

## **Parent Checklist ~ Enrollment Forms:**

Please print, review and fill out the following forms, and return no later than your child's **first day**.

- ☐ Enrollment Application - fill out if you have not previously submitted
  - ☐ Consent Forms
  - ☐ Birthday Story - to be completed by your child's birthday
  - ☐ Physical - to be completed by your child's physician
  - ☐ DCFS Licensing Standards - A separate link is provided for the DCFS Licensing Standards. Please read and keep for your records and then sign the form at the end of this document.
  - ☐ Copy of child's Birth Certificate - bring this in for your child's file
- 
- ☐ Parent Packet- A link to the Parent Packet can be found in the enrollment tab on our website. Please review and keep for your records as it contains general information and policies about the Montessori Children's Centre.

# Montessori Children's Centre Enrollment Application

3 Yount Drive Bloomington, IL 61704 (309) 663-8736

[mccmontessori@gmail.com](mailto:mccmontessori@gmail.com)

[www.montessorichildren.net](http://www.montessorichildren.net)

## **CHILD:**

Full Name (First, Middle, Last) Preferred Name

Male \_\_\_\_\_ Female \_\_\_\_\_

Birth date

Home Address

City State Zip Home Phone

## **PARENT/GUARDIAN:**

Marital Status \_\_\_\_\_

Name

Home Address

City State Zip Home Phone

Place of Employment Occupation

Employment Address Work Phone

Cellular Phone E-mail Address

## **PARENT/GUARDIAN:**

Marital Status \_\_\_\_\_

Name

Home Address

City State Zip Home Phone

Place of Employment Occupation

Employment Address Work Phone

Cellular Phone E-mail Address

## **In Case of an Emergency** (if parents cannot be contacted)

Emergency Name Home Phone Work Phone

Address City State Zip

Physician Name Phone

Address City State Zip

I am interested in (check all that apply): ☐ 5 Day ☐ 3 Day (M/W/F) ☐ 2 day (T/Th)

Our weekly newsletter will be sent to the email addresses listed on the front of the application unless otherwise specified here \_\_\_\_\_

List names and ages of siblings \_\_\_\_\_

Please list any allergies (food, medications, insects) or food restrictions (vegetarian, etc.) your child has  
\_\_\_\_\_

Are there any special educational, physical, or emotional needs of your child? \_\_\_\_\_  
\_\_\_\_\_

☐ Yes, I understand the hours of Montessori Children Centre are from 7:00 a.m. to 5:00 p.m.

Name of program(s) in which your child has been enrolled (currently or previously) \_\_\_\_\_  
\_\_\_\_\_

Why do you want your child enrolled in Montessori Children's Centre?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Did someone refer you to Montessori? ☐ If so, we would like to know the names of those who referred you so we can show our appreciation. \_\_\_\_\_

Have you heard about Montessori Children's Centre in another way? Check all that apply:  
☐ Facebook/Instagram ☐ website ☐ saw school/sign ☐ Yelp ☐ open house advertisement  
☐ other: \_\_\_\_\_

What information can you give to help us know your child better? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

RETURN THIS APPLICATION TO RESERVE A POSITION ON THE WAITING LIST AT THE MONTESSORI CHILDREN'S CENTRE. ADMISSION WILL BE MADE BASED ON THE AVAILABILITY OF SPACE AND DATE OF RECEIPT OF THE APPLICATION FOR ADMISSION. SIGNATURE OF THIS APPLICATION ACKNOWLEDGES RESPONSIBILITY FOR THE PROMPT AND COMPLETE PAYMENT OF TUITION FOR THE APPLICANT.

\_\_\_\_\_  
Parent(s)/Guardian(s) Signature Date

\_\_\_\_\_  
Parent(s)/Guardian(s) Signature Date

# **Montessori Children's Centre**

## **Consent Form Packet**

**Student Name:** \_\_\_\_\_ **Start Date:** \_\_\_\_\_

Montessori Children's Centre strives to provide you and your child the best possible service. To assist in this process, we have compiled this consent form packet. Please print, review and fill out the following forms, and return on or before your child's first day. If you have any questions or concerns regarding any form, please do not hesitate to contact us for additional information.

### **Emergency Medical Care Instructions**

In case of illness or accident, I hereby authorize the Montessori Children's Centre to obtain emergency medical care for \_\_\_\_\_ (Child's Name).

Preferred Physician \_\_\_\_\_

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

Preferred Hospital \_\_\_\_\_

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

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Child Pick-Up Permission**

I authorize only the following individuals to pick up my child when I am unavailable. MCC will not release your child to anyone unless they are listed below or we are notified in writing by the parents/guardians. Parents wishing to pick up children must also have their names included on this list.

