CFS 428
Rev. 4/2001

State of Illinois
Department of Children and Family Services

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child _____ Birthdate _____ Sex _____

Address _____

Date Child Received _____ Date Child Left _____

PARENT OR OTHER PERSONS(S) PLACING THE CHILD

Name _____ Name _____

Relation to child _____ Relation to child _____

Home address _____ Home address _____

_____ _____

Phone Number _____ Phone Number _____

Place of employment _____ Place of employment _____

_____ _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Working hours _____ Working hours _____

OTHER PERSON TO NOTIFY IF PERSON PLACING THE CHILD CANNOT BE REACHED

Name _____ Address _____

Phone Number _____ Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name _____ Address _____

Phone Number _____ Hospital or Clinic _____

PROGRAM

Days per week _____ Hours of care _____

Rate of pay (optional) _____

_____ _____ _____

Signature of parent or other person placing child **Signature of caregiver** **Date**

A completely filled in form must be kept by the licensee for each child not related to the licensee. Please have this form available at all times to licensing representatives of the Department of Children and Family Services. Contact the Area Office for supplies of this form.

If the child has any of the following, please explaining:

Medical problems _____

Physical handicaps _____

Restrictions for play—outdoors _____

Restrictions for play—indoors _____

Allergies _____

Food likes _____

Food dislikes _____

Fears _____

Does the child take a nap? _____ Time _____ Length _____

Is the child toilet trained? _____

Does the child have special names for objects? (potty, cookies, drinks, etc.) _____

Does the child regularly take medication? _____ If so, what kind and directions _____

If the child is an infant, what are the feeding instructions? _____

Time _____ Amount _____ Temperature _____

Diaper changes: Powder _____ Ointment _____

Other information that will help in caring for the child _____

Comments:

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

Student's Name (Last First Middle)	Birth Date (Month/Day/Year)	Sex	Race/Ethnicity	School /Grade Level/ID#
Address (Street City Zip Code)	Parent/Guardian	Telephone # Home	Work	

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)						
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

COMMENTS:

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**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

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

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																					**Code:**
Age/ Grade																					
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**P = Pass**
Vision																					**F = Fail**
Hearing																					**U = Unable to test** **R = Referred** **G/C = Glasses/Contacts**

Student's Name (Last / First / Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID #

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

ALLERGIES (Food, drug, insect, other)

Diagnosis of asthma?	Yes	No	
Child wakes during the night	Yes	No	
Birth defects?	Yes	No	
Developmental delay?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	
Diabetes?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No	
Seizures? What are they like?	Yes	No	
Heart problem/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			
Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

MEDICATION (List all prescribed or taken on a regular basis.)

Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List all.) When? What for?	Yes	No	
Serious injury or illness?	Yes	No	
TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
TB disease (past or present)?	Yes*	No	
Tobacco use (type, frequency)?	Yes	No	
Alcohol/Drug use?	Yes	No	
Family history of sudden death before age 50? (Cause?)	Yes	No	

Dental ☐ Braces ☐ Bridge ☐ Plate Other

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature **Date**

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

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **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 age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. **Questionnaire Administered ?** Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

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. **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		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes		Amblyopia Yes☐ No☐	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

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

PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ (If No or Modified,please attach explanation.)

INTERSCHOLASTIC SPORTS (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

Institution Name: DAY CARE RESOURCES Agreement Number: 53090014P00

Facility/Provider Name: Ivy League Day School 128

Child and Adult Care Food Program (CACFP)
Participant Enrollment Form

Dear Parent/Guardian,

Your day care facility participates in the U.S. Department of Agriculture (USDA) Child and Adult Care Food Program (CACFP). The enrolled participant will receive nutritious meals and snacks at no cost to you. CACFP needs verification of enrollment for each participant in this facility. Please fill out the parent/guardian section of this form, sign it and return it to the above facility/provider. Provide information for one participant per section. **(In order for the institution to receive reimbursement for meals served/claimed, this form must be completed for each enrolled participant annually.)**

Parent/Guardian Please Complete:

