JCC chicago

EARLY CHILDHOOD EDUCATION

Dear 2024-25 Families,

We are so excited to have you as part of our JCC Chicago family during the 2024-25 school year! We look forward to a wonderful year of working with you and your children.

We are pleased to offer you easy access to all enrollment forms online. Each year we ask that each family complete all the forms to enable our staff to best meet the needs of each individual child while also satisfying the requirements of the Illinois Department of Children and Family Services. Please visit our website at **jccchicagoearlychildhood.org/intake-forms** to conveniently find all of the **REQUIRED** enrollment forms. You have two options to complete the forms:

1. Complete them electronically using **Acrobat Reader** and print them out or email to the director of your JCC Chicago Early Childhood location.
2. Print them out and complete them by hand.

It is critical that you complete all of the forms listed below prior to the beginning of our school year. All of the forms help us provide your child with the best possible individual educational experience.

The following forms are included:

1. Family Profile Form *(two parts)*
2. CFS Medical Form *(requires physician signature and completion of health history by parent or guardian)*
3. Program Permission Form
4. Authorization for Pick-Up Form
5. Receipt and Agreement to Policies Form
6. Insurance Form
7. Preferred E-mail Form
8. Minor Participant Waiver
9. Friendship Request Form *(optional)*
10. Waiver for the Distribution of Medicine Form *(optional)*
11. Waiver for the Distribution of Sunscreen, Ointments and Insect Repellent Form *(optional)*
12. Emergency Card (2) included electronically

You will also find these guidelines and documents online for your perusal at **jccchicagoearlychildhood.org/intake-forms**:

1. Early Childhood Parent Guide
2. Early Childhood Code of Honor
3. Illinois Department of Children and Family Services Summary of Licensing for Day Care Centers
4. Late Pick Up Policy

The Illinois Department of Children and Family Services mandates that early childhood centers obtain a certified copy of each enrolled child's birth certificate or equivalent documentation. This regulation has been put in place to satisfy the Missing Children Records Act and is a required piece of documentation that must be supplied to your site.

Our guidelines require that we have an accurate medical history and an up-to-date record of immunizations on file, including a TB and Lead Screening test. For children first entering our program, a TB test and medical examination must be done no sooner than six months before starting. The medical examination must be updated yearly by your child's physician.

If you are unable to access the forms electronically, please contact your early childhood Director immediately. **All completed forms must be received by August 1, 2024.** Forms may be returned to:

- JCC Chicago Early Childhood location, c/o Director, Address, City, IL Zip Code
- You may also choose to scan or email your completed forms.

If you should have any questions about this process, please contact the director at your location.

We understand that choosing your child's school experience is an important decision. Therefore, we thank you for choosing JCC Chicago Early Childhood. We look forward to creating wonderful new memories with your family. Together, we will celebrate your child's milestones.

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jkim@jccchicago.org

BERNARD HORWICH JCC
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Chicago, IL 60645
773.516.5882
Miriam Aberman, Director
maberman@jccchicago.org

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847.763.3571
Kaitlin McGahey, Director
kmcgahey@jccchicago.org

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847.835.0008
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847.272.8707
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JACOB DUMAN EARLY CHILDHOOD CENTER AT LAKE COUNTY JCC
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Lisa Spewak, Director
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JCC Chicago is a nonprofit organization dedicated to ensuring a strong and vibrant Jewish life and community for generations to come.
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Enrollment Forms Completion

We're very happy to offer our enrollment forms electronically. You have two options:

1. Complete the forms electronically using Adobe® Acrobat Reader and print them out. If you do not have Acrobat Reader, please download it free from the Adobe website. Usage of other PDF readers may result in incomplete forms.
2. Print the forms out and complete them by hand.

Completing the enrollment forms is mandatory.

The advantage to completing them electronically is that if you have more than one child, you will be able to complete all of the forms once. Then you can save the file with a new name and replace only the information specific to each child.

If you choose to complete them electronically, please follow these steps.

1. Open and save the PDF file on your computer. Put it in a place where you'll find it – perhaps on your Desktop or in your Documents folder. Once the file has been saved, close it.
2. Now go to that file on your computer and open it by double-clicking on it. **DO NOT** open the file from the web site and edit it before you have saved it in a specific location (that you can find again) on your hard drive.
3. It is imperative that you save the PDF first. To complete the forms, open the PDF from your hard drive, not your email, and begin.

Some tips to help you complete these forms.

- Check (or click) **Highlight Fields** (at the top of the document on the right in Acrobat). It isn't required for you to fill out the forms, but it will help you see where to place your cursor.
- Where you are given more than one line to enter text, you will need to hit the **TAB** button to go to the next line, or manually click in the next field.
- Please note that the State Forms (Medical and Lead Testing) cannot be completed electronically but are included in your PDF for when you print out the packet.

NOTE State Guidelines require a signature. An electronic signature is valid and if you complete your forms electronically, you must fill out the signature fields. If you print your forms, you must sign them and mail/bring them to your center.

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EARLY CHILDHOOD EDUCATION

For Office Use Only
Date Entered Program _____
Site _____
Date Exited Program _____

2024-2025

FAMILY PROFILE FORM – PART ONE

Please complete this form in its entirety.

