CHILD INFORMATION FORM

Child's Full Name: _____

First Middle Last

Birthday: _____ Sex: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Parent/Guardian: _____

Siblings' Names: _____

Mother's Workplace and Phone Number: _____

Father's Workplace and Phone Number: _____

Other Persons to Notify in Case of Emergency:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Child's Physician: _____ Phone: _____

Hospital: _____

Lending Library Agreement

I, _____, understand that I am responsible for the books that my child borrows from the Lending Library. I understand that the books will be left in my care for a period of four days (Friday through Monday). All books must be returned by Tuesday. My child will not receive another book until previously borrowed books are returned.

_____ _____

Parent/Guardian Signature Date

Preschool Emergency Medical/Parent Release Consent Form

Student's Name: _____

Address: _____ Birth Date: _____

Mother's Name: _____ Home Phone: _____

Place of Employment: _____ Work Phone: _____

Father's Name: _____ Home Phone: _____

Place of Employment: _____ Work Phone: _____

My Child is Covered by Family Insurance: _____ Yes _____ No

Coverage by: _____ School Insurance: _____ Yes _____ No

List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Pease read carefully: In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow the physician's instructions. If it is impossible to contact the physician, the school may take whatever arrangements seem necessary.

Signature of Parent/Guardian: _____ Date: _____

Allergies: _____ Other Conditions: _____

Local Physician's Name: _____ Phone: _____

Preferred Hospital: _____

Preschool Emergency Medical/Parent Release Consent Form
Page 2

Student's Name: _____

Please list care provider (s) before and after school: _____

Phone: _____ Phone: _____

How will your child come to school? _____

How will your child leave school? _____

Authorized people to pick child up:

(These people may be asked for identification.)

1. _____ 2. _____ 3. _____

Name/Phone Number Name/Phone Number Name/Phone Number

4. _____ 5. _____ 6. _____

Name/Phone Number Name/Phone Number Name/Phone Number

*Please notify the teacher/aide with departure arrangements. If the arrangements change for just a day or completely, you need to notify the teacher in writing.

Please do not send anyone to pick up your child whom you have not listed. They will not be allowed to take your child.

Parent/Guardian Signature: _____

Date: _____

Home Language Survey

The State of Illinois requires the district to collect a Home Language Survey for every new student. This form is used to count the students whose families speak a language other than English. It also helps to identify the students who need to be assessed for English language proficiency.

Please answer the questions below and return this survey to your child's teacher.

Student's Name: _____

Is a language other than English spoken in your home?

_____ Yes _____ No

If yes, what language? _____

Does your child speak a language other than English?

_____ Yes _____ No

If yes, what language? _____

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

_____ _____

Parent/Guardian Signature Date

Social Media/Web Site Permission and Publicity Release

As part of your child's participation in the ROE#13 Preschool Program, they may have the opportunity to have a picture or project published on the ROE#13 web site, school district web site, ROE#13 newsletter, or in a local newspaper. We think this is an exciting opportunity for our students. In addition, the teacher may have a PRIVATE social media class account where their activities, classroom schedule updates, field trip pictures, party updates, etc may be posted for communication purposes.

Your child's safety is very important. Should we decide to post any pictures, projects or documents on the web site or in the newspaper, we will never publish the student's name. Please sign in the space provided below if you give the Regional Office of Education #13 permission to post your child's pictures, projects or documents on the ROE #13 website, school website, ROE#13 newsletter, or in a local newspaper.

_____ _____

Signature of Parent/Guardian Date

Parental Waiver

I, _____, parent/guardian of _____, minor do hereby release, acquit and forever discharge the Regional Office of Education #13, its officers, employees, agents and representatives and the Illinois State Board of Education, from any and all claims, causes of action, damages, or judgments, for any injuries including personal that may be incurred arising out of or in any way connected to my child's participation in field trip activities.

Preschool Program Participation

I, _____, allow my child to participate in the Regional Office of Education #13 Preschool Program.

_____ _____

Parent/Guardian Signature Date

PARENT EDUCATION AND INVOLVEMENT

A crucial aspect of the Regional Office of Education #13 Preschool Program is parental involvement. Without parental support, the program is less effective. It is our goal to have parents involved in their children's educational experiences. In the process parents will gain knowledge and skills in relation to parenting.

