1316 Bel Air Blvd., Chippewa Falls, Wi 54729 • Tel 715.723.0538 • Fax 715.723.1501 • www.macs.k12.wi.us

St. Charles Early Childhood Center

Boost-for-5s

Vision

We are the school of choice for an excellent education within the Chippewa Falls area. We welcome all families to be a part of our school community. In partnership with our parents, we form the whole child in support of our values and mission.

Our vision of the whole child consists of a lifelong learner, who upon graduation, is academically prepared for post-secondary education and career, balanced physically and emotionally, and actively engages as servant leaders in family and civic communities.

Eligibility/Enrollment

Students must be 5 years old on or before September 1 of the school year.

Tuition

Tuition: $1550.00 per student.

Billing and payment plans are handled through Jamie Dodge, Assistant Director. Any questions regarding your statements or payments can be answered by calling 715-723-2161 or emailing childcare@macs.k12.wi.us.

MCDONELL AREA CATHOLIC SCHOOLS
Est. 1882
1316 Bel Air Blvd., Chippewa Falls, WI 54729 • Tel 715.723.0538 • Fax 715.723.1501 • www.macs.k12.wi.us

Dear Parent or Guardian,

Thank you for choosing St. Charles for your child's educational experiences. If you are in need of wrap-around care at St. Charles we are happy to provide this service to you, please contact myself or the Assistant Director, Jamie Dodge, to get the appropriate paperwork or if you have any questions.

Completing the Boost-for-5s Registration packet enrolls your child into our afternoon program offered specifically to students who have completed BB4C but may not be ready for Kindergarten. Even though your child may not be enrolled in wrap-around care service, the information on these forms is required for him/her to attend this program.

To complete the registration process you must do the following:

1. Completely fill out the following forms:
    a. Boost-for-5s registration form
    b. Day Care Immunization form (or a copy from your child's primary care Physician)
    c. Health History and Emergency Care Plan
    d. Diocese of La Crosse Child Comprehensive Medical Release and Permission Form
    e. Student Pick-Up/Release Authorization form

Please turn in all completed forms as soon as possible. If you have any questions please call 715-723-2161 or email childcare@macs.k12.wi.us.

We look forward to welcoming your family into ours.

Sincerely,

Jaynee Brannen
Director of Early Childhood

Boost-for-5s Registration

Name: ____

Last Name First Name Middle Name

Child's age as of September 1, 2018: _______ **Birth Date:** _______

Please list student's YOUNGER siblings:

First Name	M.I.	Last Name	Gender	Age	Birth Date	Living at Home

Do you plan to use wrap-around childcare services? ☐ Yes ☐ No

Parent Information

Parent/Guardian Name: ______________________________________

Parent D.O.B: ______________________ **SSN:** ________________

Address: ____

Parent/Guardian Work Phone:____________ **Ext.**_____ **Cell or Home Phone:** __________

Email address: ____

Place of Employment: ____________________________________

Parent/Guardian Name: ______________________________________

Parent D.O.B: ______________________ **SSN:** ________________

Address: ____

Parent/Guardian Work Phone:____________ **Ext.**_____ **Cell or Home Phone:** __________

Email address: ____

Place of Employment: ____________________________________

Parent/Guardian Print Name	**Parent/Guardian Signature**	**Date**

Parent/Guardian Print Name	**Parent/Guardian Signature**	**Date**

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 12/2017)

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 2 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 4 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 2 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 4 days or less before the 1st birthday is also acceptable).

[4]Children entering kindergarten must have received one dose after the 4th birthday (either the 3rd, 4th or 5th) to be compliant (Note: a dose 4 days or less before the 4th 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 up to $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

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply 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: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	Date – First Day of Attendance (mm/dd/yyyy)

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply repellent to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply repellent.	Brand Name	Ingredient Strength

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
   - ☐ No specific medical condition
   - ☐ Asthma
   - ☐ Diabetes
   - ☐ Gastrointestinal or feeding concerns including special diet and supplements
   - ☐ Cerebral palsy / motor disorder
   - ☐ Epilepsy / seizure disorder
   - ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
   - ☐ Other condition(s) requiring special care – Specify.
   - ☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
   - ☐ Food allergies – Specify food(s).
   - ☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: ____________ ____________ ____________ ____________ ____________

Diocese of La Crosse
Child Comprehensive Medical Release & Permission Form

Contact Information

Name: ______________________ Date of Birth: ______________ ☐ Male ☐ Female

Parish Name/City: ______________________ Year of Graduation: ______________

Address: ______________________ City: ______________ State: ______ Zip: __________

Phone #: ______________ (Home) E-mail Address: ______________________

Mother's name: ______________ Phone: (H) __________ (W) __________ (C) __________

Father's name: ______________ Phone: (H) __________ (W) __________ (C) __________

Emergency Contact: ______________________ Relationship: ______________

Phone: (H) __________ (W) __________ (C) __________

Physician: ______________ Clinic/Hospital: ______________ Office Phone: __________

Medical Insurance Company: ______________________ Policy #: __________

Medical History

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability, or condition to which the participant is subject and of which the staff should be aware, and what, if any action of protection is required on account thereof. Submit this notification in writing and attach it to this form. Include names of medications and dosages that must be taken. The parish/Diocese of La Crosse will take reasonable care to see that the following information will be held in confidence. Some activities may be physically strenuous (especially mission trips and camps). If you desire to limit a participant's participation in any way, please submit your wishes in writing prior to the trip.

