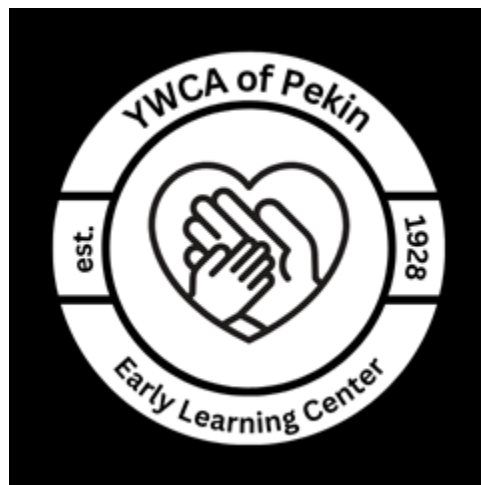


YWCA IS ON A MISSION

YWCA of Pekin Early Learning Center Child Care Application



**Please complete this document in black ink and print legibly.
[Office use only- Received Date: _____]**

Dear Prospective Family,

Thank you for your interest in placing your child in the YWCA of Pekin Early Learning Center! We are looking forward to meeting with you and your child. The first 5 years of your child's life are the most important years of their development and we are excited to partner with you during such an exciting time!

Once you have completed this registration packet, the CFS 428 Application of Child Record, the CFS 598 Consent to Day Care Providers, and the ELC Permissions Form please call the YWCA of Pekin Early Learning Center Child Care Office at 309-347-2104 ext 4028 or ext 4032 to schedule your enrollment meeting.

At this meeting, you will need to bring the following documents with you:

- The previously listed and completed registration packet and forms.
- A certified copy of the child's birth certificate (the one from the county clerk's office of the county where the child was born)
- The Certificate of Child Health Examination Form completed by the child's pediatrician/family doctor. This form is the last page of this packet and can be taken to the child's doctor to be completed.

The enrollment meeting will last approximately one hour, and we'd be delighted to meet your prospective student—please feel free to bring them along if possible! The meeting will allow us to complete all of the paperwork needed, answer all of your questions as well as set up another meeting if necessary.

Again, thank you so much for considering the YWCA of Pekin Early Learning Center for your family. If you have any questions please call the Child Care Office, email the Director at elcdirector@ywcapekin.org or the Assistant Director at assistantelcdirector@ywcapekin.org We look forward to meeting you!

Sincerely,

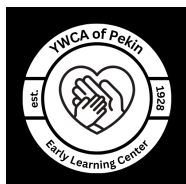
Meredith Kerley

Meredith Kerley

Child Care Director

Phone: 309-347-2104 ext 4028

Email: elcdirector@ywcapekin.org



Child's Information:

Last Name:	First Name:	M.I.:	DOB:
Circle one: Male Female Prefer not to specify	Social Security Number:	Race/Ethnicity:	Religious Preference:

Language(s) spoken at home:
Will your child be attending a different preschool program? (Circle one) Yes or No If yes, where will your child be attending? () Head Start () PFEC AM () PFEC PM () Other _____
Will your child ride a bus to and/or from the YWCA of Pekin Early Learning Center for Head Start or PFEC? (Circle one) Yes or No
Will your child require care on school holidays? (Circle one) Yes or No
Will your child require care on Early Dismissal Days? (Circle one) Yes or No

Estimated Care Schedule:

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival					
Pick-Up					

Is there a custody arrangement for your child? (Circle one) Yes or No

If yes, please provide a copy of the court document outlining the custody agreement and list
The days/times the child will be with each guardian per the court document:

Does your child have any medical conditions? (Circle one) Yes or No

If yes, please list all below, including any food allergies, as well as how to respond if an
incident occurs, if more room is needed, please attach paper to this application titled Medical
Conditions:

Please note, any medications needed to be provided and/or allergies the staff need to be aware
of (i.e. peanut allergy) must have medical documentation from their pediatrician outlining the
diagnosis and treatment plan needed attached to this application.

Does your child receive any therapies? (Circle one) Yes or No

If yes, please list the type of therapy, the company and therapist working with your child:

Pediatricians Name: _____

Phone Number: _____

Address:

Should emergency medical treatment become necessary when our staff cannot reach you or your emergency contacts, permission is needed for your child to be treated. Your child's doctor will be contacted if possible. If the YWCA of Pekin Early Learning Center Staff is unable to reach you, a family member, emergency contact, or family physician, an ambulance will transport your child to an Emergency Room. A staff member will go with your child to the ER until a parent/guardian arrives.

