MARCH 10, 2025 TO MARCH 14, 2025 Members

March 17, 2025 TO March 21, 2025 Non-Members

7:00 A.M. – 3:30 P.M. Forms picked up or returned to school office

PRE-SCHOOL – THREE AND FOUR-YEAR OLDS

(Must be three or four by September 1, 2025)

KINDERGARTEN

(Must be five by September 1, 2025)

Immanuel admits students of any race, color, or national ethnic origin to all the rights, privileges, programs and activities generally accorded or made available to students at the school. It does not discriminate on the basis of race, color, or national or ethnic origin in administration of its educational policies, admission policies, scholarship and loan programs, and athletic and other school-administered programs.

IMMANUEL LUTHERAN SCHOOL
OKAWVILLE, ILLINOIS
EARLY CHILDHOOD PROGRAM
REGISTRATION FORM

CHILD'S NAME_____ OFFICE DATA
DATE:
BIRTHDATE _____ AGE GROUP 3 4 5 #:
PLACEMENT:

PARENTS' NAME (s)_____

ADDRESS_____
City State Zip

PHONE _____ _____
Home # Emergency # Cell Phone #

E-MAIL ADDRESS _____

CHURCH MEMBERSHIP _____

Please note anything medical or educational which is important for us to know: _____
_____

***It is mandatory that children be FULLY toilet trained to attend preschool. Children need to be three, four, or five by September 1, 2025.**

NON-REFUNDABLE REGISTRATION FEE: (Pre-school) $75.00 (Kindergarten) $100.00

ENROLLMENT OPTIONS: (Please check your preference) *Subject to Change

___ Preschool 3's - 3 mornings per week, Tuesday, Wednesday, Thursday, 8:00 a.m. – 11:00 a.m. (3-year-olds)
___ Preschool 3's - 5 mornings per week Monday - Friday 8:00 a.m.-11:00 a.m. (3- year-olds)

___Pre-school 4's - 3 afternoons per week Tuesday, Wednesday, Thursday – 12:00 noon – 2:30 p.m. (4-year-olds)
___ Preschool - 4's - 5 afternoons per week Monday – Friday 12:00 noon-2:30 p.m. (4-year-olds)

___ All Day - Monday thru Friday, 8:00 a.m. – 2:30 p.m. (Kindergarten)

PLEASE INDICATE BELOW TIME AND DAYS NEEDED FOR DAYCARE (Check days needed and put time frame on blank behind day of week, example: Monday 7:00 a.m. – 6:00 p.m.)
___ Monday _____(time) ___ Tuesday _____ (time)

___ Wednesday _____(time) ___ Thursday _____ (time)

___ Friday _____ (time)

Please sign and date on back.

Space will be reserved for your child only with payment of a non-refundable registration fee of $75.00 which is used to hold a place in the 3-year-old or 4-year-old pre-school class and to help cover other registration costs.
The non-refundable registration fee for kindergarten students is $100/child. You may pay all other kindergarten fees when registration is held for all students at the end of the 2024/2025 school year. This registration is held so that parents can update their child(ren's) personal information and other school related information about the up-coming school year. Please make checks payable to Immanuel Lutheran School. Enrollment will be on a first-come first served basis. Admission policies for the Early Childhood Program are that of Immanuel Lutheran School, namely, that admission is open first to members of Immanuel Lutheran Church, secondly, to members of sister congregations, thirdly, to children presently enrolled in the program, and finally, to the general public.

We will supply you with the forms necessary to complete enrollment at a later date.

Date: _____ Signature: _____

PRESCHOOL FEE SCHEDULE

Rates for 2025-2026 will be determined on March 9th at Immanuel's Voters Meeting. Please call the school office or pick up a tuition sheet when dropping off your child's registration form.

State of Illinois

Certificate of Child Health Examination

Student's Name (Last / First / Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address / City / ZIP Code	Parent/Guardian / Telephone (home/work)

HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	☐ Yes ☐ No	List:	**MEDICATION** (Prescribed or taken on a regular basis)	☐ Yes ☐ No	List:

Diagnosis of Asthma?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ Yes ☐ No		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Diabetes?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Seizures? What are they like?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Additional Information:

Ear/Hearing problems?	☐ Yes ☐ No	
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No	

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature _____ Title _____ Date _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease _____ Signature _____ Title _____

3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ B/P _____

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

☐ No test needed ☐ Test performed **Skin Test:** Date Read _____ Result: ☐ Positive ☐ Negative mm _____

Blood Test: Date Reported _____ Result: ☐ Positive ☐ Negative Value _____

LAB TESTS (Recommended)	Date	Results	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		Endocrine	☐	
Ears	☐	Screening Result:	Gastrointestinal	☐	
Eyes	☐	Screening Result:	Genito-Urinary	☐	LMP:
Nose	☐		Neurological	☐	
Throat	☐		Musculoskeletal	☐	
Mouth/Dental	☐		Spinal Exam	☐	
Cardiovascular/HTN	☐		Nutritional Status	☐	
Respiratory	☐	☐ Diagnosis of Asthma	Mental Health	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			Other	☐	

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone