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,

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). 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 Christian kindergarten 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 Kindergarten program can offer your child, please call the school office at 618-243-6142 or email jliszewski@immanuelokaville.org. I would enjoy having the opportunity to meet with you.

Mrs. Jody Liszewski is our kindergarten teacher. She has been teaching for 27 years. She holds both a Bachelor's degree and a Master's degree in Elementary Education. For her Master's degree, she wrote her thesis on reading disabilities and dyslexia. She has a twenty-three-year-old son, Hunter. She also has a twenty-year-old daughter, Hope, who is currently attending SIUE. She enjoys teaching because *"it is as challenging as parenthood – every day is a new adventure."*

In His Service,

Ms. Jody Liszewski

Ms. Jody Liszewski, MS
Kindergarten Teacher

IMMANUEL LUTHERAN SCHOOL
606 South Hanover
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.

IMMANUEL LUTHERAN SCHOOL KINDERGARTEN PROGRAM

CURRICULUM OVERVIEW

PHONICS/READING READINESS

- We focus on a different letters.
- We also work on blends and diagraphs.
- We learn a new sight words each week.
- We listen to the hooked on phonics tape.
- We practice writing out letters on white boards.
- We read a story a week.
- We work on being able to retell stories we have heard and comprehending what we hear.
- We learn new vocabulary through the stories we hear and the things we talk about.
- We learn about opposites.
- We learn to sound out words and use the sight words we know in order to read a selection of books which rely on the use of a particular vowel sound.
- We talk about the different punctuation marks at the end of a sentence. We also talk about asking and telling sentences, nouns, verbs and adjectives.

MATH - Curriculum

The following is a list of the topics that are covered in a year:

- Sorting and Classifying
- Geometry and Patterns
- Exploring Numbers to 10
- Shapes and Graphing
- Exploring Numbers to 20
- Measurement
- Time and Money
- Exploring Greater Numbers
- Exploring Addition
- Exploring Subtraction
- Numbers to 100
- Application and Problem Solving

HANDWRITING

- In handwriting, we learn the correct way to write all of our letters. We practice single letters and words using those letters. We copy writing from charts and the board in order to learn to observe, write, and then be able to go back to the place they left off.

JOURNAL WRITING

- We use our journal folders to begin learning to write and even spell on our own. We begin by completing story starting sentences with single words and pictures and eventually work up to writing entire sentences on our own. We use inventive spelling in our writing. Inventive spelling allows a child to use their previous knowledge of letter sounds and blends to attempt to spell words on their own. We then look at the attempts and correct them together.

SCIENCE

- Plants, Animals, and People
- Earth, Our Home and the Solar System
- Weather and the Sky
- Describing Matter
- Energy Sources and Motion
- Magnets
- Oceans

SOCIAL STUDIES

- My Family, My School
- Everybody Works
- Where We Live
- Our Traditions
- Life Then and Now

COMPUTERS , CHROME BOOKS, AND PROMETHIAN BOARD

- We use computers daily for keyboarding practice, playing educational games, and internet use.
- Surface RT tablets and the Promethian Board are used on a regular basis.

RELIGION

- We teach values and hopes from a LCMS Christian perspective. We begin our day with prayer and devotion, and learn about a specific story from the Bible. We use echo pantomimes, coloring sheets, books we make, songs, and crafts to learn and remember the stories of the Bible that we talk about. We attend chapel on Wednesday mornings for an hour. We lead chapel with grades 1 and 2 once a year.

FIELD TRIPS/PROVIDED WE HAVE A "NORMAL" YEAR.

- Highland - swimming
- Pumpkin Patch
- Zoo
- Music Concerts

EXTRAS:

- We visit our school library once each week.
- We participate in activities for Lutheran Schools Week.
- We sing in our classroom, generally, on a daily basis. We may sing as part of religion, our theme, or just for fun.
- Iowa Basics testing is done in April each school year.
- We are able to receive special services from Kaskaskia Special Education District if needed. We also receive speech therapy through Okawville Grade School.
- We also have music once a week for a half an hour
- Regular visits by Ag in the Classroom

I am with the children all day, with the exception of recess. Our typically small class size allows for one-on-one attention and a family-like atmosphere. I believe in making school fun for the students while helping them learn to the best of their ability. Every activity we do in Kindergarten is part of the learning process, whether it is specifically curriculum oriented or learning valuable life skills (getting along with others, learning responsibility).

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 _____

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

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

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Additional Information:

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

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

Address _____

_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois

IOCI 15-391

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City		ZIP Code
Name of School: ZIP Code		Grade Level:	Gender: ○ Male ○ Female
Parent or Guardian: Last Name	First Name		

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other_____

To be completed by dentist:

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Additional comments: _____

Signature of Dentist _____ License #:_____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov