TRIPOLI COMMUNITY SCHOOLS
PRESCHOOL PROGRAM INFORMATION

Please complete the attached paperwork if you have a new Tripoli Preschool student(s). If your student(s) has already attended please update any new information for our records. Payment must be paid at registration and a copy of your child's birth certificate must be provided. Space is limited, so please register soon. **Paperwork and payment must be received in order to guarantee your student(s) place in the Preschool program**. Registration will be closed on **January 31st** and will reopen depending on space availability.

The following criteria will determine which students are admitted into our preschool or placed on a waiting list. The following list is not necessarily the order that will be used.

1. Tripoli student
2. Student was enrolled the previous year
3. Age
4. Academic/Behavioral IEP students
5. Date of enrollment

Thank you,
The Tripoli Preschool Program

TRIPOLI COMMUNITY SCHOOLS
PRESCHOOL PROGRAM INFORMATION

There is a $55.00 operational fee for this program. In order to enroll, your child needs to be at least 3 years old by September 15, 2024 and a copy of your child's birth certificate must be provided.

Tripoli resident students that are 4 years old by September 15, 2024 will be eligible for half price tuition.

Preschool Tuition Scholarship applications will be available to income-eligible families as a result of funding through the Together 4 Families Collaborative. Applications are typically available in the spring. If you would like an application, please contact the elementary office at 882-4203. This scholarship is not funded by Tripoli Schools. **The school will not be able to help with fees if scholarships are not approved.**

Monthly payments are due the first school day of each month. Weekly payments are due every Monday. You may pay for more than one month/week if you choose to do so.

Weekly payments that are past due for more than two weeks and monthly payments that are not paid by the second week of the month will result in your child not attending the program until fees are paid.

Breakfast is served each morning at 7:50am. Lunch will be served at 11:10am for preschool students. Students eating breakfast and/or lunch will need a family meal/milk account. Snack milk will be added to the family meal/milk account.

Preschool hours are 8:15am to 11:15pm for AM half day students. All payments for tuition, meals and snack milk can be made online with our School Pay program. https://www.schoolpay.com/login

A Parent Meeting will be announced later in the year.

Please call the elementary office at 319-882-4203 if you have any questions or concerns.

Thank you,
The Tripoli Preschool Program

Tripoli Community Schools
Preschool Registration

Date_____

Student Name _____ Male_____ Female_____
Last First Middle

Preferred School Name _____ Date of Birth_____

Birthplace_____ Primary Home Language _____

Ethnicity:(Circle what applies) No, not Hispanic/Latino Yes, Hispanic/Latino

Race: (Circle all that apply) 1-Am. Indian/Alaska Native 2-Asian 3-Black or African American
4-Native Hawaiian/Pacific Islander 5-White

Parent/Guardian Information

____Parent 1 Living ____Parent 2 Living

____Primary Contact ____Secondary Contact

Parent 1_____
First Last

Guardian_____
First Last

Address_____
Street PO Box

County_____

City_____Zip_____

E-Mail _____

Cell # _____

Employer _____

Employer Telephone _____

____Divorced ____Parents Separated

____Primary Contact ____Secondary Contact

Parent 2_____
First Last

Address_____
Street PO Box

County_____

City_____Zip_____

E-Mail _____

Cell # _____

Employer _____

Employer Telephone _____

Please list two emergency contacts who will assume temporary care of your child if you cannot be reached.

Name_____Phone_____
Relationship

Name_____Phone_____
Relationship

In case of an accident or serious illness, I request the school contact me. If the school is unable to reach me, I authorize the school to use their best judgment to contact emergency services as needed and make whatever arrangements are necessary. I will not hold the school district financially responsible for the emergency care and/or transportation for said child/children.

I give permission to the Tripoli Community School Certified Personnel to give a non-aspirin pain reliever to my child/children? (Please circle) YES or NO

Physician _____Phone_____
Address City State

Dentist _____Phone_____
Address City State

Parent/Guardian Signature _____Date_____

TRIPOLI COMMUNITY SCHOOLS
BUS TRANSPORTATION

PLEASE FILL THIS FORM OUT IF YOU ARE AN ALL DAY PK STUDENT!

Student's Name

Transportation will be available for students to ride the bus in the morning before school and at the end of the day. There will be no transportation for the AM preschool session.

_____My Child will not need bus transportation.

_____My Child will need bus transportation.

The bus that goes by our house is _____

My child will ride the AM bus from:

_____ _____

Name Address

My child will ride the PM bus to:

_____ _____

Name Address

Parent Signature **Date**

Before & After School Child Care Program

Our Before & After School Child Care Program is open during the school year everyday that school is in session. Hours and availability are subject to change.