Communication between Home and School

- Group meetings are offered to encourage the parent and child interaction and exposure to literacy.
- Personal visits are available to provide parental support and child development information.
- Parents will receive regular and sustained information pertaining to their child's progress plan that is reflective of the Early Learning Standards.
- Parent participation is encouraged in the classroom and events at school.
- Consistent conferences between parents and teachers.
- Parents are offered multiple parent education opportunities.
- Variety of family activities will be available.
- Literacy bags and lending library is available.
- Parents and staff shall communicate consistently in an open, honest and productive environment in a variety of ways.

Provisions are made for communication with parents who do not speak English.

I agree to make a reasonable effort to take an active role in my child's educational experience while he/she is enrolled in the Regional Office of Education #13 Preschool Program.

_____ _____

Signature Date

Parent Information

Communication Between Home and School:

- Group meetings are offered to encourage parent and child interaction and exposure to literacy.
- Home visits are available to provide parental support and child development information.
- Parents will receive regular and sustained information pertaining to their child's progress plan that is reflective of the Illinois Early Learning Standards.
- Parent participation is encouraged in the classroom and events at the child's school.
- Conferences between parents and teachers will be provided throughout the school year.
- Parents are offered multiple parent education opportunities.
- Recognition that both mothers and fathers play an essential role in their children's development.
- A variety of family activities will be available.
- Literacy bags and children's toy/book lending library is available.
- Parents and staff shall communicate consistently in an open, honest and productive environment in a variety of ways.
- Provisions are made for communications with parents who do not speak English.
- Resources are available in the family's home/native language

Parent Education Meetings:

- Parent education meetings will be offered four times throughout the school year at each preschool site.
- Topics will be decided upon by the preschool teachers, aides and the preschool director based on the needs/requests of the parents.
- Presenters for the parent education meetings will be program staff, parent educators, or a presenter will be provided.

Parent/Child Activities:

- Teachers will create lesson plans for parent and child activities to be implemented every month at each preschool site.
- Opportunities will be provided for parents and children to become involved in early literacy experiences based upon the lesson plans created by the teaching staff.
- Each parent will be required to sign in at each meeting they attend and also to complete a *Parent Feedback Form* at the completion of each parent and child activity.

Parent Goals for the Upcoming School Year

1. What would you like your child to learn in preschool this year?

2. What existing skill, talent, or knowledge would you like your child to increase or expand upon this school year?

3. What are some goals you have set for yourself as a parent that you would like to accomplish this year?

Date: _____ Student: _____

Parent/Child Activity Survey

Please Circle Two Topics That Would Best Fit Your Family Needs

1. Technology/Screen Time (setting limits)
2. Building Strong Families (Behavior Management Strategies)
3. Fun with Math (ways to incorporate math skills into your routines)
4. Literacy/Language (importance of reading with your child/building language skills)
5. Health/Nutrition (healthy snacks/gross motor activities)
6. Social/Emotional Development (activities/skills to promote positive interactions)
7. Kindergarten Transition (helping your child get ready for Kindergarten)
8. Other (Please specify in the space below)…

Circle The Day Of The Week That Best Fits Your Schedule

Monday Tuesday Wednesday Thursday Friday

Circle The Time That Best Fits Your Schedule

Morning Afternoon Evening

Child's File Checklist

Child's Name:_____ Date of Birth: _____ School Year: _____

ITEM	DATE FILED	NOTES
PreK Family Inv. Record (on-line)		
Parental Waiver		
Parent Ed. & Involvement		
Social Media/Web Site Permission/Release		
Parent Goals for Upcoming Year		
Parent Handbook Sign Off		
Lending Library Agreement		
Child Information Form		
Parent Release Consent Form		
PreK Program Participation		
Home Language Survey		
PreK Emer. Med. Form		
Hearing/Vision Screenings (Done at screening or must be done at the school)		
Field Trip Perm. Form (as needed)		
Parent Interview Questions (done at conferences)		
Accident Reports (as needed)		
Parent Contact Rep. form		
Permission to Screen (Brigance only)		
Prek Eligibility Worksheet		
PreK Screening Reg. Form		
ESI-P, ESI-K or Brigance		
Prek Screening Clinical Results		
Physical (30 days of 1st day) with updated Immunization Records		
Diabetes/Lead Screening Results		
Copy of Medicaid Card (if applicable)		
Birth Cert. (Certified Copy)		
Proof of Household Income (see attached ISBE document)		
Proof of Residency-2 Items		