Participant's (Child) Name: _____ Date of Birth: _____ Age: _____

Sex: ☐ Male ☐ Female Date participant enrolled in the facility: _____

Food Allergies: ☐ Yes ☐ No If "yes" specify: _____

Check Days of Normal Care at facility: ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

Check meals normally eaten at facility: ☐ Breakfast ☐ AM Snack ☐ Lunch ☐ PM Snack ☐ Supper ☐ Evening Snack

Please list the normal times of arrival and departure (check am or pm) **Arrive:** _____ ☐ am ☐ pm **Depart:** _____ ☐ am ☐ pm

Participates in CACFP? Yes ☐ No ☐ School Times: **Depart:** _____ ☐ am ☐ pm **Return:** _____ ☐ am ☐ pm

Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
☐ Hispanic or Latino	☐ Asian	☐ America Indian/Alaska Native
☐ Not Hispanic or Latino	☐ White	☐ Native Hawaiian or Other Pacific Islanc
	☐ Black or African American	

If participant is an infant (0-11 months), please complete this box, Check all applicable choice(s) below:

This institution/facility offers _____ formula for infants through CACFP. It is your choice
(To be completed by facility/provider)

whether or not to use this formula based on your infant's needs. Baby foods provided by the institution/facility must be in compliance with the infant meal pattern as required by 7CFR 226.20.

☐ I will use the formula offered by this facilty. I give permission for the formula to be mixed and/or bottles to be prepared for my infant by this facility's staff.

☐ I will not use the formula offered by this facilty.
If not, which formula will you send for your infant? _____
If the formula you provide is a special formula, a medical statement must be submitted.

☐ I will provide breastmilk for my infant.

Choose One Infant Foods Option -

☐ 1. Facility supplies supplemental foods when developmentally appropriate

☐ 2. Parent supplies supplemental foods and refuses the facilities foods

Parent/Guardian Signature: _____ Date: _____

Print Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____

Work Telephone Number: _____ Check Work Shift: ☐ 1st ☐ 2nd ☐ 3rd ☐ Other (Specify)

For Facility/Provider Use Only:

Signature of Facility Representative/Provider: _____ Date: _____

Date the Participant Withdrew: _____

This institution is an equal opportunity provider.

HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS
CHILD AND ADULT CARE FOOD PROGRAM

1. All Household Members		**2.**	**3.**
NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	**FOSTER CHILD** Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to #6.	**SNAP or TANF CASE NUMBER** Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

4. Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

_____ _____
Signature of Homeless Liason, Migrant Coordinator, or Head Start Director Date

5 Total Household Gross Income (before deductions) You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	**GROSS INCOME AND HOW OFTEN IT WAS RECEIVED** (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	Earnings from Work (Before Deductions)		**Welfare, Child Support, Alimony**		**Pensions, Retirement, Social Security**		**Worker's Comp., Unemployment, SSI, etc. (All other income)**	
	Amount	How Often?	Amount	How Often?	Amount	How Often?	Amount	How Often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "*I do not have a Social Security Number*" box.

* * * - * * - _ _ _ _
Social Security Number

☐ **I do not** have a social security number.

I certify all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date *Printed Name of Adult Household Member* *Signature of Adult Household Member*

7 Contact Information (Optional)

Work Telephone Number (Include Area Code) *Home Telephone Number (Include Area Code)* *Home Address (Number, Street, City, State, ZIP Code)*

8 Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Mark one or more racial identities:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

9 Optional - Sharing Information With All Kids Insurance Program

May we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If **yes**, do not sign below.
☐ No, I do not want my information from this application shared with the *All Kids Insurance Program*

Date: _____ Sign here: _____

CHILD CARE REPRESENTATIVE USE ONLY
Eligibility Determination - Complete Sections A and B Below

SECTION A **Annual Income Conversion Weekly X 52 Every 2 Weeks X26 Twice a Month X 24 Once a Month X 12** **Convert income only if different frequencies of pay are reported.**