Emergency treatment may be given to my child(ren):

Signature of 1st Primary Guardian: _____ Date:

Signature of 2nd Primary Guardian: _____ Date:

Hospital Preference: _____

(If not specified, Carle at Pekin will be used)

Health Insurance Carrier: _____

Policy Number: _____

Does your child have an ISFP or IEP? (Circle one)

Yes or No

If yes, a copy must be provided to be kept in your child's file.

May we apply sunscreen for outdoor play? (Circle one) Yes or No

May we take and maintain a photo of your child for security purposes?

(Circle one) Yes or No

May we use your child's photo on social media? (Circle one) Yes or No

May other media entities (i.e. newspaper or new broadcast) take pictures/video of your child to use in print or video format? (Circle one) Yes or No

Parent/Guardian Information

Please list the parent/guardian who you would like the YWCA of Pekin Early Learning Center to contact first in the case of sickness or emergency as primary.

Please be advised that anyone picking up your child(ren) must be willing to show a state issued identification card (i.e. Driver's License or State ID card) for comparison with your list. Under no circumstances will a child be released to anyone without proper identification. If someone other than those on the Authorized Pick-Up List is planning to pick up your child(ren), a signed notice must be given to your child's teacher. If someone is sent to pick up your child(ren) that is not on the Authorized Pick-Up List, the staff at the YWCA of Pekin Early Learning Center must reach the parent via phone call before the child can be released. Additions or changes to the Authorized Pick-Up List must be put in writing in the childcare office.

Primary Parent/Guardian Contact

Last Name:	First Name:	Relationship to Child:
Email Address:	Home/Cell Phone:	Work Phone:

Address: Apt. #:	City:	Zip Code:
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Primary Parent/Guardian Information Continued:

Employer Name and Address: _____
Job Title: _____
Work Phone: _____
Work Schedule: _____
School Name: _____
Degree/Certification: _____
School Schedule: _____

Second Parent/Guardian Contact

Last Name:	First Name:	Relationship to Child:
Email Address:	Home/Cell Phone:	Work Phone:
Address: Apt. #:	City:	Zip Code:

Employer Name and Address:

Job Title: _____

Work Phone: _____

Work Schedule: _____

School Name: _____

Degree/Certification: _____

School Schedule:

Third Contact:

Last Name:	First Name:	Relationship to Child:
Email Address:	Home/Cell Phone:	Work Phone:

Fourth Contact:

Last Name:	First Name:	Relationship to Child:
Email Address:	Home/Cell Phone:	Work Phone:

_____ Child's Information:

Last Name:	First Name:	M.I.:	DOB:
Circle one: Male Female Prefer not to specify	Social Security Number:	Race/Ethnicity:	Religious Preference:

Language(s) spoken at home:
Will your child be attending a different preschool program? (Circle one) Yes or No If yes, where will your child be attending? () Head Start () PFEC AM () PFEC PM () Other _____
Will your child ride a bus to and/or from the YWCA of Pekin Early Learning Center for Head Start or PFEC? (Circle one) Yes or No
Will your child require care on school holidays? (Circle one) Yes or No
Will your child require care on Early Dismissal Days? (Circle one) Yes or No

Estimated Care Schedule

Day	Monday	Tuesday	Wednesday	Thursday	Friday
Arrival					
Pick-Up					

Is there a custody arrangement for your child? (Circle one) Yes or No If yes, please provide a copy of the court document outlining the custody agreement and list

the days/times the child will be with each guardian per the court document:

Does your child have any medical conditions? (Circle one) Yes or No

If yes, please list all below, including any food allergies, as well as how to respond if an incident occurs, if more room is needed, please attach paper to this application titled Medical Conditions:

Please note, any medications needed to be provided and/or allergies the staff need to be aware of (i.e. peanut allergy) must have medical documentation from their pediatrician outlining the diagnosis and treatment plan needed attached to this application.

Does your child receive any therapies? (Circle one) Yes or No

If yes, please list the type of therapy, the company and therapist working with your child:

Pediatricians Name: _____

Phone Number: _____

Address: _____

Should emergency medical treatment become necessary when our staff cannot reach you or your emergency contacts, permission is needed for your child to be treated. Your child's doctor will be contacted if possible. If the YWCA of Pekin Early Learning Center Staff is unable to reach you, a family member, emergency contact, or family physician, an ambulance will transport your child to an Emergency Room. A staff member will go with your child to the ER until a parent/guardian arrives.

