

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:

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
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

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, herby 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.



**State of Illinois
Certificate of Child Health Examination**

FOR USE IN DCFS LICENSED
CHILD CARE FACILITIES
CFS 600
Rev 11/2013



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		2		3	
	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
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)	COMMENTS:					
MMR Combined Measles Mumps Rubella						
Single Antigen Vaccines						
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) <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Varicella						
Lab Results	Date	MO	DA	YR	(Attach copy of lab result)	

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN															
Date														Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
Age/Grade															
	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?	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? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____		Parent/Guardian Signature	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)		Date	
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

HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI > 85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
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 <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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 <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	

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)

FIREARM(S) NOTIFICATION

In accordance with the Department of Children and Family Service

Licensing standards for Day Care Homes (December 13, 2013), Section

406.8a17B, this shall serve as notification to parent(s) or other persons placing

the child that "firearm(s) and ammunition are stored on the premises.

Such firearm(s) are kept in a disassembled state, without ammunition, in locked storage in a closet, cabinet or other locked facility inaccessible to children.

Ammunition for such firearm(s) is kept in a locked storage, separate from that of the disassembled firearm(s), inaccessible to children.

Parent's Signature

Date

Provider's Signature

Date