PRESCHOOL REGISTRATION CHECKLIST FOR PARENTS

The following items are required to register your child for preschool:

- ☐ Certified birth certificate
- ☐ Proof of residency (provide two items):
  - ☐ Utility bill with name and address
  - ☐ Current lease, rental agreement or warranty deed from the purchase of your home
  - ☐ Illinois Driver License with current address
- ☐ Proof on income (Please see the ISBE document.)
  - ☐ Pay stubs
  - ☐ Proof of WIC
  - ☐ Medicaid information
  - ☐ Proof of Supplemental Nutrition Assistance Program (SNAP)
  - ☐ Proof of Child Care Assistance Program (CCAP)
  - ☐ Tax Statement
  - ☐ Signed written statement from the family (also applies for homeless students)
- ☐ Physical exam records with immunizations and diabetic screening (within the past twelve months)
- ☐ Proof of vision exam
- ☐ Lead screening

Thank you for your cooperation in obtaining the above needed documents.

Dear Parent or Guardian,

The State of Illinois requires that all students entering Early Childhood Preschool Programs receive the following:

PHYSICAL EXAMINATION is required for ALL students entering preschool. The physical exam must be within the past twelve months of the beginning of school and recorded on the *Certificate of Child Health Examination* form. The exam must include the diabetic screening section along with height, weight, BMI and blood pressure. This form must be completed and signed by a medical doctor, advanced practice nurse, or physician assistant. The *Health History* section must also be completed, signed and dated by a parent/guardian.

LEAD SCREENING is required for any student age six years or below prior to enrolling in preschool or kindergarten.

IMMUNIZATIONS:
DTP/Dtap-4 or more doses
IVP-3 or more doses
MMR-1 or more doses
Hep B-3 doses
Varicella-1 dose or history of disease

All health requirements need to be turned in at the time of preschool registration.

Illinois Certificate of Child Health Examination Code

A copy of the State of Illinois *Certificate of Child Health Examination* form is provided on the next two pages. Please take this form to your child's doctor at the time of the required physical.

Health examination for all public, private/independent and parochial school students in Illinois shall include:
Physical examination shall include an evaluation of: height, weight, blood pressure, BMI, skin, eyes, ears, nose, throat, mouth/dental, cardiovascular, respiratory, gastrointestinal, genito-urinary, neurological, musculoskeletal, spinal examination, nutritional status, lead screening and other evaluation deemed necessary by the examiner. The strongly recommended evaluations include hemoglobin or hematocrit, urinalysis, and sickle cell. The examiner should list any medication the child takes routinely, diet restrictions/needs, special equipment needed, or the other needs, and known allergies.

A medical history shall be completed and signed by the parent or legal guardian of the student. The medical history shall be inclusive as indicated on the *Certificate of Child Examination* form.

At or about the same time that he/she receives a health examination, every child shall present proof to the local school authority of having received immunization again preventable communicable diseases as required by Section 665 of the *Child Health Examination Code.*

A diabetes screening shall be included as a required part of each health examination and the health care provider shall document results of the diabetes risk assessment of the *Certificate of Child Health Examination* form.

Lead screening is a requires part of the health examination for children ages six years or younger prior to the admission to a preschool, nursery school, kindergarten, or other child care program. If the health care provider did not perform the assessment, the school nurse could administer the questionnaire. Any single *Yes or Don't Know* answer requires a blood test, as does residing in a high risk ZIP Code

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

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	
Vision																			
Hearing																			

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

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 night coughing?	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.			
Bone/Joint problem/injury/scoliosis?	Yes	No		**Parent/Guardian Signature**			**Date**

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

HEAD CIRCUMFERENCE if < 2-3 years old 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. (Blood test required if resides in Chicago or high risk zip code.)

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

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **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 Agonist) ☐ 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** Yes ☐ No ☐ Limited ☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

(Complete Both Sides)