ST. MARK'S PRESCHOOL - Enrollment Form 2025-2026
101 S. 6th Avenue St Charles, IL 60174
Office: (630) 584-4850 Fax: (630) 584-8646
E-Mail: preschool@stmarkslife.org

Student's Name: ____ **Date of birth:** __ __/__ __/__ __

__Male ___Female **Nickname:**_______________ *(What they like to be called [ex: Jonathan/Johnny)*

Church affiliation/Church home: ______________________________ **Baptized:** Yes/No

Are you interested in receiving information about St. Mark's Lutheran Church worship/ Bible Study opportunities: Yes/No

PARENT OR GUARDIAN INFORMATION

Home address: ____

City: ______________________ **Zip:** __________ **Home Phone#** _________________

Father's name: ________________________________ Work Phone # _______________

Father's Cell phone # ________________ Email: ____________________________________

Home Address (if different from above): ____

Mother's name: ________________________________ Work Phone # _______________

Mother's Cell phone # ________________ Email: ____________________________________

Home Address (if different from above): ____

Parent's Marital Status: __________________

Siblings: **(names/ages)**____

Please indicate class preference:

___ MW 2s 9:30-12:00 (5 hr/wk) (3 by 1/31/26) $185/mo.

___MWF 3s 9:15-12:15 (9 hr/wk) (3 by 9/1/25) $245/mo.

___ M-TH 4s 9:15-12:15 (12 hrs/wk) (4 by 9/1/25) $330/mo.

___TTH 2s 9:30-12:00 (5 hrs/wk) (2 by 9/1/25) $185/mo.

___TTHF 3s 9:15-12:15 (9 hr/wk) (3 by 9/1/25) $245/mo.

___ M-TH 4s 9:15-12:15 (12 hrs/wk) (4 by 9/1/25) $330/mo.

___Extended Day Tuesday - 12:15-2:15 (Ages 3-5) $65/mo. (2 hrs/wk)
___Extended Day Friday - 9:15-11:15 (Enrolled in 4s program) $65/mo (2 hrs/wk)

*Your first choice will be accommodated if space in that class is available; otherwise, the second choice will be assigned. *St. Mark's Preschool reserves the right to cancel a class.* Enrollment is determined on a first come, first served basis contingent upon payment of a $100 non-refundable fee payable to "St. Mark's Preschool" (additional siblings $50 each). Current families can submit Enrollment Packet & fee starting Tuesday, January 21, 2024. New students can begin registering on Monday, January 27, 2024.

____ ________________
Parent (Guardian) signature Date

*Office Reference: Date*________*Ck#*_______ *Amt. $* ______ *Env#* _______ *List* _____ *Reg* ______ *Shep* ______

ST. MARK'S PRESCHOOL - Emergency Information
101 S. 6th Avenue St. Charles, IL 60174
Office: (630) 584-4850 Fax: (630) 584-8646
E-Mail: preschool@stmarkslife.org

Emergency Information

Student's Name: ____ DOB _ _/_ _/_____

Child's Doctor:

Doctor Name	Doctor's Address & Phone #	Hospital Association

Allergy Information:

Does your child have any allergies? (medications, foods, etc) **Yes/No**

If yes, please list all allergies: ____

**If your child has any allergies, please complete, "Allergy Emergency Action Plan" form, with the doctor's signature.*
**If your child requires medication prescribed by a doctor-medications & doctor note must be at school by the first day*

Person (2 or 3) to call In Case of Emergency if parents are unable to be notified

Name	*Relationship to Child*	*Address*	*Phone*
1.			
2.			
3.			

Person (2 or 3) to whom child maybe Released To in absence of parents

Name	*Relationship to Child*	*Address*	*Phone*
1.			
2.			
3.			