Name

Address

Telephone

|  |  |  |
|--|--|--|
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Directory Information Release**

I give permission to have my child's name, parents' names, home address, email and telephone number listed in a directory to be given only to families, upon their request, of the children enrolled in MCC.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Permission to Administer Prescription or Over-the-Counter Medicine**

I authorize the Montessori Children's Centre to administer prescribed or over-the-counter medicine to my child, as per specified written instructions, from the parents/guardians. To least disrupt your child's day, MCC gives medicine after lunch and before siesta begins.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Release of Information Permission**

I authorize the Montessori Children's Centre to release information about my child upon receiving notification regarding such an authorized request (typically from your child's next school).

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Field Trip Permission**

MCC may take field trips periodically. MCC will provide responsible adult supervision for these excursions. Your signature will give your permission for your child to participate.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Bounce House/Waterslide Permission**

We have a bounce house that will be set up on our playground periodically throughout the year. Teachers monitor the bounce house closely and will only allow 2 children in at a time. We also have an inflatable waterslide that we use once or twice in the summer (we will let you know in advance if we will be having a water day). Teachers monitor closely and only allow one child at a time. Your signature will give your permission for your child to participate.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

### **Sunscreen Permission**

Your signature will give your permission for teachers to apply sunscreen, as provided by parents/guardians, on your child when appropriate.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## Student Picture Usage Policy

Yes      No

☐      ☐ I GIVE MY PERMISSION for MCC to use my child's image or voice in photographs, recordings, or video for internal purposes. MCC may use these for the enhancement or development of their teaching methods. MCC will not use information, such as first or last names, in any presentation. MCC will restrict these pictures for use at Montessori Children's Centre and will **not** be available to others who are not directly affiliated with our school.

Yes      No

☐      ☐ I GIVE MY PERMISSION to allow organizations in the media (newspapers, television, radio) when covering stories about Montessori Children's Centre, to take pictures, videos, or recordings of my child without compensation.

Yes      No

☐      ☐ I GIVE MY PERMISSION to use **pictures** of my child (no first or last name mentioned) on the MCC Facebook/Instagram page, MCC website, or MCC publications, without compensation.

Yes      No

☐      ☐ I GIVE PERMISSION to use **video clips** of my child (no first or last name mentioned) on the MCC Facebook page, MCC website, or MCC publications, without compensation.

Yes      No

☐      ☐ I GIVE PERMISSION to use pictures or video clips of my child in Class Dojo (an app used for communication between teachers and parents). These pictures and videos are shared only with current families of your child's class.

Yes      No

☐      ☐ I GIVE PERMISSION to use pictures of my child in the weekly newsletter. This newsletter is sent weekly via email, and is only sent to families of children currently enrolled in our school.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

## **Pick-Up Policy**

The hours of operation at Montessori Children's Centre are 7:00 a.m. to 5:00 p.m., Monday through Friday.

For any child that is picked up later than 5:00 p.m., there will be a charge of \$1 per minute. Two staff members are always present, therefore payment is payable upon arrival to the teachers that stay after 5:00 pm to care for your child.

If a parent or guardian does not pick their child up by 5:00 pm and has not contacted MCC, staff will attempt to contact parents/guardians at all numbers listed on our contacts. If parents cannot be reached after trying those numbers, staff will begin calling emergency contacts.

If, after one hour, we are unable to make contact with parents/guardians or emergency contacts, we will notify the police so they may assist in finding parents or emergency contacts.

It is extremely important that you keep all of your contacts and emergency contacts up-to-date with MCC so that we will be able to contact you or someone else in the event that you can't be reached.

In the event that a parent/guardian is late, we will provide the same level of care for your child and will not make the child feel responsible in any way for the situation. Discussion of this situation will only be with the parent/guardian and never with your child.

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Parent/Guardian Signature

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Date

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Parent/Guardian Signature

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Date

## **Tuition Payment Policies**

As stated in our Parent Packet: Montessori Children's Centre offers a full-day, year-round program with 5-day, 3-day or 2-day options for three, four, and five-year-olds. Tuition is broken down into a weekly rate for our all day program. Please check with the director for current tuition rates. MCC will assess a \$50 materials and technology fee annually every October.

Annual tuition may be paid weekly, bi-weekly, monthly, or by the semester. Tuition payments may be made via 1Core, Montessori's online tuition payment system, which is withdrawn from your checking/savings account or credit card (a 2.5% fee is applied for credit card payments). Tuition may also be paid via cash, checks, or through your bank's on-line payment options. Payments of tuition over two weeks in arrears will be assessed \$10 per week. A fee of \$20 will be charged for bank returned checks, and a \$10 fee will be charged for declined or failed ACH/Credit Card transactions.

