CFS 428
Rev. 4/2001

State of Illinois
Department of Children and Family Services

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child _____ Birthdate _____ Sex _____

Address _____

Date Child Received _____ Date Child Left _____

PARENT OR OTHER PERSONS(S) PLACING THE CHILD

Name _____ Name _____

Relation to child _____ Relation to child _____

Home address _____ Home address _____

_____ _____

Phone Number _____ Phone Number _____

Place of employment _____ Place of employment _____

_____ _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Working hours _____ Working hours _____

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

Name _____ Address _____

Phone Number _____ Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name _____ Address _____

Phone Number _____ Hospital or Clinic _____

PROGRAM

Days per week_____ Hours of care _____

Rate of pay (optional) _____

_____ _____ _____

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

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

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

Medical problems _____

_____

Physical handicaps _____

_____

Restrictions for play—outdoors _____

_____

Restrictions for play—indoors _____

_____

Allergies _____

_____

Food likes _____

_____

Food dislikes _____

_____

Fears _____

_____

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

Is the child toilet trained? _____

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

_____

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

_____

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

Time _____ Amount _____ Temperature _____

Diaper changes: Powder _____ Ointment _____

Other information that will help in caring for the child _____

_____

_____

Comments:

_____

_____

_____

_____

_____

_____

_____

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY

AUTHORIZATION FOR PICK UP

Please list all persons, including parents and guardians, authorized to pick up your child along with a 4 digit ID code that will allow them to sign in and/or out your child. The 4 digit code cannot start with a 0.

Name	Address	Phone #	Relationship to Child	ID Code

Parent Signature: _____ Date:_____

MISS MONA'S EMERGENCY INFORMATION FORM

Child's Name: _____ Age: _____ Birth Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Father's Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Emergency Contact: _____

Relationship to Child: ____ _____ Phone: _____

List Authorized Adults Allowed to Pick Up Child:

Name	Address	Phone

List Any Medical Conditions: _____

_____

Allergies: _____

Name of Physician: _____ Phone: _____

Address: _____

Choice of Hospital: _____

My Child May View Movies Rated: (Please circle): G PG PG13

If I cannot be reached in an emergency, please seek medical attention: Yes No

Signature of Parent/Guardian: _____ Date: _____

Late Pick Up Policy Amendment
June 2005

The late pick-up policy of Miss Mona's Child Care Center states that if your child is here past the center's closing time, you will be charged the late pick-up fee of $10.00 for 15 minutes or any part of thereof and $1.00 per minute thereafter. This policy remains in effect with the following additions:

1. The staff member in charge will attempt to reach the parents via emergency contact information, which has been provided by the parent. After a reasonable amount of time as passed, if the parents have not been contacted, staff member would contact authorities for help in contacting parents.

2. The director will periodically check emergency information as to accuracy for this exact purpose.

3. The staff member in charge will be certain at all times to be responsible for the child's well-being and at no time will the staff member make the child feel responsible for the situation.

I _____
parent/guardian

of _____
child

Have read and understand this amendment to the Late Pick Up Policy of Miss Mona's Child Care Center.

_____ _____
Signed Date

Miss Mona's Child Care Center

Hopedale Medical Complex

Consent to Treat/Wavier and Release

Minor Child's Name: _____

Waiver & Release

Miss Mona's, LLC, d/b/a Miss Mona's Childcare Center, and the Hopedale Medical Foundation, d/b/a Hopedale Medical Complex, hereinafter referred to individually and collectively as "Miss Mona's", is committed to conducting its programs and activities in a safe manner and holds the safety of our children in high regard. The parents/guardians and custodians of minors enrolled in our program(s)/activity(ies) understand that although child safety is Miss Mona's number one concern, there is still an inherent risk of injury to children when they participate in our programs/activities, especially when playing or engaging in physical activity.

In light of the above, in consideration of Miss Mona's providing its services to the minor child/children, the undersigned on his/her behalf and on behalf of the minor child/children, does hereby fully release and forever discharge Miss Mona's , LLC and the Hopedale Medical Foundation, d/b/a the Hopedale Medical Complex, and their respective managers, officers, directors, employees, agents, successors and assigns, from and against any and all claims for injuries, damages or losses and liability that the undersigned or the minor child/children may sustain or which may accrue to the undersigned or the minor child/children, which arises out of, or is connected with Miss Mona's program and activities, unless said losses/liability or damages are the result of willful and wanton conduct.

The undersigned has read and fully understands the above waiver and release of all claims. The undersigned's signature below is on his/her behalf of any and all minor child/children enrolled in or participating in Miss Mona's programs and activities, even if said minor child/children's names are not specifically listed below. If both parents/guardians have not signed this document, the undersigned states that he/she is authorized to sign on behalf of the other parent/guardian, and the undersigned agrees to indemnify and hold harmless Miss Mona's, LLC and the Hopedale Medical Foundation and the released entities from and against any and all liability, losses, claims/demands made against said entities by the non-signing parent/guardian.

Consent to Treat:

In the event of an accidental injury or sudden acute illness to the minor child participant, the undersigned, for himself/herself and on behalf of the minor child participant, HEREBY CONSENTS and permits the Miss Mona's and Hopedale Medical Complex personnel to administer First Aid or contact local EMS to care for and treat the minor child and to transport said child to the hospital Emergency Room if deemed necessary by EMS, HMC or Miss Mona's personnel. If Hopedale Medical Complex or Miss Mona's personnel are unable to immediately reach the parent/guardian of the minor child participant to obtain verbal consent, said permission to treat and transport by HMC and/or EMS personnel is granted. Note: Miss Mona's personnel will always attempt to immediately contact a parent/guardian/authorized person in an emergency.

This release and consent also applies to any other related programs conducted at or by Miss Mona's, regardless of location, whether on site or off premises, and shall remain in force and effect for 5 years or until revoked by the undersigned in writing by delivering a copy to the C.O.O of Hopedale Medical Complex, whichever occurs first. This consent may not be retroactively evoked.

_____

Parent/Guardian (Signature) Date

_____

Name of Minor Child (Please Print) Age

Emergency number where parent/guardian/authorized person can be reached if minor child participant is in need of Emergency medical treatment or in an emergency:

Authorized Contact No. 1:_____ Phone # _____

Authorized Contact No 2:_____ Phone # _____

PO Box 267

Hopedale, IL 61747

CONSENT TO PHOTOGRAPH AND USE IMAGES

The undersigned parent/guardian hereby consents to the photographing of his/her minor child doing activities at Miss Mona's. These photos will be taken by an agent of Hopedale Medical Complex (HMC) and Miss Mona's Childcare. In consideration of the above the undersigned will be provided a free copy of any photographs taken by HMC of his/her child/ward and **the undersigned hereby gives consent** to Miss Mona's and HMC to publish and display said photographs on site at Miss Mona's, on HMC or Miss Mona's advertising or brochures. No further consideration will be paid for the use of said photos.

Signed_____

Minor Child's name_____

Date_____

MISS MONA'S AUTHORIZATION FORM

EMERGENCY MEDICAL TREATMENT

This authorizes the staff at Miss Mona's Child Care Center to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. In the event of an emergency a staff member will take your child to be treated at the Hopedale Medical Complex Emergency Room. I/we will be responsible for the emergency medical charges upon receipt of the statement.

Signature of Parent/Guardian **Date**

ADMINISTER PRESCRIPTION MEDICATION

I/we authorize Miss Mona's Child Care Center to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Signature of Parent/Guardian **Date**

ADMINISTER OVER THE COUNTER MEDICATION

I/we authorize Miss Mona's Child Care Center to administer over the counter medication to my/our child as specified in written instructions.

Signature of Parent/Guardian **Date**

FIELD TRIPS

I/we authorize Miss Mona's Child Care Center to take my/our child on walking trips, special excursions, and to nearby public park facilities.

Signature of Parent/Guardian **Date**

PUBLICITY

I/we authorize Miss Mona's Child Care Center to photograph/video tape my/our child with the understanding that such photos or videos may be used for publicity.

Signature of Parent/Guardian **Date**

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.

Miss Mona's

Nurturing the Whole Child

Parent Policies and Informational Packet

Updated 1/2025

Miss Mona's Child Care Center
107 Tremont Street
Hopedale, IL 61747
(309) 449-4933

Introduction

Welcome to Miss Mona's Child Care Center! We feel that every child has the right to receive quality childcare in a child-centered program. We offer a safe and nurturing environment in which your child can learn and have fun. Children are offered opportunities to develop cognitive, social, emotional and physical skills. Developmentally appropriate activities are planned for each age group and offer a wide range of hands-on experiences. Children develop skills that will be used all their lives through play experiences, and we consider "play" to be a child's "work".