ST. MARK'S PRESCHOOL - CONSENT FORM

CONSENT FOR: ____
Please print child's name

EMERGENCY/FIRST AID: In case of emergency or sickness, I hereby give my consent for St. Mark's Preschool to administer first aid or obtain emergency care. Should my child have a minor cut, small lump or bruise, I give my consent to the staff to provide basic first aid; such as washing the wound, applying a bandaid, applying an ice pack and also to control a minor nosebleed. Emergency care is through a clinic, hospital, or private doctor and this procedure will be used only if I cannot be reached.	**NO**	**YES**
FIELD TRIP: Field trips can provide for your child a variety of learning experiences. During the school year your child may be involved in trips away from school that may include car or neighborhood walks. This signed permission slip must be on file for your child to be able to participate. My child has my permission to be on any field trip that might occur during the year. **Parents will be notified of such trips in advance**.	**NO**	**YES**
PUBLICITY: I hereby give my consent for my child to be photographed, filmed or videotaped for security/publicity purposes, such as school/church newsletters, newspaper, slide shows and social media. No names are released/published without parent permission.	**NO**	**YES**
RELIGIOUS INSTRUCTION: I hereby give my consent for my child to receive religious instruction from St. Mark's Preschool.	**NO**	**YES**
PERMISSION TO DISTRIBUTE CLASS LIST: I hereby give my consent for St. Mark's Preschool to print my name, address, phone number and email on the class list that is distributed by the school.	**NO**	**YES**
SCHOOL PHOTOS: I hereby give my consent for St. Mark's Preschool to share my name, my child's name and my email with the approved school photographer for the purpose of me viewing/ordering my child's school picture.	**NO**	**YES**

E-MAIL ADDRESS: By sharing your email address with us we would be able to electronically send you the monthly newsletter and other important preschool related correspondence. Your email address will not be published or shared with anyone without your permission.

Email address: ____
(Your email address will not be shared without your permission.)

Signature of Parent/Guardian________________________________**Date**________

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ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

** If your child does NOT have an allergy, please complete"Name", "Allergy to: NONE" and sign at the bottom

NAME: ______________________ D.O.B: __________

TEACHER: ______________________ GRADE: __________

ALLERGY TO: ______________________

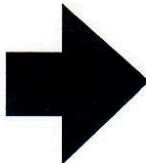
ASTHMA: ☐ YES (HIGHER RISK FOR A SEVERE REACTION) ☐ NO WEIGHT: ______

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)

Or COMBINATION of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain



INJECT EPINEPHRINE IMMEDIATELY

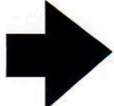
- Call 911
- Begin monitoring (see below)
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis)→use Epinephrine

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Vomiting, crampy pain



GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): ______________________

ANTIHISTAMINE (BRAND AND DOSE): ______________________

OTHER (E.G., INHALER-BRONCHODILATOR IF ASTHMA): ______________________

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ **Student may self-carry epinephrine** ☐ **Student may self-administer epinephrine**

CONTACTS: Call 911 Rescue Squad: ______________________

Parent/Guardian: ______________________ Phone: ______________________

Name/Relationship: ______________________ Phone: ______________________

Name/Relationship: ______________________ Phone: ______________________

LICENSED HEALTHCARE PROVIDER SIGNATURE: ______________________ Phone: ______________ Date: __________

(REQUIRED)

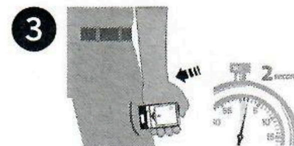
I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Grardian Signature: ______________________ Date: __________

FARE Food Allergy Research & Education — FOOD ALLERGY & ANAPHYLAXIS EMERGENCY CARE PLAN

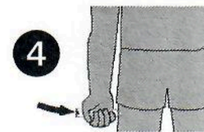
HOW TO USE AUVI-Q® (EPINEPHRINE INJECTION, USP), KALEO

1. Remove Auvi-Q from the outer case. Pull off red safety guard.
2. Place black end of Auvi-Q against the middle of the outer thigh.
3. Press firmly until you hear a click and hiss sound, and hold in place for 2 seconds.
4. Call 911 and get emergency medical help right away.