TOTAL INCOME $ _____ **Per:** ☐ **Week** ☐ **Every 2 Weeks** ☐ **Twice a Month** ☐ **Month** ☐ **Year** **NUMBER IN HOUSEHOLD:** _____

☐ **Free based on:**
- ☐ foster child
- ☐ SNAP or TANF
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ household's income
- ☐ Head Start

☐ **Reduced based on:**
- ☐ household's income

☐ **Denied -- Reason:**
- ☐ income too high
- ☐ incomplete application
- ☐ Non-qualifying SNAP/TANF

SECTION B **Signature *of Determining Official:*** _____ ***Date*** _____

ISBE 69-88 (5/20) Effective July 1, 2020

INSTRUCTIONS FOR APPLYING - COMPLETE ONE APPLICATION PER HOUSEHOLD

Follow These Instructions and Return the Completed form to your Center. Once approved for meal benefits, a child's Household Eligibility Application is effective for 12 months.

FOSTER CHILD(REN)

A foster child remains the legal responsibility of the state through a foster care agency or the court. If you submit documentation from the state or local agency that the child is in foster care, that documentation replaces completing a Household Eligibility Application.

1) If all children in your household (who attend this center) are foster children that are the legal responsibility of a foster care agency or court, provide the following:
- Part 1 - List the name(s) and age(s) of your foster child(ren) attending this center.
- Part 2 - Check the box(es) indicating a foster child(ren).
- Part 3-5 Skip
- Part 6 - Provide a signature of an adult household member and date the application.
- Parts 7-9 - (OPTIONAL)

2) If you have some foster children that are the legal responsibility of a foster care agency or court along with other children attending this center, please provide the following:
- Part 1 - List ALL household members, including the foster child(ren), and the age(s) of the child(ren) attending the center.
- Part 2 - Check the box(es) identifying the foster child(ren).
- Part 3 - Record a valid SNAP/TANF case number if applicable
- Part 4-Skip
- Complete Parts 5 and 6 if applicable. See the instructions for INCOME-HOUSEHOLDS REPORTING section.
- Parts 7-9 - (OPTIONAL)

SNAP OR TANF BENEFITS - HOUSEHOLDS RECEIVING

If any member (child or adult) of your household receives SNAP or TANF benefits, provide the following:
- Part 1 - List ALL people in your household (including grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the center.
- Part 2 - Skip
- Part 3 - Record a valid SNAP or TANF case number for any member (child or adult) of this household. You will find your SNAP or TANF case number on your letter of eligibility for benefits.
- Part 4 - 5 Skip
- Part 6 - Provide a signature of an adult household member and date the application.
- Parts 7-9 - (OPTIONAL)

HOMELESS, MIGRANT, RUNAWAY, OR HEAD START

If no one in your household receives SNAP or TANF benefits and if any child is homeless, a migrant, a runaway, or head start, follow these instructions.
- Part 1 - List ALL household members, and the age(s) of the child(ren) attending the center.
- Part 2 - 3 Skip
- Part 4 - If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your local school.
- Part 5 - Complete only if a child in your household isn't eligible under Part 4. See instructions for INCOME - HOUSEHOLDS REPORTING section below and complete Parts 5 and 6.
- Part 6 - Provide a signature of an adult household member and date the application.
- Parts 7-9 - (OPTIONAL)

INCOME - HOUSEHOLDS REPORTING

If no one in your household receives SNAP or TANF benefits, please report all household income. The Household Eligibility Application must include the following information:
- Part 1 - List the names of ALL household members and the age(s) of the child(ren) attending the child care center.
- Part 2 - 4 Skip
- Part 5 - List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for last month. If the income last month was not the usual amount you normally receive, you may provide a projected amount that better represents your gross income.
  - For ONLY the self-employed, list income after expenses. This is for your business, farm, or rental property.
  - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
  - If you have no income, list zero in the earnings from work column.
- Part 6 - Provide a signature of an adult household member and date the application. Also, provide the last four digits of the Social Security Number for the adult signing the application. If you refuse to provide the last four digits of the social security number, the application cannot be approved. If the adult does not have a Social Security Number, mark the box, I do not have a Social Security Number.
- Parts 7-9 - (OPTIONAL)

PRIVACY AND DISCRIMINATION STATEMENT

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.