Emergency treatment may be given to my child(ren):

Signature of 1st Primary Guardian: _____

Date: _____

Signature of 2nd Primary Guardian: _____

Date: _____

Hospital Preference: _____

(If not specified, Carle at Pekin will be used)

Health Insurance Carrier: _____

Policy Number: _____

Does your child have an ISFP or IEP? (Circle one) Yes or

No

If yes, a copy must be provided to be kept in your child's file.

May we apply sunscreen for outdoor play? (Circle one) Yes or No

May we take and maintain a photo of your child for security purposes?

(Circle one) Yes or No

May we use your child's photo on social media? (Circle one) Yes or No

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child _____ Birthdate _____ Sex _____

Address _____

Date Child Received _____ Date Child Left _____

PARENT OR OTHER PERSONS(S) PLACING THE CHILD

Name _____ Name _____

Relation to child _____ Relation to child _____

Home address _____ Home address _____

Phone Number _____ Phone Number _____

Place of employment _____ Place of employment _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Working hours _____ Working hours _____

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

Name _____ Address _____

Phone Number _____ Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name _____ Address _____

Phone Number _____ Hospital or Clinic _____

PROGRAM

Days per week _____ Hours of care _____

Rate of pay (optional) _____

Signature of parent or other person placing child

Signature of caregiver

Date

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

Medical problems _____

Physical handicaps _____

Restrictions for play—outdoors _____

Restrictions for play—indoors _____

Allergies _____

Food likes _____

Food dislikes _____

Fears _____

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

Is the child toilet trained? _____

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

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

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

Time _____ Amount _____ Temperature _____

Diaper changes: Powder _____ Ointment _____

Other information that will help in caring for the child _____

Comments:

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

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

YWCA of Pekin Early Learning Center Permissions Form

Field Trip Permission:

Occasionally the childcare classes at the YWCA of Pekin Early Learning Center take field trips. The YWCA Child Care staff will issue prior notification for all field trips that require transportation via a school bus and a subsequent permission slip to be signed. However, walking field trips will be arranged without prior notification. All classrooms A-F go on walking field trips. Classrooms A-D use strollers or buggies on walking trips. Signing below indicates that you as the parent/guardian understand that your child will be taking walking field trips as a part of their curriculum.

Parent/Guardian Signature: _____ **Date:** _____

Swimming Permission:

Classroom E is the only classroom that swims as a part of their weekly curriculum. Per this, children ages 4-5 years old will swim up to twice a week with their classmates and their teachers. The YWCA of Pekin Early Learning Staff in Classroom E are trained in both Water Safety and CPR/First Aid. There is also a Lifeguard on duty during the duration of swim time and the lifeguard does not count toward adult to child water ratios. Children wear swim suits and safety devices (i.e. puddle jumpers or life vests) for the duration of their time in the pool. Signing below indicates that you as the parent/guardian understand that your child will be swimming as a part of their curriculum in Classroom E.

Parent/Guardian Signature: _____ **Date:** _____

Sunscreen Permission:

Children go outside daily, weather permitting. The YWCA of Pekin Early Learning Center will provide sunscreen that is SPF 30 or higher to your child when venturing outside. The YWCA of Pekin Early Learning Center uses hypoallergenic, waterproof and sweatproof sunscreens. Sunscreen may be reapplied as necessary, due to the length of sun exposure. Signing below indicates that you as the parent/guardian understand that your child will be receiving sunscreen when they go outside.

Parent/Guardian Signature: _____ **Date:** _____

Or

YES, but I will provide the sunscreen of my preference with my child's full name written on the container.

Parent/Guardian Signature: _____ **Date:** _____

YWCA of Pekin Early Learning Center Permissions Form

Diaper Cream Permission Slip

By signing this slip, I give the YWCA of Pekin Early Learning Center Staff permission to use the diaper cream I have provided for my child. The staff will use the cream as often as requested by the parent/guardian or when deemed necessary.

Parent/Guardian's Signature: _____

Date: _____

Late Pick Up Policy

By signing below, you are indicating the following:

I acknowledge and understand the Late Policy implemented by the YWCA Early Learning Center and designed by the Department of Children and Family Services (DCFS). I agree to conform to the 5:30 pm closing time to avoid the unnecessary follow up procedures set forth by the closing staff. The full policy is outlined in the YWCA of Pekin Early Learning Center Handbook. If you fail to pick up your child prior to 5:30pm closing time of the Early Learning Center, you will be issued a late fee of \$10 for the first 5 minutes and \$1 for every subsequent minute after. These charges will be added to your tuition fees. Failure to pay or continued abuse of this policy can result in a withdrawal of care for your child.