1. Is the participant in good health and able to participate in normal activities? ☐ Yes ☐ No
   If not, please submit a statement indicating limitations and/or restrictions.
2. Please give the date of the participant's most recent physical examination: __________
3. Immunization History (Please give dates)
   Date of last Tetanus Shot: __________
   Please fill in below only for foreign mission trips:
   DPT ______ DPT Booster ______ Polio Booster ______ Polio Series ______
   Other, if any necessary, for specific trip: ______________________
   *Note: You are responsible for consulting your doctor about immunizations necessary for foreign missions.
4. Allergies: ☐ Yes ☐ No
   If Yes, list all specific causes of allergic reactions, e.g., pollen, bee stings, etc. __________
   Identify all symptoms from each type of allergy: ______________________
   If respiratory distress or anaphylaxis is listed, are you prescribed epinephrine (an "EpiPen")? ______
5. Has the participant ever suffered from or been treated for any of the following:
   Asthma ______ Epilepsy/seizure disorder ______ Heart trouble ______
   Diabetes ______ Frequently upset stomach ______ Physical handicap ______
   Depression ______ Emotional/Mental Disorder ______ Other ______
6. Operations, serious injuries, or major illnesses in the past year: ______________________
   ______________________ Dates: __________
7. Is the participant subject to chronic homesickness, emotional reactions to new situations (sleepwalking, bedwetting, fainting)? ______________________
8. Has the participant recently been exposed to contagious disease or conditions, such as mumps, measles, chickenpox, etc.? If so, list date and disease or condition: ______________________
9. Does the participant have a medically prescribed diet? ☐ Yes ☐ No
10. The participant is a ☐ swimmer ☐ non-swimmer

Medical Treatment

Emergency Medical Treatment: In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment at my expense. I wish to be advised prior to any further treatment by the hospital or doctor. In the event that you are unable to reach me, such treatment may be administered if deemed necessary. In the event of an emergency, if you are unable to reach me at the numbers given above, please contact the emergency contact listed above.

Initials of Parent Guardian: __________ Date: __________

Other Medical Treatment: In the event it comes to the attention of the parish, its officers, directors and agents, and the Diocese of La Crosse, chaperones, or representatives associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called collect (with phone charges reversed to myself).

Initials of Parent Guardian: __________ Date: __________

Medications: My child is taking medication at present. My child will bring all such medications necessary, and such medications will be well labeled. Names of medications and concise directions for seeing that the child takes such medications, including dosage and frequency of dosage, are as follows: ______________________________

Initials of Parent Guardian: __________ Date: __________

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life-threatening and emergency treatment is required.

Initials of Parent Guardian: __________ Date: __________

OR

I hereby grant permission for non-prescription medication (such as aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges, cough syrup) to be given to my child if deemed appropriate.

Initials of Parent Guardian: __________ Date: __________

Parental/Guardian Consent and Liability for Minors

I, ____________________ (Parent or guardian's name), grant permission for my child, ____________________ (Child's name) to participate in this diocesan/parish event that requires transportation to a location away from the parish site. This activity will take place under the guidance and direction of diocesan/parish employees and/or volunteers from ________________ (Name of Parish).

A brief description of the activity follows:

Type of activity: All School Sponsored Field Trips during the 2018-19 School year

Individual in Charge: Teachers and Volunteers

Estimated time of departure and return: TBA (to be announced)

Mode of transportation to and from activity: Bus or Walking

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("participant").

I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend ________________ (Name of Parish), its officers, directors, employees and agents, and the Diocese of La Crosse, its employees and agents, chaperones, or representatives associated with the event, from any claim arising from or in connection with my child attending the event or in connection therewith, and I agree to compensate the parish, its officers, directors and agents, and the Diocese of La Crosse, its employees and agents and chaperones, or representative associated with the event for reasonable attorney's fees and expenses which may incur in any action brought against them as a result of such injury or damage, unless such claim arises from the negligence of the parish/diocese.

Initials of Parent Guardian: __________ Date: __________

Code of Conduct

We expect each participant to conform to these rules of conduct:

No possession or use of alcohol, drugs, tobacco, or pornography.
No fighting, weapons, fireworks, lighters, or explosives.
No offensive or immodest clothing.
No student may drive.
No males in female sleeping quarters, and no females in male sleeping quarters.
Participation with the group is expected.
Respect property.
Respect one another, staff, and leaders.
Respect and comply with event schedules and with any other specific event rules established by leaders.