We encourage parents to visit the classroom whenever they can. Daily sheets will be filled out for each child ages 6 weeks to two years. Teachers provide information about the child's activities, meals and naptime. Please feel free to speak with the teachers or director about any suggestions or concerns. Comments may also be left in the payment box. If you have confidential communication regarding the Director, or if problems are not resolved to your satisfaction, please contact the Hopedale Medical Complex Chief of Operation Office at 309-449-4296.

Admission

Our center is open to all children ages 6 weeks through 6 years. Beginning, June 2010, only children of Hopedale Medical Complex and siblings of current enrollees, ages 4 years of age and over. Unless granted pre-approval by the COO.

Hours of operation are 5:30 a.m. to 5:30 p.m.

Miss Mona's offers **all-day childcare** available for children ages 6 weeks to kindergarten on a full-time or part-time basis. Days and times must be arranged in advance.

All children must be registered in advance and must comply with the Department of Children and Family Services regulations in regard to physical exams; immunizations, including a TB skin test and lead screening or waiver; and other appropriate paperwork. All enrollment paperwork must be completed before a child can receive services.

All parents must download the ProCare app prior to enrollment in order to receive communication regarding their child's care.

In addition to the enrollment packet, all children are required to have a copy of their latest physical, shot records, and birth certificate in their file.

Tuition

- Tuition is determined according to current rates as from time to time determined by management.
- Tuition is due weekly and no later than the child's first day of attendance.
- Checks can be made payable to **Hopedale Medical Complex** and can be placed in the payment box in the parent information area.
- Tuition can be paid through the ProCare app
- Families enrolling more than one child will receive a 10% discount.
- HMC employees may use payroll deduction.

Fees

- **Late pick-up fee** – If your child is not picked up by the center's closing time, you will be charged $10.00 for the first 15 minutes and $1.00 per minute thereafter.
- **Late payment** – If payment is not received by your child's second day of attendance there will be a $5.00 fee added to the weekly tuition. Failure to provide payment for two weeks may result in refusal of admittance unless payment arrangements have been made with the childcare director.
- **Insufficient funds** – A fee of $20.00 will be charged for each returned check. After two returned checks, you will be asked to make tuition payments in cash.
- **Responsible Party** – (parents and guardians) agree to pay collect on costs and reasonable attempts filed if sent to collections is required.

Severe Weather

- In case of severe weather, the Director will make the decision to close the daycare for our children's safety, as well as our staff members. Announcements and notifications will be made at the time of closing. All tune into NBC 25/WHOI 19/WEEK television channels, for update reports. We reserve the right not to adjust your tuition whether the center is open for all or part day due to severe weather.

Holidays

- The center will be closed on the following holidays: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day, the day after Thanksgiving, Christmas Eve, and Christmas Day.
- When a holiday falls on a weekend, we reserve the right to close on the "observed day", especially if it is low census.

Termination of Service

- We ask that a two-week notice be given, in writing, if you choose to end service.
- The center reserves the right to re-evaluate any child's continued participation in the program. The center may request withdrawal of the child and will recommend a suitable alternative that may better suit his or her needs. A two-week notice will be given unless the child is an immediate danger to himself or others.

Drop-off and Pick-up Procedures

- **When dropping off your child, please be sure to sign them in, and out when picking them up. There is a QR code located on the door near the Director's office. You may scan that to clock your child in using the ProCare app.**
- **We ask that your child be at the center by 9:00 a.m., if possible. When arriving after 9:00 a.m., your child misses' part of the morning routine and classroom involvement. This also helps us calculate staffing as well as meals. Please alert the Director if your child will be later than 9:00 a.m.**

Your child will only be released to people listed on the Pick-up Authorization form. The center staff is only allowed to release your child only to those on the pickup list unless you notify the Director in advance. The pickup person must be at least 18 years of age or older, unless it is the child's parent.
Anyone with whom the staff is not familiar will be asked to present a photo I.D.

