

# YWCA ALTON IS ON A MISSION

## YWCA of Alton Enrollment and Policy Acknowledgement Form

Name of Child: \_\_\_\_\_ Age: \_\_\_\_\_

Ethnicity:  African American  Asian  Caucasian  Hispanic  Native American  
 Other: \_\_\_\_\_ (for data reporting purposes)

Grade (Fall 2018): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Pronoun Preference  She/Her  He/His  They/Them

Date child will start program: \_\_\_\_\_

### Program Option:

Full- Time After School (4-5 days - \$67.50) \_\_\_\_\_ Full Time Before School (4-5 days - \$47.50)  
Part-Time After School (3 or less - \$40.50) \_\_\_\_\_ Part Time Before School (3 or less - \$28.50)  
Full-time Before and After \$100 \_\_\_\_\_ Part Time Before and After \$65 \_\_\_\_\_  
Holiday Day Camps (all day) \$28.50

Parent pay CHASI DCFS **(100% Payment required until CHASI/DCFS approved)**

Will you have other children enrolled in the YWCA of Alton Child Enrichment Program?

\_\_\_\_\_ Yes \_\_\_\_\_ No

- There is a multi-child discount of \$5 taken off the weekly total.

Does your child have an IEP (Individualized Education Plan) or a 504 Plan?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If so, please send us a copy of the Plan so we may better serve your child in our program.

School child attends: \_\_\_\_\_

### Site Attending:

Alton YWCA, 304 E.3<sup>rd</sup> St. Alton, IL  
North Elementary, 5600 Godfrey Rd, Godfrey IL  
Lewis and Clark Elementary, 501 E Lorena Ave. Wood River IL  
Roxana- Ivy Heights Church of God, 1901 Old Edwardsville Rd. Wood River IL

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Parent/Legal Guardian: \_\_\_\_\_

Driver's License No.: \_\_\_\_\_

Address: \_\_\_\_\_

E-mail: \_\_\_\_\_

Telephone: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Parent/ Legal Guardian: \_\_\_\_\_

Driver's License No.: \_\_\_\_\_

E-mail: \_\_\_\_\_

Telephone: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

# YWCA ALTON IS ON A MISSION

Child's Name: \_\_\_\_\_

Child Enrichment Program Site:  Lewis and Clark  Alton  Roxana  Wood River

Program:  Part-time (1 – 3 days)  Full-time (4 – 5 days)

Session:  Before School  After School  Before and After School

CHASI:  Parent Pay DCFS:

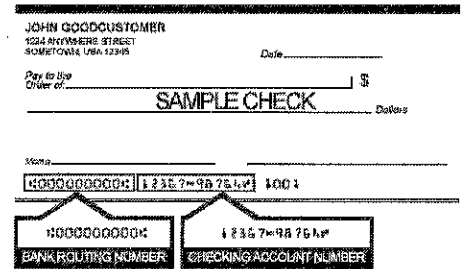
**Regardless of who is paying we must have one payment method completed below to approve your registration, unless approved by the Finance Manager. All fees will be drafted by 5 p.m. on Friday unless otherwise scheduled through the YWCA Finance Department. Your account must be current for your child to continue attending the program.**

I am authorizing a weekly Electronic Funds Transfer (EFT) from this account:

Bank \_\_\_\_\_

Account Number \_\_\_\_\_

Routing Number \_\_\_\_\_



I am authorizing a weekly draft from my credit card

Card type:  Master Card  Visa  Discover  American Express

Name as it appears on card \_\_\_\_\_

Card number \_\_\_\_\_ Expiration date \_\_\_\_\_

CSC (three-digit security code on back of card) \_\_\_\_\_

Billing address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

Payment Default and Consumer Report: All payments are due and payable as agreed. You agree and understand that you shall be responsible for all late fees, collection cost, attorney fees, court cost and any other monies required to secure the sum owed, within the limits of the law. In addition, upon default of your agreement, you understand and agree the default shall be reported to one or more reporting agencies.

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

Printed Name: \_\_\_\_\_ SS #: \_\_\_\_\_

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## YWCA Child Enrichment Program Consents

My child has permission to go on neighborhood walks and all field trips.

Yes     No

I give permission for my child to be included in publicity or press releases for the YWCA Child Enrichment Program and YWCA of Alton. This release shall cover written materials, Facebook posts and YWCA of Alton webpage. Children's names will not be utilized.

Yes     No

I have received and read the YWCA of Alton Child Enrichment Program Parent Handbook.

Yes     No

I acknowledge that my child must have a completed physical to participate in YWCA Child Enrichment programs. The attached physical form must be completed by a physician and returned to the YWCA before the child can attend the program. Alternatively, parents may grant the YWCA permission to obtain a copy of the child's latest physical form from the nurse's office at their child's school (see attached form).