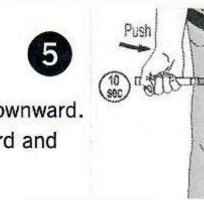
HOW TO USE EPIPEN®, EPIPEN JR® (EPINEPHRINE) AUTO-INJECTOR AND EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF EPIPEN®), USP AUTO-INJECTOR, MYLAN AUTO-INJECTOR, MYLAN

1. Remove the EpiPen® or EpiPen Jr® Auto-Injector from the clear carrier tube.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, remove the blue safety release by pulling straight up.
3. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
4. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.



HOW TO USE IMPAX EPINEPHRINE INJECTION (AUTHORIZED GENERIC OF ADRENACLICK®), USP AUTO-INJECTOR, AMNEAL PHARMACEUTICALS

1. Remove epinephrine auto-injector from its protective carrying case.
2. Pull off both blue end caps: you will now see a red tip. Grasp the auto-injector in your fist with the red tip pointing downward.
3. Put the red tip against the middle of the outer thigh at a 90-degree angle, perpendicular to the thigh. Press down hard and hold firmly against the thigh for approximately 10 seconds.
4. Remove and massage the area for 10 seconds. Call 911 and get emergency medical help right away.

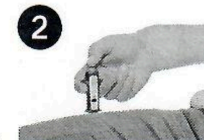


HOW TO USE TEVA'S GENERIC EPIPEN® (EPINEPHRINE INJECTION, USP) AUTO-INJECTOR, TEVA PHARMACEUTICAL INDUSTRIES

1. Quickly twist the yellow or green cap off of the auto-injector in the direction of the "twist arrow" to remove it.
2. Grasp the auto-injector in your fist with the orange tip (needle end) pointing downward. With your other hand, pull off the blue safety release.
3. Place the orange tip against the middle of the outer thigh at a right angle to the thigh.
4. Swing and push the auto-injector firmly into the middle of the outer thigh until it 'clicks'. Hold firmly in place for 3 seconds (count slowly 1, 2, 3).
5. Remove and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.

HOW TO USE SYMJEPI™ (EPINEPHRINE INJECTION, USP)

1. When ready to inject, pull off cap to expose needle. Do not put finger on top of the device.
2. Hold SYMJEPI by finger grips only and slowly insert the needle into the thigh. SYMJEPI can be injected through clothing if necessary.
3. After needle is in thigh, push the plunger all the way down until it clicks and hold for 2 seconds.
4. Remove the syringe and massage the injection area for 10 seconds. Call 911 and get emergency medical help right away.
5. Once the injection has been administered, using one hand with fingers behind the needle slide safety guard over needle.



ADMINISTRATION AND SAFETY INFORMATION FOR ALL AUTO-INJECTORS:

1. Do not put your thumb, fingers or hand over the tip of the auto-injector or inject into any body part other than mid-outer thigh. In case of accidental injection, go immediately to the nearest emergency room.
2. If administering to a young child, hold their leg firmly in place before and during injection to prevent injuries.
3. Epinephrine can be injected through clothing if needed.
4. Call 911 immediately after injection.

OTHER DIRECTIONS/INFORMATION (may self-carry epinephrine, may self-administer epinephrine, etc.):

Treat the person before calling emergency contacts. The first signs of a reaction can be mild, but symptoms can worsen quickly.

EMERGENCY CONTACTS — CALL 911

RESCUE SQUAD: ____________________

DOCTOR: ____________________ PHONE: __________

PARENT/GUARDIAN: ____________________ PHONE: __________

OTHER EMERGENCY CONTACTS

NAME/RELATIONSHIP: ____________________ PHONE: __________

NAME/RELATIONSHIP: ____________________ PHONE: __________

NAME/RELATIONSHIP: ____________________ PHONE: __________

ST. MARK'S PRESCHOOL - Pest Control Policy
101 S. 6th Avenue St. Charles, IL 60174
Office: (630) 584-4850   Fax: (630) 584-8646
E-Mail: preschool@stmarkslife.org

Dear Parents and Guardians,

The Illinois Department of Health requires that all licensed day care centers implement a pest management program. Public Act 95-0058 may be viewed on the Illinois General Assembly web site at: http://wwwilga.gov/legislation/publicfacts/fulltext.asp?Name=095-0058&GA=095.