Because the programs at MCC are year-round, tuition is not credited for days missed by your child. Should you choose to take a vacation, it is your responsibility to continue tuition payments to MCC. Whether the vacation is a few days or a few weeks, our policy remains. If an extended vacation is to be taken, resulting in 4 weeks or more of absences, and you are unable to pay weekly with TAP (Tuition Auto Pay) or TPD (Tuition Pay Direct), we ask that you pay ½ of the tuition (for the missed weeks) prior to leaving. The remaining balance (the second ½) is due upon your return.

We thank you for understanding and complying with our policies and procedures. If you have any questions, please do not hesitate to contact Rachel Broach (309-530-6777), Executive Director or Stacy Hanks, Director.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I understand that if my child has to miss school due to illness, the Montessori Children's Centre's tuition will not be refunded and will be charged as normal. I also understand that if the Montessori Children's Centre is mandated by DCFS, the State of Illinois, or the Health Department, to quarantine students/close or partially close a classroom for any reason, tuition will not be refunded and will be charged as normal.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **Withdrawal Policy**

Signature of parties responsible for tuition payments:

\_\_\_\_\_ (Parent/guardian)

\_\_\_\_\_ (Parent/guardian)

\_\_\_\_\_ (Other)

### **Withdrawal Policy**

Montessori Children's Centre requires **written notice 4 FULL WEEKS** prior to withdrawal from the program. We always start students at the beginning of the week; therefore, when written notice is given it takes effect starting the following week. *Ex:* If you give written notice on a Monday-Friday, the first of the 4 weeks starts the *following* Monday.

I understand and accept the terms of the Montessori Withdrawal Policy and start date.

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director Signature

\_\_\_\_\_  
Date

## **Written Notice of Student Withdrawal**

(Please do NOT fill out until time of withdrawal. Refer to Withdrawal Policy Box above.)

Student Name \_\_\_\_\_

Student Withdrawal Date: \_\_\_\_\_

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Director Signature

\_\_\_\_\_  
Date

## **Guidance and Discipline Policy**

MCC will administer all discipline in a loving, consistent, fair, and positive manner. Parents will be notified of serious discipline problems immediately. However, even minor problems can be solved through communication and consistency between school and home. This communication serves as a valuable tool to enable both teachers and parents to have similar expectations in the guidance and discipline of their child.

The Montessori Children's Centre uses a discipline program called "Conscious Discipline" developed by Dr. Becky Bailey. No use of physical punishment is ever used. This loving discipline compliments our Montessori philosophy by allowing children to acknowledge their emotions by giving them helpful tools to handle their feelings in an appropriate manner. It is a comprehensive social and emotional intelligence classroom management program that empowers both students and teachers. We also give our parents monthly information to allow them to learn the same methods and techniques we use at school. We feel that it is important for both parents and teachers to work together, providing consistency as a team, to help the children. We hope this will be a positive tool to benefit children both at school and at home.

In the case of extreme disciplinary problems, MCC will make every attempt to work together with parents to establish specific ground rules and expectations for the future. However, if this behavior support does not meet the child's individual needs, both staff and parents should reevaluate the benefits of the child staying in our program. If it is determined that a different setting would better meet the child's needs, we will work with the family on a plan to transition their child out of our school.

I/We read, understand, and MCC's policy on guidance and discipline:

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

## Personalized Birthday Story

On each child's birthday, we have a special ceremony to celebrate his or her life. We place a sun in the center of the red line, and the birthday child holds the earth in his or her hands and walks around the sun as many times as the earth has revolved around the sun in his or her lifetime. For example, if Jon is turning five, he revolves around the sun five times. As the child is walking, the teacher is telling the class about what he or she was doing each year of his life. The children have had lessons on this and know the earth rotates on its axis every day and the earth revolves around the sun one time each year.

We like to have input from the parents on the highlights of your child's life. Some ideas of things to list are: learning to walk, learning to ride a bike, going on a special vacation, starting school at Montessori, and any other special milestones in your child's life. **If bringing a snack to celebrate your child's birthday, please remember our DCFS-mandated policy of no home-baked food and peanut products.** Thank you!

