Little Friends Preschool

Application/Record of Child Information

Name of Child _____ Birthdate _____ Gender _____

Address _____

Date Child Received _____ Date Child Left _____

PARENT OR GUARDIAN PLACING THE CHILD

Attach a copy of each parent's Drivers License

Name _____	Name _____
Relation to Child _____	Relation to Child _____
Home address _____	Home address _____
_____	_____
Phone Number _____	Phone Number _____
Email Address _____	Email Address _____
Place of Employment _____	Place of Employment _____
Address _____	Address _____
Phone Number _____	Phone Number _____

OTHER PERSON TO NOTIFY IF PARENT/GUARDIAN CANNOT BE REACHED

Name _____ Address _____

Phone Number _____ Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name _____ Address _____

Phone Number _____ Hospital or Clinic _____

OTHER MEDICAL

Special medical needs _____

Allergies _____

PHOTO RELEASE FORM

I hereby grant permission to Little Friends Preschool to use photographs and/or video of my child in publications, news releases, online, and in other communications related to the mission of Little Friends Preschool. Names will not be listed.

Signature _____ Date _____

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

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE EVALUATED FOR LEAD POISONING (410 ILCS 45/6.2)

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area
- all Medicaid-eligible children should have a blood lead test prior to 12 months of age and 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If responses to all the questions are "No":

- re-evaluate at every well child visit or more often if deemed necessary

Child's name _____ Today's date _____

Age_____ Birthdate_____ ZIP Code_____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**		
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes	No	Don't Know
2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	Yes	No	Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes	No	Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes	No	Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes	No	Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes	No	Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes	No	Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes	No	Don't Know
9. Does this child reside in a high-risk ZIP code area? (see reverse side of page for list)	Yes	No	Don't Know

If there is any **"Yes"** or **"Don't Know"** response; **and**

- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), **and**
- there has been no change in the child's living conditions, a blood lead test is not needed at this time.

Test 1: Blood Lead Result _____mcg/dL Date _____ Test 2: Blood Lead Result _____mcg/dL Date _____

_____ _____

Signature of Doctor/Nurse *Date*

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

IOCI 15-678

Printed by Authority of the State of Illinois

State of Illinois
Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams
62301
62320
62324
62339
62346
62348
62349
62365

Alexander
62914
62988

Bond
62273

Boone
61038

Brown
62353
62375
62378

Bureau
61312
61314
61315
61322
61323
61328
61329
61330
61337
61338
61344
61345
61346
61349
61359
61361
61362
61368
61374
61376
61379

Calhoun
62006
62013
62036
62070

Carroll
61014
61051
61053
61074
61078

Cass
62611
62618
62627
62691

Champaign
61815
61816
61845
61849
61851
61852
61862
61872

Christian
62083
62510
62517
62540
62546
62555
62556
62557
62567
62570

Clark
62420
62442
62474
62477
62478

Clay
62824
62879

Clinton
62219

Coles
61931
61938
61943
62469

Cook
All Chicago
ZIP Codes
60043
60104
60153
60201
60202
60301
60302
60304
60305
60402
60406
60456
60501
60513
60534
60546
60804

Crawford
62433
62449
62451

Cumberland
62428

DeWitt
61727
61735
61749
61750
61777
61778
61882

DeKalb
60111
60129
60146
60550

Douglas
61930
61941
61942

DuPage
60519

Edgar
61917
61924
61932
61933
61940
61944
61949

Edwards
62476
62806
62815
62818

Effingham
None

Fayette
62458
62880
62885

Ford
60919
60933
60936
60946
60952
60957
60959
60962
61773

Franklin
62812
62819
62822
62825
62874
62884
62891
62896
62983
62999

Fulton
61415
61427
61431
61432
61441
61477
61482
61484
61501
61519
61520
61524
61531
61542
61543
61544
61563

Gallatin
62934

Greene
62016
62027
62044
62050
62054
62078
62081
62082
62092

Grundy
60437
60474

Hamilton
62817
62828
62829
62859

Hancock
61450
62311
62313
62316
62318
62321
62330
62334
62336
62354
62367
62373
62379
62380

