Lockport Township High School District 205 Foundation

Lockport Township High School District 205
Development and Public Relations Department/LTHS Foundation
Administrative Center
1323 East Seventh Street
Lockport, Illinois 60441-3899

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N E W S R E L E A S E

DATE: January 9, 2012

CONTACT: Kim Brehm

INSTRUCTIONS: For Immediate Release

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Petite Porters Preschool

Lockport Township High School District 205 (LTHS) is accepting applications for the Petite Porters Preschool. The purpose of the program is to provide high school students enrolled in Mrs. Courtney Oxley-Turner's Family and Consumer Sciences Department's child care and guidance course a practical, hands-on experience that will enable them to develop and teach age-appropriate, enriching activities to youngsters aged three to five years of age.

Petite Porters Preschool will be housed at District 205's East Campus, 1333 East Seventh Street in Lockport (Room 96), and sessions will run from 8:40-10:00 every Tuesday, Wednesday, and Thursday, from March 6th- May 3rd. The $100 fee will help offset supply, and activity costs. Because the program is limited to 12 preschoolers, applications will be accepted on a first-come, first-served basis.

Participating children must be toilet trained.

Applications are available at the front desk at East Campus or at www.lths.org. Please return the completed application and general information sheet as well as a current copy of the child's health exam (required) to the front desk. Upon acceptance into Petite Porters Preschool, an informational meeting for parents will be held. Parents will view the room and hear about the curriculum.

Mrs. Oxley-Turner and her students look forward to this unique experience that is designed to prepare students for a career in the early child care field. "Types of early child care programs and career opportunities will be explored. In order to work successfully with young children, you need to understand them," Mrs. Oxley-Turner explained. "Using this information, students will plan developmentally appropriate activities to be used in a preschool setting, and teaching techniques will be developed through practical applications."

For more information, contact Mrs. Oxley-Turner at 815/588-8453 or at cturner@lths.org.

# # #

Lockport Township High School District 205 will create a nurturing and challenging environment in which all students achieve success, develop personal responsibility, and become lifelong learners. We will promote a partnership with students, parents, businesses, and community; utilize effective teaching methods and current technology; and provide quality, comprehensive academic, career, and extracurricular experiences.

CT:bah

Petite Porter Preschool Application

Child's name ____

(Last) (First) (Middle)

Child's preferred name or nickname______________________________

Address ______________________City________________Zip_______

Phone (___)______________________ Cell (___)_________________

Birthday_______________________ Sex: M F Age in March _______

Mother's name _________________

Occupation_______________________

Business phone (___)______________ Work hours _____________

Business address __________________City ___________Zip_________

Home address (if different)_____________________________________

Phone (if different) (___)_________________ Marital status: M S D W

Father's name _________________

Occupation_______________________

Business phone (___)______________ Work hours _____________

Business address __________________ City___________Zip_________

Home address (if different)____

Phone (if different) (___)_________________ Marital status: M S D W

Siblings: Names/Ages

____

____

Please list three friends or relatives for us to contact in case of emergency and you cannot be reached. **All information must be complete**.

1. Name ____________________________ Phone (___)__________________
Address___________________________ City_________________Zip_______
2. Name ____________________________ Phone (___)__________________
Address__________________________ City_________________ Zip_______
3. Name ____________________________ Phone (___)__________________
Address___________________________ City_________________Zip_______

My child can be released to the persons listed below: **All information must be complete**.

1. Name _____________________________Phone (___)_________________
Address_____________________City_________________Zip____________
2. Name ____________________________ Phone (___)__________________
Address_____________________City_________________Zip____________
3. Name ____________________________ Phone (___)__________________
Address_____________________City_________________Zip____________

In case of emergency: **All information must be complete**.

Child's Doctor: _______________________ Phone (___)__________________
Doctor's address:
____________________City_________________Zip____________
Child's Dentist: _______________________ Phone (___)__________________
Dentist's address:
____________________City_________________Zip____________
Please list any allergies:____
____
Please list any medications your child takes on a regular basis:
____
____
____

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	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 Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying 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** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																			**Code:** P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/ Grade																			
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																			
Hearing																			

Student's Name Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID #

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor ______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

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

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **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 QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionairre Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

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. **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		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**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 Antagonist) ☐ 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** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)