Illness

- All children attending the center should be well enough to participate comfortably in daily indoor and outdoor activities.
- Children with a fever of over 100.4 degrees Fahrenheit should be excluded from care while the fever persists. They may return after being fever free for 24 hrs without fever reducing meds.
- Children need not be excluded from minor illness unless any of the following exists, in which case exclusion from the center is required by DCFS Licensing Standards:
    - An illness which calls for greater care than staff can provide without compromising the health and safety of other children
    - Rash combined with fever over 101 degrees Fahrenheit
    - Rash with a fever or behavior change, unless a physician has determined the illness to be non-communicable
    - Unusual lethargy, difficulty breathing or other signs of possible severe illness
    - Diarrhea (child will be sent home after 3rd watery stools) or diarrhea combined with fever of 101 degrees or higher
    - Vomiting two or more times in the previous 24 hours
    - Mouth sores associated with the child's inability to control his or her saliva, until the child's physician or the local health department states (in writing) that the child is non-infectious
    - Purulent conjunctivitis until 24 hours after treatment has been initiated
    - Impetigo until 24 hours after treatment has been initiated
    - Strep throat until 24 hours after treatment has been initiated and until the child has been without fever for 24 hours
    - Head lice until the morning after the first treatment (the center may require proof of treatment) must be nit free.
    - Scabies until the morning after the first treatment
    - Chicken Pox until at least six (6) days after onset of the rash and all lesions are crusted over
    - Whooping cough until five (5) days of antibiotic treatment have been completed
    - Mumps until nine (9) days after the onset of parotid gland swelling
    - Measles until four (4) days after the disappearance of the rash
    - Hand, Foot, & Mouth Disease after all sores are dried and/or crusted.
    - Any respiratory virus (Influenza, Covid-19, RSV, etc) once fever free and minimal symptoms are present.

- Symptoms which may be indicative of one of the serious, communicable diseases identified in the Illinois Department of Public Health Control of Communicable Diseases Code

- Children who have been absent due to a contagious disease (including, but not limited to, the above listed illnesses) must have prior written consent from a physician upon return to the center when the disease has not completely run its course
- The center reserves the right to require a physician's written consent to return to childcare when a contagious disease is suspected.

Medication

- All medications must be signed in daily on the Medication Chart located in your child's room. Please include specific instructions on the administering of any medicine. We ask that you do not sign medicine in to be given "as needed". We feel strongly that "as needed" should be a decision made by a parent and not left to the discretion of the child care staff.
- Prescription and over-the-counter medications must be given to a teacher for proper storage.
- All medication must be in the original container. Prescription medication must display the proper pharmacy label with the child's name. Over-the-counter medication must be labeled with your child's name.
- Medicine will not be given before 9:30 a.m.

Medical Examinations and Immunizations

- All children enrolled in the centers' programs are required by DCFS regulations to have a physical exam on file completed no more than six (6) months prior to enrollment. The exam shall be updated every two (2) years.
- In accordance with the Child Care Act of 1969, as amended, a parent may request that immunizations, physical examinations and/or medical treatment be waived on religious grounds. A request for such a waiver shall be in writing and kept in the child's record.
- Exceptions made for children who should not be subject to immunizations or tuberculin tests for medical reasons shall be indicated by the physician on the child's medical form.
- The number of non-immunized children enrolled shall be available to parents on request.

Emergency Medical Treatment

All accidents occurring on the center's property must be reported to the Director. First aid will be administered by the staff for minor scrapes, cuts and bumps. In serious cases where immediate medical attention is required, the parents or emergency contacts will be notified. If the center is unable to reach anyone, the child will be treated in the Hopedale Medical Complex Emergency Room, and the parents/guardians are consenting thereto.

Personal Items

- All children will have a basket or cubby labeled with their name to store personal items such as extra clothes or a small stuffed animal for naptime.
- All items need to be labeled with your child's name.
- Please do not allow your child to bring toys or other "treasures" to the center. These items often get lost, broken or cause conflict between the children. Your child's teacher may choose to designate a special show-and-tell day when the children can bring a small item to share with the class. Absolutely no war toys will be allowed into the center. Playing or acting violently will not be tolerated.
- Children are welcome to bring a book to share with the class occasionally. Please be sure to mark it with your child's name and be prepared to leave it for a couple of days as the teacher may not be able to read it the same day.

Field Trips

All classrooms take short walking field trips. The children may walk to the nearby park or pond.

Outside field trips are taken periodically. The HMC bus is used for these field trips. To allow your child to go on a fieldtrip, a permission slip must be signed, and a car seat available for the bus.