Hardin
62919
62982

Henderson
61418
61425
61454
61460
61469
61471
61480

Henry
61234
61235
61238
61274
61413
61419
61434
61443
61468
61490

Iroquois
60911
60912
60924
60926
60930
60931
60938
60945
60951
60953
60955
60966
60967
60968
60973

Jackson
62927
62940
62950

Jasper
62432
62434
62459
62475
62480

Jefferson
62883

Jersey
62030
62063

Jo Daviess
61028
61075
61085
61087

Johnson
62908
62923

Kane
60120
60505

Kankakee
60901
60910
60917
60954
60969

Kendall
None

Knox
61401
61410
61414
61436
61439
61458
61467
61474
61485
61489
61572

Lake
60040

LaSalle
60470
60518
60531
61301
61316
61321
61325
61332
61334
61342
61348
61354
61358
61364
61370
61372

Lawrence
62439
62460
62466

Lee
60553
61006
61031
61042
61310
61318
61324
61331
61353
61378

Livingston
60420
60460
60920
60921
60929
60934
61311
61313
61333
61740
61741
61743
61769
61775

Logan
62512
62518
62519
62548
62543
62635
62643
62666
62671

Macon
62514
62521
62522
62523
62526
62537
62551

Macoupin
62009
62033
62069
62085
62088
62093
62626
62630
62640
62649
62672
62674
62685
62686
62690

Madison
62002
62048
62058
62060
62084
62090
62095

Marion
None

Marshall
61369
61377
61424
61537
61541

Mason
62617
62633
62644
62655
62664
62682

Massac
62953

McDonough
61411
61416
61420
61422
61438
61440
61470
61475
62374

McHenry
60034

McLean
61701
61720
61722
61724
61728
61730
61731
61737
61770

Menard
62642
62673
62688

Mercer
61231
61260
61263
61276
61465
61466
61476
61486

Monroe
None

Montgomery
62015
62019
62032
62049
62051
62056
62075
62077
62089
62091
62094
62538

Morgan
62601
62628
62631
62692
62695

Moultrie
61937

Ogle
61007
61030
61047
61049
61054
61064
61091

Peoria
61451
61529
61539
61552
61602
61603
61604
61605
61606

Perry
62832
62997

Piatt
61813
61830
61839
61855
61929
61936

Pike
62312
62314
62323
62340
62343
62345
62352
62355
62356
62357
62361
62362
62363
62366
62370

Pope
None

Pulaski
62956
62963
62964
62976
62992

Putnam
61336
61340
61363

Randolph
62217
62242
62272

Richland
62419
62425

Rock Island
61201
61236
61239
61259
61265
61279

St. Clair
62201
62203
62204
62205
62220
62289

Saline
62930
62946

Sangamon
62625
62689
62703

Schuyler
61452
62319
62344
62624
62639

Scott
62621
62663
62694

Shelby
62438
62534
62553

Stark
61421
61426
61449
61479
61483
61491

Stephenson
61018
61032
61039
61044
61050
61060
61062
61067
61089

Tazewell
61564
61721
61734

Union
62905
62906
62920
62926

Vermilion
60932
60942
60960
60963
61810
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61865
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61876
61883

Wabash
62410
62852
62863

Warren
61412
61417
61423
61435
61447
61453
61462
61473
61478

Washington
62214
62803

Wayne
62446
62823
62843
62886

White
62820
62821
62835
62844
62887

Whiteside
61037
61243
61251
61261
61270
61277
61283

Will
60432
60433
60436

Williamson
62921
62948
62949
62951

Winnebago
61077
61101
61102
61103
61104

Woodford
61516
61545
61570
61760
61771

IOCI 15-678

Printed by Authority of the State of Illinois

April 2015

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)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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																						
Age/ Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L		
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
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)

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

Diagnosis of asthma? Child wakes during the night	Yes Yes	No No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ •Bridge ☐ •Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes	No					

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 (If No or Modified,please attach explanation.)
PHYSICAL EDUCATION **Yes ☐ No ☐ Modified ☐** **INTERSCHOLASTIC SPORTS** (for one year) **Yes ☐ No ☐ Limited ☐**

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

Address **Phone**

(Complete both sides)