McDONELL AREA CATHOLIC SCHOOLS
Est. 1882
ST. CHARLES PRESCHOOL & PRIMARY SCHOOL

REGISTRATION FORM

2024-2025

CHILD INFORMATION:

Child's Full Name: _____ Age: _____ D.O.B.: _____
Child's Full Name: _____ Age: _____ D.O.B.: _____
Child's Full Name: _____ Age: _____ D.O.B.: _____

Child's Home Address: _____

Child(ren) Live With: Both Parents _____ Mother _____ Father _____ Other _____

PLEASE CHECK A BOX BELOW:

□ Current St. Charles Preschool Family *(Only Fill Out Parent Information Below if Anything Has Changed)*
□ New St. Charles Preschool Family *(Fill out Parent Information Below)*

PARENT / GUARDIAN INFORMATION:

Parent/Guardian Name: _____
Parent D.O.B.: _____ SSN: _____
Address: _____
Work Phone: _____ Home / Cell Phone: _____
Email Address: _____
Place of Employment: _____
Catholic: □ *Yes* □ *No If Yes, Please List Parish Name Here:* _____
Signature: _____ Date: _____

Parent / Guardian Name: _____
Parent D.O.B.: _____ SSN: _____
Address: _____
Work Phone: _____ Home / Cell Phone: _____
Email Address: _____
Place of Employment: _____
Catholic: □ *Yes* □ *No If Yes, Please List Parish Name Here:* _____
Signature: _____ Date: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ BEST Phone #: _____
Relationship to Child: _____

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GETTING TO KNOW YOUR CHILD

(Age 3 Years & Up)

Child's Name: _____

Parent / Guardian's Name: _____

Parent / Guardian's Email: _____

Has your child been in childcare before? □ Yes □ No

What does your child prefer to be called: _____

Favorite activities: _____

Favorite food(s): _____

Least favorite food(s): _____

Favorite color: _____

Other favorites: _____

Fears: _____

Allergies: _____

How does your child go to sleep? (Does not apply to SUPERS kids): _____

_____

Are there any special dolls or items that he / she will need to fall asleep? _____

_____

What is the usual time and length of naps taken each day? _____

Anything else that you feel we should know about your child? _____

_____

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

http://dcf.wisconsin.gov

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care

Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off. If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

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 the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

DEPARTMENT OF CHILDREN AND FAMILIES
Division of Early Care and Education

CHILD HEALTH REPORT – CHILD CARE CENTERS

Use of form: Use of this form is voluntary; however, completion of this form meets the requirements of DCF 202.08(4), DCF 250.07(6)(L)3., and DCF 251.07(6)(k)3. Failure to comply with these rules 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: Each child under 2 years of age shall have an initial health examination not more than 6 months prior to nor later than 3 months after being admitted to the center and a follow-up health examination at least once every 6 months thereafter. Except for a school-aged child, each child 2 years of age or older shall have an initial health examination not more than one year prior to nor later than 3 months after being admitted to a center and a follow-up health examination at least once every 2 years thereafter. The parent / guardian shall give this form to the physician, physician assistant or HealthCheck provider to be completed, signed and dated. The licensee shall obtain a copy for the child's record. Note: Children are also required to have on file at the child care center documentation of immunizations; it may be helpful if the parent / guardian were to include a copy of the child's immunization record when submitting this form to the child care center.

PARENT OR GUARDIAN – Complete this section.

Name – Child (Last, First, MI)	Birthdate – Child (mm/dd/yyyy)

Address – Child (Street, City, State, Zip Code)

Name – Parent or Guardian (Last, First, MI)

Address – Parent or Guardian (Street, City, State, Zip Code)

HEALTH PROFESSIONAL – Complete this section.

Instructions for feeding and care of child with special problems, including allergies – Specify (attach information as necessary).

☐ Yes ☐ No Does the child have a milk allergy? If "Yes", identify the recommended milk substitute.

Date of most recent blood lead test: _____ (mm/dd/yyyy). Note: Children on Medicaid are required to be tested at around ages 12 months and 24 months or once between the ages of 3 and 5 years if no previous test is documented. Lead testing is optional for children who are not on Medicaid.

Immunization(s) not to be administered to child due to medical reason(s) – Specify.

AUTHORIZATION

I certify that I have examined the above child on this date and that he / she is able to participate in child care activities.

Name – MD, PA or HealthCheck Provider (type or print)	Address (Street, City, State, Zip Code)

SIGNATURE – MD, PA or HealthCheck Provider	Date of Examination

DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44192 (Rev. 09/08)

STATE OF WISCONSIN
ss. 252.04,Wis. Stats.

DAY CARE IMMUNIZATION RECORD

COMPLETE AND RETURN TO DAY CARE CENTER . State law requires all children in day care centers to present evidence of immunization against certain diseases within **30 school days (6 calendar weeks) of admission to the day care center.** These requirements can be waived only if a properly signed health, religious, or personal conviction waiver is filed with the day care center. See "Waivers" below. If you have any questions on immunizations or how to complete this form, please contact your child's day 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 (4) 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 day care entrance. Children who reach a new age/grade level while attending this day 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 day care center), OR

IF THE CHILD **DOES NOT** MEET ALL REQUIREMENTS (check the appropriate box below, sign and return this form to day 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 day care center in writing as each dose is received.

NOTE: Failure to stay on schedule or report immunizations to the day 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.

	Brand Name	Ingredient Strength
☐ 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.		
☐ 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: _____ _____ _____ _____ _____

Student Pick- Up / Release Authorization Form

Name of Student

_____

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 #

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 <u>specific</u> 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 Catholic School/Catholic School System, its administrators, teachers, support staff, coaches, field trip chaperones, or representatives associated with an event or activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

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: _____

Parental/Guardian Consent and Liability for Minors

I,_____, grant permission for my child,_____to participate in Catholic School/Catholic School
Parent or guardian's name Child's name
System events that require transportation to a location away from the Catholic School. Activities will take place under the guidance and direction of Catholic School/Catholic School System from_____.
Name of Catholic School/Catholic School System

As parent and/or legal guardian, I remain legally responsible for any personal actions taken by the above named minor ("student"). I agree on behalf of myself, my child named herein, or our heirs, successors, and assigns, to hold harmless and defend _____, its officers, directors, employees and agents, and the Diocese of La Crosse, its employees
Name of Catholic School/Catholic School System
and agents, chaperones, or representatives associated with events or activities, from any claim arising from or in connection with my child attending the events or activities or in connection therewith, and I agree to compensate the Catholic School/Catholic School System, its officers, directors and agents, and the Diocese of La Crosse, its employees and agents and chaperones, or representative associated with the events or activities 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 Catholic School/Catholic School System/Diocese of La Crosse.

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: _____