Meals and Snacks

- The center serves breakfast, lunch, and two snacks in accordance with the nutritional guidelines of the Department of Children and Family Services.
- Children are not allowed to bring food into the classroom. You may occasionally bring a snack for the entire class to celebrate a special day such as a birthday or holiday. Unfortunately, we are not allowed to serve homemade treats. All treats must be in unopened packages from the store or bakery.
- If your child your child requires anything for a special diet outside of what Miss Mona's provides, we must have a written form from their physician.

Dress Code

- Children will go outside daily except in extreme conditions. Your child's attire at the center should be chosen regarding activity and comfort. Remember that spills, paint, dirt and glue happen!
- For safety and comfort reasons, we highly recommend that tennis shoes and socks be worn daily.
- Sandals are not recommended. Children often have difficulty running and climbing in sandals. Socks should be worn if your child must wear sandals.

Supplies and Extra Clothes

We ask that parents provide the following items:

- Blanket for naptime (child sized)
- Complete change of clothes including socks to be left in the child's basket (3 or 4 if potty training or prone to accidents)
- Disposable diapers or training pants (if needed)

- Pacifier (if needed)
- Weather appropriate outerwear

*Please remember to put your child's name on all items.

Donations

Miss Mona's Child Care Center accepts any clean, safe indoor or outdoor toy donations for appropriate age levels. Please check with the director before donations occur.

Guidance and Discipline Policy

Our childcare staff will help individual children develop self-control and assume responsibility for their own actions.

- Limits and consequences shall be clear and understandable to the child, consistently enforced and explained to the child before and as part of any disciplinary action.
- Firm positive statements about behaviors or redirection of behaviors shall be the accepted techniques for use with infants and toddlers.
- Removal from the group to help a child gain control shall not exceed one minute per year of age and will be used if the child cannot be redirected. Removal from the group should not be used for children less than 24 months of age.
- Children shall not be disciplined or shamed for toilet accidents.
- Discipline shall be the responsibility of adults who have an ongoing relationship with the child.
- When there is a specific plan for responding to a child's pattern of behavior, all staff who affect the child shall be aware of the plan and cooperate with its implementation.

The following behaviors by staff and children are prohibited in all childcare settings.

- Corporal punishment or threats of corporal punishment including hitting, spanking, swatting, beating, shaking, pinching and other measures intended to induce physical pain or fear.
- Threatened or actual withdrawal of food, rest or use of the bathroom.
- Abusive or profane language.
- Any form of private or public humiliation including threats of physical punishment.
- Any form of emotional abuse including shaming, rejecting, terrorizing or isolating a child.

Parents/guardians are seen as partners in the guidance and discipline process. On occasion children may exhibit some behavioral challenges. Childcare staff will openly share concerns and suggestions regarding the child's behavioral challenges and parents are encouraged to do the same. By working together, parents and staff can provide consistent guidance and discipline. Should challenging behaviors persist, parents will be asked to attend a conference with the classroom teacher and childcare director in order to discuss additional strategies to assist the child in managing his or her behavior in the classroom. In the case of extreme or serious behavioral issues, the parent may be asked to remove the child from the center for the day. If behavioral issues cannot be resolved satisfactorily, parents may be asked to withdraw their child from the center. Parents will

be given two weeks' notice unless the behaviors are so disruptive they seriously impact the classroom activities.

Mandated Reporter

The Abused and Neglected Child Reporting Act requires a wide range of professionals to report suspected child maltreatment. Under this law, all childcare staff is considered to be mandated reporters and are required to report suspected child abuse or neglect immediately to the Department of Children and Family Services. Willful failure to report suspected incidents of child abuse or neglect is a misdemeanor. State law protects the identity of all mandated reporters, and they are given immunity from legal liability because of reports they make in good faith. State law does not require that the mandated reporter notify parents of the report.

Pest Control

If the need for use of pest control arises, there will be a note posted at the center 48 hours beforehand. It will only be done after hours and/or the weekend. If you wish to be notified verbally, please let the director know.

Policy Sign-off

I/we, the parent/guardians of _____, have received and read a copy of Miss Mona's Child Care Policies and Informational Packet, understand it including the Guidance and Discipline Policy, and agree to its terms.

Signature_____ Date_____

Signature_____ Date_____

**Please sign and return to childcare director.

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

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

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)