Parent/Guardian Signature: _____

Date: _____

Confidentiality:

By signing below, you are indicating the following:

I understand the content in my child's file is to be kept current and I will update information as needed and requested. The content is confidential but is immediately available to administrators, teaching staff, the legal guardian, or regulatory agencies upon request.

Parent/Guardian Signature: _____

Date: _____

Photos for Publicity:

The YWCA of Pekin Early Learning Center uses photography to appropriately identify children within our care within the Procure Application. There have also been instances in which a local news broadcaster or newspaper will take video or photographs at an event that your child may be attending for a field trip. Please indicate below if you give your permission for your child to be photographed and/or videotaped and/or recorded for public use.

- Yes, my child can be photographed, videotaped or recorded for public use such as the newspaper, TV, social media, etc.

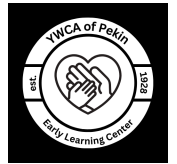
YWCA of Pekin Early Learning Center Permissions Form

- No, my child can NOT be photographed, videotaped or recorded for public use such as the newspaper, TV, social media, etc.

Parent/Guardian Signature: _____ **Date:** _____



YWCA of Pekin Early Learning Center Tuition Rates

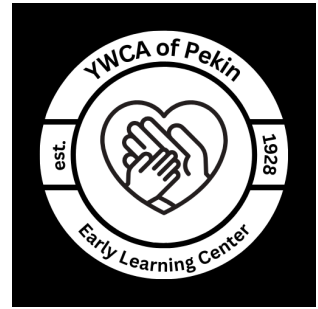


The YWCA of Pekin Early Learning Center does not offer 1 day per week, drop-in care, or hourly care. Tuition charges are based on room enrollment and DCFS ratios, not necessarily the exact chronological age of the child.

Classroom (child:teacher ratio)	Full Time 4-5 days a week	Part Time 3 days a week	Part Time 2 days a week
Room A (4:1 ratio)	\$315	\$216	\$144
Room B (4:1 ratio)	\$315	\$216	\$144
Room C (5:1 ratio)	\$315	\$216	\$144
Room D (8:1 ratio)	\$255	\$180	\$120
Room E (10:1 ratio)	\$215	\$165	\$110
Room F (10:1 ratio)	\$215	\$165	\$110

Families requiring care less than 5 days per week are reserving a spot in the classroom for a set number of days. Tuition does not change for attendance less than the scheduled number of days per week. Any child attending less than 5 days per week must request a set schedule of days of attendance. Those days cannot be changed without request and approval at least 1 week prior from the child care director.

YWCA of Pekin Early Learning Center Fees



These fees are in addition to the weekly tuition rates and are the sole responsibility of the parent/guardian.

Registration Fee	\$15
YWCA of Pekin Annual Membership (For parent/guardian of children under 6 years old)	\$42
Late Pick-Up Fee	\$10 for the first 5 minutes, \$1 per minute after
Insufficient Funds Fee/Decline Payment Fee	\$20 per incident
Diaper Fee (Charged when child has none in the Center and no donations are available)	\$1 per diaper



Certificate of Child Health Examination

Student's Name			Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Last	First	Middle				

Street Address	City	ZIP Code	Parent/Guardian	Telephone (home/work)
----------------	------	----------	-----------------	-----------------------

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

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

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

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

Comments: * indicates invalid dose

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature _____ Title _____ Date _____

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

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

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease _____ Signature _____ Title _____

3. Laboratory Evidence of Immunity (check one) Measles* Mumps** Rubella Varicella **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.

**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

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

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ B/P _____

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes No **And any two of the following:** **Family History** Yes No

Ethnic Minority Yes No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes No **At Risk** Yes No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? Yes No **Blood Test Indicated?** Yes No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed Test performed **Skin Test:** Date Read _____ Result: Positive Negative mm _____

Blood Test: Date Reported _____ Result: Positive Negative Value _____

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

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

NEEDS/MODIFICATIONS required in the school setting _____ **DIETARY** Needs/Restrictions _____

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup) _____

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes No If yes, please describe: _____

On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** Yes No Modified

Print Name _____ MD DO APN PA Signature _____ Date _____

Address _____ Phone _____