This letter is to inform you that St. Mark's Preschool practices Integrated Pest Management. This is a program that combines preventive techniques, non-chemical pest control methods, and the appropriate use of pesticides with a preference for products that are the least harmful to human health and the environment. Applications of pesticides are made only when deemed necessary to control a pest problem and after trying other means to control the problem. The term "pesticides" includes insecticides, herbicides, rodenticides and fungicides.

Please sign below to indicate you have read and understand the Pest Control Policy.

Sincerely,
Julie Zimmermann, Director

••

I have read and understand the Pest Control Policy and that if there is an immediate threat to health or property that requires treatment before notification can be sent out, I will receive notification as soon as practical.

Parent/Guardian (please print) ____

Signature ____ Date ____________

Student's name ____

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ST. MARK'S PRESCHOOL - Late Pick-up Policy
101 S. 6th Avenue   St. Charles, IL 60174
Office: (630) 584-4850   Fax: (630) 584-8646
E-Mail: preschool@stmarkslife.org

The ILLINOIS DEPARTMENT OF CHILDREN AND FAMILY SERVICES is requiring all licensed programs to adhere to a late pick-up policy. Below is St. Mark's Preschools policy for you to read, sign, date and return to us. The Illinois Department of Children and Family Services (DCFS) requires us to keep a signed copy of this form in your child's folder. This policy is included as part of the parent handbook.

Please contact the school if you will be late in picking-up your child. This will enable the staff to reassure the child he/she has not been forgotten and someone will be here soon.

If we have not heard from the parent within 10 minutes of dismissal, attempts will be made to reach the parent/guardian. In the event we are unable to reach the parent/guardian within the next 10 minutes, the emergency contact persons will be called. The staff will make no less than four attempts to reach the parent/guardian and/or contact persons.

If the staff is unable to contact a parent/guardian or emergency contact person within 45 minutes of the dismissal of the class, DCFS mandates that we contact the police or DCFS for assistance.

The child will remain with the teacher until the parent or outside authority arrives. The Director or a staff member will stay with the child if the classroom staff is unable to remain with the child after class hours. At no time will the child be held responsible for the late situation. No discussion of the situation will be held in the presence of the child.

There is no charge for late pick-up unless it becomes a chronic situation. In that situation, after a one time warning, $10.00 will be charged after 15 minutes and every 15 minutes thereafter. This fee will be collected at the time of pick-up or added to the next month's tuition.

For the protection, well-being, and safety of your child, it is important that we have current, local emergency contact names and numbers as well as cell phone numbers for the parents/guardians.

Parent/Guardian (please print) ____

Signature ____ Date ____________

Student's name ____

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ST. MARK'S PRESCHOOL - Checklist
101 S. 6th Avenue   St. Charles, IL 60174
Office: (630) 584-4850   Fax: (630) 584-8646
E-Mail: preschool@stmarkslife.org

St. Mark's Preschool Registration Check-list 2025-2026

- ☐ Enrollment Form and $100 non-refundable deposit *(Check made out to "St.Mark's Preschool")*
- ☐ Emergency Information Form
- ☐ Consent Form
- ☐ Emergency Action Plan (if child has ANY allergies complete the form, *if not just sign and return*)

**IF your childs is prescribed medications for his/her allergy, we require a note from the doctor & the medications to be kept at school by the first day of class

- ☐ Pest Control Policy Form
- ☐ Late Pick-up Policy Form
- ☐ Copy of Birth Certificate *(If a current 24/25 student, we have this on file already)*
- ☐ Physical Form (*signed by your child's doctor and you*)

All forms can be dropped off or mailed to:

St. Mark's Preschool
101 South 6th Ave.
St. Charles, IL 60174
OR
Faxed to: (630) 584-8646

Please contact our office with any questions
(630) 584-4850 or preschool@stmarkslife.org