Registration for the Before & After School Child Care Program will be available during school registration.

TRIPOLI COMMUNITY SCHOOLS
PRESCHOOL PROGRAM SESSION

Please indicate which session you prefer and return with all registration materials and fees to the elementary office. Due to availability not all selections can be honored.

In order to enroll, your child needs to be at 3 years old by September 15, 2024.

A non-refundable $55 operational fee (per student) must be paid at registration and a copy of your child's birth certificate must be provided.

Student Name_____

_____4 year old only Full Day Program – 5 days/Week (M-F) $50.00/Week with the applied 4 yr old grant for Tripoli residents.

_____1/2 Day Program – 5 Days/Week (M-F) $150.00/Month

_____AM

_____1/2 Day Program – 4 Days/Week (M-TH) $120.00/Month

_____AM

****Tripoli resident students that are 4 years old by September 15, 2024 will be eligible for half price tuition. ****

Comments:

From the School Nurse:

Your child will need a preschool physical and updated immunization sheet by the first day of school. Medical offices become very busy as it gets close to the beginning of school in August, so it is a good idea to schedule the physical earlier to avoid this. Please bring the physical and immunization forms to the elementary school office.

Thank you.

Infant, Toddler, Preschool Age – Child Health Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name	Child's birthdate	Child Care Facility _____ Telephone # _____
Parent/Guardian name #1	Parent/Guardian name #2	
Child home address #1		Telephone # 1
Child home address #2		Telephone #2
Where parent/guardian # 1 works	Work address	Home phone # Work # Cellular # Home email Work email
Where parent /guardian # 2 works	Work address	Home phone # Work # Cellular # Home email Work email

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian. ☐ **YES** ☐**NO**

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: _____ Date _____

Alternate emergency contact person's name:_____ Phone # _____

Relationship to child: Cellular # _____

Child's doctor's name	Doctor telephone # 1	Hospital choice **Phone #**_____
Doctor's address	After hours telephone #	Does child have health insurance? ☐Yes, Company _____ **ID #**
Child's dentist's name (or family's dentist name)	Dentist Telephone # 1	Does child have dental insurance? ☐Yes, Company _____ **ID#**
Dentist's Address	After hours telephone #	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.**
Other health care specialist name Type of specialty	Telephone #	☐ **Please help us find health or dental insurance.**

PARENT/GUARDIAN COMPLETE THIS PAGE **Child's Name:** _____

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

Growth
☐ I am concerned about my child's growth.

Appetite
☐ I am concerned about my child's eating/ feeding habits or appetite.

Rest -
☐ I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child
☐ had a serious illness, injury, or surgery..

Please describe:

Physical Activity - My child
☐ must restrict physical activity.

Please describe:

Development and Learning
☐ I am concerned about my child's behavior, development, or learning.

Please describe:

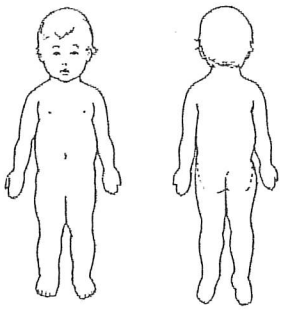
☐ **Allergies**-My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

Please describe:

☐ **Special Needs Care Plan** – My child has a special needs care plan (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

Body Health - My child has problems with
☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses
☐ Ears \ hearing, hearing aides or device, earaches, tubes in ears
☐ Nose problems, nosebleeds, runny nose
☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough, croup
☐ Heart, heart murmur
☐ Stomach aches, upset stomach, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

Parent/Guardian questions or comments for the health care provider:

Dr. Completes

Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child's Name: _____

Birthdate: _____ **Age today:** _____

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI– starting at age 24 mo. _____

Head Circumference- age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr: _____

Hgb or Hct- @ 12 mo: _____

Lead Risk Assessment: _____

Blood Lead Level: date _____ results _____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐ No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth

Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Health Care Provider comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious.

☐ TB testing completed (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at the child care facility: (include *over-the-counter* and *prescribed*)

Medication Name	Dosage
☐ Diaper crème:	
☐ Fever or Pain reliever:	
☐ Sunscreen:	
☐ Other	

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

☐ Referred to ***hawk-i*** today 1-800-257-8563

☐ Other: _____

Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(please attach)

May use stamp

Signature _____
Circle the Provider Credential Type: MD DO PA ARNP
Address: Telephone:

[1] Iowa Child Care Regulations require an admission physical exam report within the previous year and annually.
The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015)
https://www.aap.org/en-us/Documents/periodicity_schedule.pdf