



# Marquette Academy

*Academic Excellence in a Catholic Community*

March 19, 2024

Dear Parents,

We are beginning to prepare for the next school year at Marquette Academy.

We will host a Preschool Open House on Tuesday, 3/19 from 5:00 – 6:00 pm. The registration process will also open that evening.

**A preschool student will be considered registered when the \$300 registration fee is paid and all required forms have been completed and turned in.**

The required forms are:

- Preschool Application
- Copy of your child's birth certificate (if this is their first year in preschool)
- Medical Information / Emergency Form
- Permission Form for School Walking Trips
- Complete doctor physical with updated immunizations –**turned in when school starts in August (if this is their first year in preschool).**

**All registration will be on a first come first serve basis.** Each class will have a cap of 20 students. If you have any questions regarding the Preschool programs or the registration process, please contact the office at 815-433-1199. Thank you for sending your students to Marquette Academy.

Respectfully yours,

Brooke Rick  
Principal  
Marquette Academy

# MARQUETTE ACADEMY PRESCHOOL APPLICATION

Students Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age as of 9/01/24 \_\_\_\_\_ Current Date: \_\_\_\_\_

Street address: \_\_\_\_\_ City \_\_\_\_\_ Zip Code: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name \_\_\_\_\_

Marital Status: Married  Single Parent  Divorced

Parent Email Address: \_\_\_\_\_ Mom

Parent Email Address: \_\_\_\_\_ Dad

If divorced, who has legal custody/who does the child live with? Mom \_\_\_\_\_ Dad \_\_\_\_\_

Phone#: \_\_\_\_\_ Father's Cell: \_\_\_\_\_ Mother's Cell: \_\_\_\_\_

Father's Place of Employment: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mother's Place of Employment: \_\_\_\_\_ Phone #: \_\_\_\_\_

Name of Parish in which you are registered and participating: \_\_\_\_\_

\*\*\*Medical/health conditions we should be aware of: \_\_\_\_\_

**\$300.00 non-refundable down payment is required to register**

Paid Cash  Paid w/check (# \_\_\_\_\_)

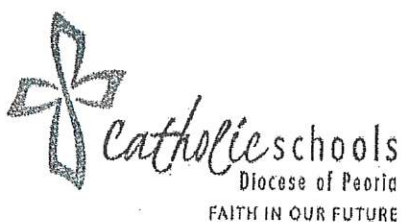
\_\_\_\_\_ Power Pre-School - 4 year old full week all-day program (M-F)  
8:05 a.m. until 2:35 p.m. on M, W, Th and Fri and 8:05 am until 2:05 pm on Tues

\_\_\_\_\_ Traditional Pre-School - 4 year old full week half day program  
(MTWRF) 8:15 a.m. until 11:15 a.m.

\_\_\_\_\_ Three year old Pre-School - 3 year old half-day (MWF) 8:15 a.m.  
until 11:15 a.m.

\_\_\_\_\_ Three year old Pre-School - 3 year old half-day full week (M-F) 8:15 a.m.  
until 11:15 a.m.

In regards to daycare, I'm interested in the following hours: \_\_\_\_\_



## MEDICAL INFORMATION

STUDENT/MINOR NAME (first, middle, last): \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

STUDENT/MINOR'S DOCTOR (first, middle, last): \_\_\_\_\_ Phone: \_\_\_\_\_

MEDICAL CONDITIONS: Please list any medical conditions of the student/minor (asthma, diabetes, epilepsy, etc.):  
\_\_\_\_\_  
\_\_\_\_\_

List any allergies or allergic reactions to medications of the student minor: \_\_\_\_\_  
\_\_\_\_\_

List any medications the student/minor is presently taking: \_\_\_\_\_  
\_\_\_\_\_

Other pertinent medical information: \_\_\_\_\_

Date of student/minor's most recent tetanus shot: \_\_\_\_\_

MEDICAL INSURANCE INFORMATION: Insurance Company: \_\_\_\_\_

Plan Number: \_\_\_\_\_ Employee Identification#: \_\_\_\_\_

EMERGENCY CONTACTS: Parent or Guardian (first, middle, last name): \_\_\_\_\_

Cell: \_\_\_\_\_ Work: \_\_\_\_\_ Home: \_\_\_\_\_

Other Contact: Name (first, middle, last): \_\_\_\_\_

Phone (with area code): \_\_\_\_\_ Relationship to student/minor: \_\_\_\_\_

### AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

*This information will be kept in the possession of the school/parish. A copy may be distributed to the person in charge of each trip or athletic activity in which the student/minor participates. Should the need arise this information will be given to the proper medical authorities.*