I acknowledge I am responsible for all program charges. I understand that all weekly fees are due by 5 p.m. on Friday. I understand my account must be current for my child to continue attending the program. The YWCA accepts electronic funds transfer (EFT), and credit card. A receipt will be provided for all payments made on site or at the YWCA. I acknowledge a \$25 fee will be charged for all returned checks or refused EFT payments. The YWCA reserves the right to require cash, credit card, or money order payments for repeated returned checks or refused EFT payments. Repeated NSF payments may result in child's dismissal from our programs.

I acknowledge that I must, as soon as possible, notify the YWCA front desk or the Child Enrichment Director at (618) 465-7774 if my child is going to be absent from the program.

I acknowledge that I must notify the Child Enrichment Director in writing two weeks in advance if I elect to remove my child from the YWCA Child Enrichment Program.

I certify that the information I have provided is complete and accurate to the best of my knowledge.

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Parent /Guardian Signature

Date

### Arrival/Departure Form

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*(Please complete even if your child walks from his/her classroom to the program)*

Child's Name: \_\_\_\_\_

Grade: \_\_\_\_\_ Name of Parent: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Secondary Number: \_\_\_\_\_

Name of School: \_\_\_\_\_ Phone: \_\_\_\_\_

## **Arrival at Center Before School:**

Approximate Time of Arrival: \_\_\_\_\_ Time School Begins: \_\_\_\_\_

Time of Departure from Center: \_\_\_\_\_

Means of Travel from Center to School: \_\_\_\_\_

If Child Travels by Bus:

Name of Bus Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Bus Number: \_\_\_\_\_

## **Arrival at Center After School:**

Time of Dismissal: \_\_\_\_\_ Time Child Should Arrive at Center: \_\_\_\_\_

Means of Travel from School to Center: \_\_\_\_\_

If Child Travels by Bus:

Name of Bus Company: \_\_\_\_\_

Phone: \_\_\_\_\_

Bus Number \_\_\_\_\_

If Child Walks to Center from School, please indicate route: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# YWCA ALTON IS ON A MISSION

## Guidance and Discipline Policy

The YWCA Child Enrichment Program strives to provide our families with a safe, fun, and quality child care experience. To achieve this, we work together as a team to promote positive behavior in every area of our program. It is an important aspect of a child's development to practice self-control and learn positive problem-solving skills. We believe it is our responsibility to create a safe and consistent environment that will allow children to gain self-confidence, self-control, and an understanding of their feelings. This is the perfect age for children to learn that their behavior is their choice!

We use the following as behavior guidelines:

- Be Responsible & accountable for your own behavior
- Respect yourself
- Respect others
- Respect Property – Do your part to keep our spaces clean and tidy!

The YWCA Child Enrichment Program has zero tolerance for the following:

- Physical Aggression/ Fighting/ or Physical harm to self or others
- Disobedience & Disrespect
- Sexual or verbal harassment
- Bullying in any form
- Threats to staff or other students
- Inappropriate Language / Profanity/ Obscene gestures
- Non- Compliance

All children are expected to follow program rules.

- Children must remain in the program area. Children must notify a staff member if they need to leave the program area for any reason.
- No running inside the building.
- No standing or jumping on furniture.
- Replace all materials and toys when done using them and before getting out something else.
- Respect others and their property.
- Listen when spoken to; obey staff directions.
- Report any incidents with other children to staff.
- No name calling, fighting, yelling, cursing, pushing, biting, hitting, or threatening other children. No spitting or throwing items will be tolerated.

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- No toys, games, or other items from home are allowed – unless otherwise noted
- No candy or gum.

The Child Enrichment Staff will:

- Interact with children in a safe and respectful manner. We believe it is important for us to model the behavior we expect the children to learn and show themselves.
- Use strategies that promote self-esteem, and self- respect.
- Use positive ongoing communication and consistent guidance practices.
- Work with children and families to resolve problems and issues as they occur.

For all day camps, if a student is exhibiting unsafe or inappropriate behavior towards themselves, staff or other children, the Site Coordinator may remove student from the program for the day with approval from the Child Enrichment Director.

**The YWCA child enrichment program reserves the right to remove a child from the program for excessive unsafe or inappropriate behavior.**

## Disciplinary Action Process

Mild misbehavior	<b>Verbal Warning – Redirection</b> When unwanted behavior occurs, staff will warn student verbally of their misbehavior and remind child of appropriate behavior. This is best done by pulling the child to the side and speaking to them one on one.
Repeated behavior or 1 <sup>st</sup> Incident	<b>Redirection – Time Spent away from Group- Written Warning if necessary-</b> Verbally remind child of first warning and why they must now be separated from the group or receive a warning slip. Notify parents upon arrival and have them sign warning slip if applicable. *If a child has received 2 or more written warnings in the week for the same or comparable behavior, staff will proceed to third incident.
2 <sup>nd</sup> Incident	<b>Time spent away from group- Loss of Privilege- Behavior Incident Report</b> Student is removed from the group. Behavior incident report is written by staff. Parents are notified and behavior is discussed upon pick up. During this time the student will write a letter explaining their behavior.

