Students Name _____

Pre-School Checklist

This checklist must be completed before your child's first day of school.

_____ 1. Physical Form with doctors signature.

_____ 2. Health History completed on physical form and signed.

_____ 3. Immunizations filled out on physical form by the health provider and signed.

_____ 4. Hepatitis B, Hib, & Varicella vaccination is required.

_____ 5. TB test by Mantoux method and results

_____ 6. Lead Screen test and results.

_____ 7. Certified Copy of Birth Certificate

Physical and TB test will not accepted if it is more than 6 months prior to enrollment. Lead screen results take several weeks to get back. Please make arrangements to have this completed as soon as possible so you will have results back before the first day of school. Please bring this pre school checklist with you the day of Open House. A letter will be sent to you in the summer on the exact date of Open House and first day of school.

Special Information about

_____
(Child's Name)

Please help me know more about your child by telling me about the following:

- Your child's special abilities:

- Your child's favorite toys or playthings:

- Your child's favorite foods:

- Your child's favorite games, activities, songs:

- What quiets your child:

- What scares your child:

- What excites your child:

- Names of special people (brothers, sisters, friends):

- Things that are hard for your child:

- Things that come easily for your child:

- Other special information or concerns you may wish to share:

Emergency Information

Child's Name_____
Address_____
Home Telephone Number_____ Birth Date_____
Where Can Parents Be Reached If Not At Home?

Mother_____ Telephone_____
Name Address

Father_____Telephone_____
Name Address

List Two People Who Will Assume Temporary Care Of Your Child If You Cannot Be Reached.

Name_____
Address_____ Telephone_____

Name_____
Address_____ Telephone_____

In case of an accident or serious illness I request the staff at Little Prairie Pre School to contact me. If the staff is unable to reach me, I hereby authorize the staff at Little Prairie Pre School to call the physician indicated below and to follow the physicians instructions. If it is impossible to contact the physician the staff at the school will make whatever arrangements seem necessary.
Signature of Parent_____
Remarks:

Allergies:

Other Conditions:
Local Physicians Name_____
Address_____
Office Telephone_____
List the people who are allowed to pick up your child anytime during the school year.

Application for Enrollment of Students

School Year:_____

Name of Child:_____

Address:_____ Phone #:_____

_____

_____

Child's Date of Birth:_____

Name of Parents/Guardians: (Mother)_____

(Father)_____

Parents'/Guardians' Employment: (Mother)_____

(Father)_____

Recommended to Little Prairie Preschool by:_____

Number of Days per Week for Enrollment: 2_____ or 3_____

My child will be in the morning session 8:00 a.m. - 11:00 a.m. _____

My child will be in the afternoon session 12:00 Noon - 3:00 p.m. _____

Able and willing to serve as a parent volunteer for special occasions? Yes____ No____
Comments:_____

A $50.00 registration fee for 2 day students or a $60.00 registration fee for 3 day students must accompany this application.

Paid: $_____

Parent/Guardian Signature:_____

Date:_____

For School Office Use ONLY:

Approved:_____Date:_____
(Director's Signature)

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

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
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 1/2012

DCFS

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

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

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

COMMENTS:

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

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

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

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

Date of Disease **Signature** **Title** **Date**

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

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																				
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 No Yes 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)

Guidance and Discipline Policy

The Director and Teacher's responsibility is to protect your child's physical and emotional well being. We are here to give your child a desire to learn and to become an independent learner. Children are encouraged to express themselves. We will give them understanding, affection and support when needed.

It is our responsibility to restrain your child to prevent them hurting other children or damaging property. Unacceptable behavior such as: hitting, kicking, biting, talking back or running away from the teachers will not be accepted. Teachers will be speaking to your child about their unacceptable behavior. We will then give your child a choice on how to take care of the situation. If we see that your child continues to show unacceptable behavior and will not cooperate or gets angry and loses control, your child will sit on a Time Out Mat located in the room. Your child will sit there to think about their behavior. Removal from the group to sit on the Time Out Mat will not exceed one minute per year of age. A timer will be set. After the time is up your child is ready, he or she may come back and join the group. If the child comes back to join the group and continues to show behavior that is unacceptable, and then we will exclude your child from the group by sitting them at a table. A Disciplinary note will be sent home about their behavior and will be put in their backpacks. A conference meeting can be made to meet with the parents to discuss the child's behavior. On the first day of class, we will be teaching your child about safety, care of property and consideration of others. Rules will be explained to the children and acceptable or unacceptable and consequences will be explained in a cheerful manner.

The teacher has the right to ask the parents to remove a child from the school if the teacher sees that the child is not benefiting from the school or if the child is a danger to the other children. This action will not be taken until the teacher and parents have conferred about the problem and a week's notice has been given by the school.

I have read this policy on Guidance and Discipline and I agree and understand the procedure that will be taken upon my child.

_____

Parent's Signature

_____

Date

Any topical products such as Sunscreen or Insect Repellent must be approved by you the parent before the staff can apply it to your child. Please sign below giving us permission to do so.

_____

Certified Birth Certificate

The State of Illinois in cooperation with the Amber Alert System is now requiring all newly enrolled children of childcare facilities to present a Certified Copy of your child's birth certificate. This is a notification of Illinois law as prescribed to and administer through DCFS. The certified copy is expected before the first day of school. The staff is required by law to notify the Illinois State Police or local law enforcement agency if the parent/guardian fails to submit proof of the child's identity within the 30 day time frame.

The staff at Little Prairie Preschool has seen on this date _____ the original certified birth certificate. The certified copy of birth certificate will remain in the child's file until the child is no longer enrolled in our program and then it will be returned to the parent or guardian.

Child Name: _____

Parent or Guardian Signature: _____

Provider Signature: _____

Date: _____

Pest Management Plan

Illinois law requires licensed childcare centers to use Integrated Pest Management Plan. This plan combines preventive techniques, non-chemical pest control methods, and the appropriate use of pesticides with a preference for products that are the least harmful to human health and the environment. Applications of pesticides are made when deemed necessary to control a pest problem and after trying other means to control the problem. The term "pesticide" includes insecticides, herbicides, rodenticides, and fungicides. Parents/guardians will be notified at least 2 days and no more than 30 days prior to the pesticide application and what chemical will be used by the licensed contractor.

Parent/Guardian Signature_____

Date_____

Pick Up Policy

It is the responsibility of the staff at Little Prairie Preschool to provide and look after the well being of your child until the parent or guardian who is designated to do so. It is important to have up to date emergency contact phone numbers on file. You must call if an unexpected emergency arises and you are running late to pick up your child. We understand that the child is not responsible for these situations and that a conversation about these situations will be between the staff and parent/guardian only and not with the child. Children are to be picked up at the time of the scheduled dismissal.

Procedures for when a child is not picked up at the designated time.

If your child is not picked up at the scheduled time and 15 minutes has passed the parent will be notified. If the parent cannot be contacted the staff will be contacting the individuals who you have given consent to pick up your child. If contacts are unsuccessful and there is a 30 minute time span, a $10.00 charge is expected and for every 30 minutes thereafter. The staff will remain at school with your child, but after the first 45 minutes have passed and contacts are unsuccessful, the staff will be contacting the police department to try and locate the parents. I have read the Little Prairie Preschool Pick up Policy.

Child's Name_____

Parent/Guardian's Name_____

Parent/Guardian Signature_____

Date_____