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Time \_\_\_\_\_

Weight: \_\_\_\_\_ Length: \_\_\_\_\_ First word(s): \_\_\_\_\_

### **Birth to 1 year:**

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### **1 to 2 years old:**

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### **2 to 3 years old:**

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### **3 to 4 years old:**

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### **4 to 5 years old:**

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## Physical Form

This form is to be filled out by a Physician. You may use the form provided by the Pediatrician's office.

| Student's Name                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       | Birth Date                                                                            | Sex                                                                                   | Race/Ethnicity                                                                        | School /Grade Level/ID#                                                               |  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|--|
| Last                                                                                                                                                                                                                                                                                                                                                                                             | First                                                                                 | Month/Day/Year                                                                        |                                                                                       |                                                                                       |                                                                                       |  |
| Address Street City Zip Code                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       | Parent/Guardian Telephone # Home Work                                                 |                                                                                       |                                                                                       |                                                                                       |  |
| <b>IMMUNIZATIONS:</b> 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 <i>after</i> 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<br>MO DA YR                                                                         | 2<br>MO DA YR                                                                         | 3<br>MO DA YR                                                                         | 4<br>MO DA YR                                                                         | 5<br>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 |  |
| 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                             |  |
| Hib Haemophilus influenza type b                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |
| Hepatitis B (HB)                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |
| Varicella (Chickenpox)                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                                                                                       |                                                                                       | COMMENTS:                                                                             |                                                                                       |  |
| MMR Combined Measles Mumps Rubella                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |
| Single Antigen Vaccines                                                                                                                                                                                                                                                                                                                                                                          | Measles                                                                               | Rubella                                                                               | Mumps                                                                                 |                                                                                       |                                                                                       |  |
| Pneumococcal Conjugate                                                                                                                                                                                                                                                                                                                                                                           |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |
| Other/Specify Meningococcal, Hepatitis A, HPV, Influenza                                                                                                                                                                                                                                                                                                                                         |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |
| <b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.                                                                                                                                          |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |
| Signature                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       | Title                                                                                 |                                                                                       | Date                                                                                  |                                                                                       |  |
| Signature                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                       | Title                                                                                 |                                                                                       | Date                                                                                  |                                                                                       |  |
| <b>ALTERNATIVE PROOF OF IMMUNITY</b>                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |
| 1. Clinical diagnosis is acceptable if verified by physician. <small>*(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)</small>                                                                                                                                                                                                                  |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |
| 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) <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Varicella<br>Lab Results Date MO DA YR (Attach copy of lab result)                                                                                                                         |                                                                                       |                                                                                       |                                                                                       |                                                                                       |                                                                                       |  |

  

| VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|---------------------------------------------------------------------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date                                                                |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Age/Grade                                                           |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|                                                                     | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L |
| Vision                                                              |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Hearing                                                             |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

IL444-4737 (R-02-13)

(COMPLETE BOTH SIDES)