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3 <sup>rd</sup> Incident	<b>Behavior Incident Report (written) - Loss of Privilege(s) - Phone Call to Parent - Conference (phone)</b>
4 <sup>th</sup> Incident	<b>Conference- Suspension</b> Child will face suspension for 1-5 days. There must be a conference with the director, site coordinator and the parents before the child may return to the program.

**I have read the YWCA of Alton Child Enrichment Program Guidance and Discipline policy in the Parent Handbook and agree to the terms stated herein.**

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Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

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Child Enrichment Director \_\_\_\_\_ Date \_\_\_\_\_



# YWCA ALTON IS ON A MISSION

## Field Trip Guidelines and Requirements

We have put together a few guidelines to ensure safety on our field trips as well as requirements to be met by each child. Each guideline and requirement must be met for children to participate in field trips.

### Guidelines and Requirements:

- Behavior expectations on field trips will be upheld as they are day to day at camp. If behavior issues arise, a child may miss out on future field trips. Parents will be notified in advance if a child must miss out on a field trip. Children who cannot attend a field trip due to behavior will be given the option to stay behind with a staff member.  
\*Examples of issues: child running off from staff, being disrespectful to others and/or property, incident that results in other children missing out on field trip, etc.
- Staff to child ratios will be 1:10 (at least) meaning that for every 10 children present there will be 1 staff member. Volunteers and/or extra staff will be used as needed.
- If a field trip must be cancelled for any reason other than behavior of children, we will do our best to reschedule for a different day of the week.
- Activity must be paid as part of monthly invoice. Parents on CHASI and DCFS, be aware that the activity costs are not covered by DCFS or CHASI and are your full responsibility.
- Financial accounts must be current.

**\*For transportation and staffing purposes, students must be signed up for trips the week before the scheduled trip\***

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Parent/Guardian Signature

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Date

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## Late Pick Up Plan

Parents are required to come into the building at each site to sign their child in or out on the appropriate form each day. Only the custodial parent or someone designated by the custodial parent on the enrollment form may pick up the child.

If, due to an emergency, you know that you will be later than 6:00 p.m., please call and notify the Site Coordinator (number to be obtained from the staff) or the YWCA of Alton at 618-465-7774. This will help relieve any concerns your child and our staff may have as to why you are running late.

**If your child is picked up after 6:00 p.m., a late fee charge may be assessed at the rate of \$1.00 per minute per child for every minute after 6:00 p.m.**

When a child is left at the program after 6:00 p.m., these steps will be followed:

**6:10 p.m.** – we will attempt to contact a parent or legal guardian,

**6:20 p.m.** – we will begin contacting people on the emergency contact list if a parent has not been reached, and

**6:40 p.m.** – we will contact the local police department to report a possible child abandonment issue if parent or emergency contacts have not been reached.

The YWCA Child Enrichment Staff would like to assure all parents that no child will ever be left alone. The staff will remain at the site until the child is either picked up or outside authorities arrive. We will never hold the child responsible and discussion of this issue will only be with the parent or guardian, not the child.

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Parent Signature

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Date

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CE Director Signature

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Date

# **YWCA ALTON IS ON A MISSION**

**THANK YOU FOR CHOOSING THE YWCA ALTON CHILD ENRICHMENT PROGRAM.  
PARTICIPATION IN OUR PROGRAM CONTRIBUTES TO THE FUTURE SUCCESS OF YOUR  
CHILD.**

Yes, I have read and received the YWCA Alton Child Enrichment Parent Handbook. I will comply with the handbook. I also understand if my child and/or I do not follow all policies and procedures, my child's placement with the program may be terminated.

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Parent/Guardian Signature

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Date

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Child's Name

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Name of Child: \_\_\_\_\_

For **data reporting purposes only** required by our various funding sources and YWCA USA.

This information will be stored in a confidential location, separate from your child's files.

Household Size \_\_\_\_\_

Annual Household Income:

\$0-\$22,311

\$22,312-\$30,044

\$30,045-\$37,777

\$37,778-45,510

\$45,511-\$53,243

\$53,244-60,976

# YWCA ALTON IS ON A MISSION

## DCFS Licensing Standards Receipt

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.

**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:

**ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY**

**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 & Emergency Contact

(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. This includes the use of public transportation.

Date \_\_\_\_\_  
Signature of parent/guardian \_\_\_\_\_  
Relationship to child \_\_\_\_\_

Date \_\_\_\_\_  
Signature of parent/guardian \_\_\_\_\_  
Relationship to child \_\_\_\_\_

## Sunscreen Application

I/we consent to my/our child using sun screen for outdoor play.

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 11/2013

Illinois Department of  
**DCFS**  
Children & Family Services

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

**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																	
DTdap: 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		
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		
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
Vision																		
Hearing																		

**Code:**  
P = Pass  
F = Fail  
U = Unable to test  
R = Referred  
G/C = Glasses/Contacts

<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
Last	First	Middle	Month/Day/ Year			

**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

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

<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI &gt; 85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ (Blood test required if resides in Chicago.)				
<b>TB SKIN OR BLOOD TEST</b> Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____				

<b>LAB TESTS</b> (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Antagonist ) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> Needs/Restrictions
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**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)