I, \_\_\_\_\_, [parent/guardian], understand that in the case of illness or injury to my child, \_\_\_\_\_ [child's name], the school/parish will try to notify me or the person I have listed as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school/parish to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_



**Marquette Academy**  
**PERMISSION FORM FOR SCHOOL WALKING TRIPS**

I am the custodial and responsible parent/guardian of \_\_\_\_\_  
Name of Student(s)

I request that Marquette Academy allow my school aged child(ren) to participate in walks to various locations around the Marquette Academy Early Education campus neighborhood. The Marquette Academy teachers and students will take walks to learn about what is currently being studied in class, such as the signs of changes in the seasons and traffic signs.

I request that Marquette Academy allow my preschool, elementary and/or high school aged child(ren) to participate in walks between the Marquette Academy campuses for Masses, plays, retreats, etc. I also request that M.A. allow my student to participate in walks to WCMY Radio Station, 216 Lafayette Street and to area parks.

The activity will be supervised by at least one school employee.

If my child is injured in any way during this trip and if I cannot be immediately contacted at the following phone number \_\_\_\_\_, I grant full power to the supervising school employee to do as follows:

1. Arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and
2. Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

I understand the risks such trips present to my child, including, but not limited to, serious personal injury or death. Any questions I have concerning these trips have been answered.

In consideration for my child being allowed to make any walking trip, I hereby RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS the Diocese, the parish, the school and their employees and agents, and the volunteers assisting the school, from any and all liability for injuries, damages, medical expenses, or any other loss to my child or family or me (including attorney's fees) arising from or related to my child's participation in an activity.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed name of Parent/Guardian

\_\_\_\_\_  
Printed name of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



# Certificate of Child Health Examination

Student's Name Last                      First                      Middle			Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Street Address                      City                      ZIP Code			Parent/Guardian		Telephone (home/work)	

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

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

**IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine/Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
Hib Haemophiles Influenza Type B																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles, Mumps, Rubella																		
Varicella (Chickenpox)																		
Meningococcal Conjugate																		
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Comments: \* indicates invalid dose

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 \_\_\_\_\_



<b>Student's Name</b>	<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>School</b>	<b>Grade Level/ID#</b>
Last _____ First _____ Middle _____				

**Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.**

**ALTERNATIVE PROOF OF IMMUNITY**

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.  
 \*MEASLES (Rubeola) (MO/DA/YR) \_\_\_\_\_ \*\*MUMPS (MO/DA/YR) \_\_\_\_\_ HEPATITIS B (MO/DA/YR) \_\_\_\_\_ VARICELLA (MO/DA/YR) \_\_\_\_\_

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

3. Laboratory Evidence of Immunity (check one)  Measles\*  Mumps\*\*  Rubella  Varicella Attach copy of lab result.  
 \*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.  
 \*\*All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Physician Statements of Immunity MUST be submitted to IDPH for review.  
 Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: \_\_\_\_\_

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

HEAD CIRCUMFERENCE if < 2-3 years old \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BMI \_\_\_\_\_ BMI PERCENTILE \_\_\_\_\_ 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 QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered?  Yes  No Blood Test Indicated?  Yes  No Blood Test Date \_\_\_\_\_ Result \_\_\_\_\_

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. [http://www.cdc.gov/tb/publications/factsheets/testing/TB\\_testing.htm](http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm)

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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Sickle Cell (when indicated)			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>
Ears	<input type="checkbox"/>	Screening Result:	Gastrointestinal	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Screening Result:	Genito-Urinary	<input type="checkbox"/>
Nose	<input type="checkbox"/>		Neurological	<input type="checkbox"/>
Throat	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>
Mouth/Dental	<input type="checkbox"/>		Spinal Exam	<input type="checkbox"/>
Cardiovascular/HTN	<input type="checkbox"/>		Nutritional Status	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis of Asthma	Mental Health	<input type="checkbox"/>
Currently Prescribed Asthma Medication:			Other	<input type="checkbox"/>
<input type="checkbox"/> Quick-relief medication (e.g., Short Acting Beta Agonist)				
<input type="checkbox"/> Controller medication (e.g., inhaled corticosteroid)				

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  Yes  No  Modified

Print Name \_\_\_\_\_  MD  DO  APN  PA Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_