Printed by Authority of the State of Illinois

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|---------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------|---------------------------------|
| Last First Middle                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |        | Birth Date<br>Month/Day/Year                                                          | Sex                                                                                                                                  | School                                                                                    | Grade Level/ID                  |
| <b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
| <b>ALLERGIES</b> (Food, drug, insect, other)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |                                                                                       | <b>MEDICATION</b> (List all prescribed or taken on a regular basis)                                                                  |                                                                                           |                                 |
| Diagnosis of asthma?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes    | No                                                                                    | Loss of function of one of paired organs? (eye/ear/kidney/testicle)                                                                  | Yes                                                                                       | No                              |
| Child wakes during night coughing?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yes    | No                                                                                    | Hospitalizations? When? What for?                                                                                                    | Yes                                                                                       | No                              |
| Birth defects?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Yes    | No                                                                                    | Surgery? (List all) When? What for?                                                                                                  | Yes                                                                                       | No                              |
| Developmental delay?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes    | No                                                                                    | Serious injury or illness?                                                                                                           | Yes                                                                                       | No                              |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Yes    | No                                                                                    | TB skin test positive (past/present)?                                                                                                | Yes*                                                                                      | No                              |
| Diabetes?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Yes    | No                                                                                    | TB disease (past or present)?                                                                                                        | Yes*                                                                                      | No                              |
| Head injury/Concussion/Passed out?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yes    | No                                                                                    | Tobacco use (type, frequency)?                                                                                                       | Yes                                                                                       | No                              |
| Seizures? What are they like?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Yes    | No                                                                                    | Alcohol/Drug use?                                                                                                                    | Yes                                                                                       | No                              |
| Heart problem/Shortness of breath?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Yes    | No                                                                                    | Family history of sudden death before age 50? (Cause?)                                                                               | Yes                                                                                       | No                              |
| Heart murmur/High blood pressure?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Yes    | No                                                                                    | Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other |                                                                                           |                                 |
| Dizziness or chest pain with exercise?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Yes    | No                                                                                    | Information may be shared with appropriate personnel for health and educational purposes                                             |                                                                                           |                                 |
| Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |                                                                                       | <b>Parent/Guardian Signature</b>                                                                                                     |                                                                                           |                                 |
| Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |        |                                                                                       | <b>Date</b>                                                                                                                          |                                                                                           |                                 |
| Far/Hearing problems?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Yes    | No                                                                                    |                                                                                                                                      |                                                                                           |                                 |
| Bone/Joint problem/injury/scoliosis?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes    | No                                                                                    |                                                                                                                                      |                                                                                           |                                 |
| <b>PHYSICAL EXAMINATION REQUIREMENTS</b> Entire section below to be completed by MD/DO/APN/PA                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
| HEAD CIRCUMFERENCE if < 2-3 years old                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |        | HEIGHT                                                                                | WEIGHT                                                                                                                               | BMI                                                                                       | B/P                             |
| <b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) BMI > 85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/> |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
| <b>LEAD RISK QUESTIONNAIRE</b> Required for children age 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.)                                                                                                                                                                                                                                                                                                                      |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
| <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |        | <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> |                                                                                                                                      | <b>Blood Test Date</b> <b>Result</b>                                                      |                                 |
| <b>TB SKIN OR BLOOD TEST</b> 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 <input type="checkbox"/> Test performed <input type="checkbox"/>                                                                                                                                                                                                      |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
| Skin Test: Date Read / /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        | Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>           |                                                                                                                                      | mm                                                                                        |                                 |
| Blood Test: Date Reported / /                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |        | Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>           |                                                                                                                                      | Value                                                                                     |                                 |
| <b>LAB TESTS</b> (Recommended)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |        | Date                                                                                  | Results                                                                                                                              | Date                                                                                      | Results                         |
| Hemoglobin or Hematocrit                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |        |                                                                                       |                                                                                                                                      | Sickle Cell (when indicated)                                                              |                                 |
| Urinalysis                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        |                                                                                       |                                                                                                                                      | Developmental Screening Tool                                                              |                                 |
| <b>SYSTEM REVIEW</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Normal | <b>Comments/Follow-up/Needs</b>                                                       |                                                                                                                                      | Normal                                                                                    | <b>Comments/Follow-up/Needs</b> |
| Skin                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |                                                                                       |                                                                                                                                      | Endocrine                                                                                 |                                 |
| Ears                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |                                                                                       |                                                                                                                                      | Gastrointestinal                                                                          |                                 |
| Eyes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        | Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>                    |                                                                                                                                      | Genito-Urinary                                                                            | LMP                             |
| Nose                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        |                                                                                       |                                                                                                                                      | Neurological                                                                              |                                 |
| Throat                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |        |                                                                                       |                                                                                                                                      | Musculoskeletal                                                                           |                                 |
| Mouth/Dental                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |        |                                                                                       |                                                                                                                                      | Spinal Exam                                                                               |                                 |
| Cardiovascular/HTN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |        |                                                                                       |                                                                                                                                      | Nutritional status                                                                        |                                 |
| Respiratory                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |        | <input type="checkbox"/> Diagnosis of Asthma                                          |                                                                                                                                      | Mental Health                                                                             |                                 |
| Currently Prescribed Asthma Medication:<br><input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)<br><input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)                                                                                                                                                                                                                                                                                                                                                                      |        |                                                                                       |                                                                                                                                      | Other                                                                                     |                                 |
| <b>NEEDS/MODIFICATIONS</b> required in the school setting                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |        |                                                                                       |                                                                                                                                      | <b>DIETARY</b> Needs/Restrictions                                                         |                                 |
| <b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup                                                                                                                                                                                                                                                                                                                                                                                                |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
| <b>MENTAL HEALTH/OTHER</b> Is there anything else the school should know about this student?<br>If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal                                                                                                                                                                                                                                     |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
| <b>EMERGENCY ACTION</b> needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> 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.)                                                                                                                                                                                                                                                                                                                                                                                                                                               |        |                                                                                       |                                                                                                                                      |                                                                                           |                                 |
| <b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                              |        | <b>INTERSCHOLASTIC SPORTS</b>                                                         |                                                                                                                                      | Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/> |                                 |
| Print Name                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |        | (MD, DO, APN, PA) Signature                                                           |                                                                                                                                      | Date                                                                                      |                                 |
| Address                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |        | Phone                                                                                 |                                                                                                                                      |                                                                                           |                                 |

(Complete Both Sides)

## **DCFS Licensing Standards Acknowledgment of Receipt**

A link is provided for the DCFS Licensing Standards. Please review that document and then sign the form below.

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.**