CFS 593
Rev 7/2007

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD _____

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES.

Parent(s) or legal guardian placing the child may sign any or all of the following consents:

EMERGENCY MEDICAL CARE

This authorizes _____ to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement. _____ is the preferred doctor/clinic/hospital.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize _____ to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER OVER-THE-COUNTER MEDICINE

(Administer only in accord with the appropriate standards for licensure)

I/we authorize _____ to administer over-the-counter medicine to my/our child as specified in written instructions.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

- over -

CHILD PICKUP

(Use additional sheet of paper if more than 3 people are authorized to pick up child)

I/we authorize _____
Name Address Phone

and/or

_____
Name Address Phone

and/or

_____
Name Address Phone

to pick up my/our child when I am/we are unavailable.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES

I/we authorize _____ to take my/our child on walking trips, special excursions, and to nearby public park facilities. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the above-named person(s). I/we understand all such trips are under the supervision of the above-named person(s) and that health and safety precautions are taken in compliance with DCFS standards for licensure.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

SWIMMING

I/we consent to my/our child using the swimming pool of _____
Name of Provider

at _____.
Address

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Photo, Video, & Internet Consent

I give Clark Academy permission to take photos of my child(ren) Yes or No

I give Clark Academy permission to take video of my child(ren) Yes or No

I give Clark Academy permission to use my child(ren)'s likeness on social media Yes or No

Student's Name (s):_____

Parent Signature:_____

Date:_____

Parent Handbook Acknowledgement

I have read and understand the guidelines set forth in the Clark Academy, INC Parent Handbook. I am aware that violation of the polices outlined in the handbook will result in the expulsion of my child/children from Clark Academy, INC. I acknowledge that by signing below I am agreeing to all stated policies and procedures.

Parent Signature:_____

Date:_____

Certified Birth Certificate

The State of Illinois in cooperation with the Amber Alert system is now requiring all newly enrolled children of childcare facilities to have a copy of your child's birth certificate on file. The certified copy is that which you received from the court house of the county and state of which the child is born. We are required to report to the State Police or local law enforcement if you fail to comply within 30 days of enrollment.

I certify that I, _____, licensee of this daycare center have seen on this date, _____the original birth certificate and a copy was made and the original returned to the parent.

Child(ren) Name(S):_____

Parent Signature:_____

Director Signature:_____

Parent Portal

The parent portal tracks your child's day. Please sign up with your email and we will send you a link to register for the Portal online. There is also a parent app that can be downloaded. With the Portal you can see your child's daily chart, send and receive messages from teachers and receive pictures throughout the day. You can also view your account and make payments using the Portal.

Procare Connect is the name of the App for downloading.

List names and email addresses from the Parent Portal:

_____

_____

Registration Fees

A registration fee for enrollment is due before enrollment folders are given. A single child packet is $25 and a family packet is $50.

☐Fee has been paid ☐A fee of _____is due

Director Signature:_____

Procare App

Parents/teachers can download the Procare Connect App, by using the code in the email provided to you. Parents can communicate and keep up to date on daily activities of their child/children.

Online Payments

Families can make online payments and view their accounts by going to www.myprocare.com. Online payments cannot be made through the Procare Conncect App.

Child Information Sheet

This page will be given to your child's teacher. Please answer each question in detail so we can provide the best care for your child!

Name:_____ Birthdate: _____

Drop off (who, when, routine):

Food (likes, dislikes, kind of cup used, silverware, bottle info, or accommodations):

Words or gestures ("ba-ba" for bottle, etc):

Sleeping routine (tucked in, lights off, etc.):

Potty/diapering routine (assistance, cream, sitting or standing, etc.):

Specific interests (dinosaurs, toys with lights, etc.):

Other comments or concerns:

Pick-up (who, when, any specifics):