Students who fail to comply with these expectations may be sent home at their parents' expense.

I, the student, have read the rules of conduct, the above evaluation of my health, and permission to participate in youth group activities. I agree to abide by the stated personal limitations and code of conduct.

Initials of Student: ________________ Date: __________

Initials of Parent Guardian: _________ Date: __________

Permission to Use Participant Photos

You have my permission to use said participant's photos for commercial purposes (ex: advertising this event in flyers, on the web, etc.).

Initials of Student: ________________ Date: __________

Initials of Parent Guardian: __________ Date: __________

Statement of Truth and Accuracy

I hereby certify that all of these statements are true and accurate to the best of my knowledge.

Signature of Parent/Guardian: ____ Date: ________________

Signature of Student: ____ Date: ________________

Student Pick- Up / Release Authorization Form

Name of Student(s):

____

Mother/Guardian Name:

____

Father/Guardian Name:

____

Authorized to Pick-Up Student

Please list below all persons, besides parents/guardians, who are authorized to pick up your child from school.
Note: For your child's safety, authorized persons may be asked for photo identification. Please inform the person on the list in advance on this precautionary measure. **Persons may be added to the list or removed at any time, just inform the office staff of any changes to this form.**

Name	Relation	Phone #

EMERGENCY CONTACT - The person to be notified in an emergency when parents/guardians cannot be reached.
☐ Yes ☐ No This person is authorized to pick up my child.

Name and relationship to Child	Home/Cell Phone No.	Email Address	Place of Employment & Phone No.

St. Charles
2018-2019 Boost-for-5s Supply List

1 - Large backpack. Needs to fit snow boots and snow pants. (No wheels please)

1 - Crayola Pan Washable Watercolor Paints (8 colors)

1 - box Crayola **Fine Line** Markers (8 count)

1 - box Kleenex

1 - box of Ziploc baggies (size per last name):

- A - M quart
- N - Z gallon

1 - plastic 2-pocket folder (please label)

1 - roll of paper towel

1 - package of wipes (per last name)

- A - M Clorox wipes
- N - Z baby wipes

1 - box of crackers (ex: Goldfish, Ritz, Cheez-Its, Wheat Thins)

1 - box of thin Expo dry erase pens

You do not need to label your child's supplies besides their folder. We will be sharing supplies as needed.

Please put a change of clothes and socks in a Ziploc bag marked with your child's name to keep in their backpack for accidents or messy days.

St. Charles Early Childhood | Boost-for-5s

2018 - 2019 School Calendar

August '18

Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

September '18

Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

October '18

Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

November '18

Su	M	Tu	W	Th	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

December '18

Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

January '19

Su	M	Tu	W	Th	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

February '19

Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

March '19

Su	M	Tu	W	Th	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

April '19

Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

May '19

Su	M	Tu	W	Th	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

June '19

Su	M	Tu	W	Th	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

July '19

Su	M	Tu	W	Th	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Boost-for-5s School Days

Early Release – No Boost-for-5s

Orientation Days

Make-up Days (Snow)

No Boost-for-5s

School Calendar Template © calendarlabs.com

MCDONELL AREA CATHOLIC SCHOOLS
Est. 1882
1316 Bel Air Blvd., Chippewa Falls, Wi 54729 • Tel 715.723.0538 • Fax 715.723.1501 • www.macs.k12.wi.us

Frequently Asked Questions

What time does school start for my child?
Boost-for-5s runs from 11:45 am - 3:05 pm on Monday, Tuesday, Wednesday, and Thursday when school is in session. It is important that your child be in school everyday because of the sequence of learning experiences that take place. However, your child should not be in school if he or she is ill.

When should I keep my child home?

- When your child is experiencing any of the following:
  - Throwing up
  - A fever of 100.0 or more
  - Diarrhea
- Your child needs to be symptom free for 24 hours in order to be able to return

Who should I contact if my child is ill?
If your child is ill or will be out of school, please email your child's teacher directly or call the center at 715-723-2161.

I am going to bring my child to school, where should I park?
When transporting your child, please drop your child off as close to the start of class time as possible and no earlier than 11:40 am. The drop off/pickup location is on the street in front of the school building on Spruce Street. When dropping your child off, you will need to bring your child to his or her classroom. When you are picking up, a teacher will bring your child to the front doors of the school and will release your child to you upon visually seeing you outside of the building. If you need wrap-around childcare services, please contact Jamie Dodge to enroll.

How will I know if school is canceled?
Our schedule for weather related closings will run with the district school schedule. We will also follow the Chippewa Falls Area Unified School District for days when school is not in session. (See enclosed calendar)