Date Completed _____

CHILD

Child's Name _____ Nickname _____ Date of Birth _____
Gender at birth ❍ M ❍ F Preferred Pronoun _____ Hebrew Name, if any _____
Child's Class _____ Days of Week _____ Hours _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Email _____
School to attend upon Kindergarten entrance _____
Who has legal custody of child? _____
Any restrictions? *(Please provide legal documentation)* _____

❍ Parent ❍ Guardian

Name _____
Age _____ Education _____
Are there any health issues that you feel are important for us to know? _____

Occupation _____
Business Name _____
Business Phone _____
Business Address _____
Work Days/Hours ❍ M ___ ❍ T _____ ❍ W _____
❍ Th __ ❍ F _____ ❍ Sa _____ ❍ Su _____
Do you travel for business? ❍ Yes ❍ No
How Often? _____
Cell Phone _____
Pager Number _____
Email _____

❍ Parent ❍ Guardian

Name _____
Age _____ Education _____
Are there any health issues that you feel are important for us to know? _____

Occupation _____
Business Name _____
Business Phone _____
Business Address _____
Work Days/Hours ❍ M ___ ❍ T _____ ❍ W _____
❍ Th __ ❍ F _____ ❍ Sa _____ ❍ Su _____
Do you travel for business? ❍ Yes ❍ No
How Often? _____
Cell Phone _____
Pager Number _____
Email _____

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2024-2025

FAMILY PROFILE FORM – PART TWO

YOUR FAMILY

Marital Status of Parents ❍ Married/Date _____ ❍ Widowed/Date _____ ❍ Single
❍ Separated/Date _____ ❍ Divorced/Date _____ ❍ Other _____

Other Children in Family

Name *D.O.B.* *Gender at Birth* *Pref. Pronoun* *Resides With* *Health* *School* *Grade*

_____

_____

_____

_____

Place of Worship _____

Child's Physician _____ Phone _____

Child's Dentist _____ Phone _____

Hospital Affiliation _____

Other adults living in home _____ Relationship _____

Kind of family pets _____ Name of pets _____

What languages are spoken in your home? _____

Is there a caregiver other than parents? ❍ Yes ❍ No Who? _____

Does this person live in child's home? ❍ Yes ❍ No How long has caregiver worked for family? _____

What activities does this person like to do with child? _____

Has your child ever been left with a sitter? ❍ Yes ❍ No How often? _____

Child's reaction to a sitter? _____

_____

Has your child experienced any of the following? Please check and list dates.

❍ Household Moves _____ ❍ Change in caregiver _____
❍ Parental Job Changes _____ ❍ Death in Family _____
❍ Parent Work Hours _____ ❍ Loss of Pet _____
❍ New Baby _____ ❍ Other Loss _____
❍ Serious Illness _____ ❍ Hospitalization _____
❍ Operation _____ ❍ Accident _____
❍ Serious Injury _____ ❍ Other _____
❍ Parent Attending School _____

What was child told about family changes? _____

How did they react? _____

_____

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2024-2025

FAMILY PROFILE FORM – PART THREE

YOUR CHILD

How does your child handle changes in routine?_____

How does your child react to new situations? _____

Please note specific situations in which your child tends to become upset, angry, afraid, withdrawn, or other_____

_____

Describe how you help your child handle these situations? _____

_____

How would you describe your child's temperament or personality?_____

_____

What three adjectives would you use to describe your child? _____

_____

Describe your approach to discipline and how your child responds_____

_____

_____

PLAY HABITS

What are your child's play habits?_____

_____

Does your child make friends with children easily or cautiously?_____

Does your child make friends with adults easily or cautiously?_____

How would you describe your child's attitude towards adults? _____

How would you describe your child's play? _____

How does your child interact with playmates? _____

_____

How does your child get along with their siblings? _____

_____

What does your child enjoy doing with other members of the family?_____

_____

Does your child have any special interests or hobbies? _____

_____ _____

_____

Are there special family times or excursions they enjoy? _____

_____

_____

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FAMILY PROFILE FORM – PART FOUR

PRENATAL & POSTNATAL

Did you have any illnesses or take medications during pregnancy? _____

_____

Any complications with pregnancy/delivery? _____

Were you: ❍ Full term ❍ Premature Child's length at birth _____ Child's weight at birth_____

Complications after birth? _____

Did you have any anesthesia or medication during delivery? _____

Was child as baby ❍ Easy-going ❍ Active ❍ Colicky ❍ Other _____

GENERAL HEALTH

Were or are there any physical or medical factors of which we should be aware? If yes, please describe. (Required)

Yes No

❍ ❍ Allergies _____

❍ ❍ Vision _____

❍ ❍ Hearing _____

❍ ❍ Ear infections How often?_____ Fluid? ❍ Yes ❍ No

❍ ❍ Coordination _____

❍ ❍ Food Restrictions _____

❍ ❍ Eating Difficulties _____

❍ ❍ Constipation _____

❍ ❍ Diarrhea _____

❍ ❍ Seizures_____

Does your child use adaptive equipment, medical or health equipment (tubes, glasses)? ❍ Yes ❍ No

Does your child take medication regularly? ❍ Yes ❍ No Please describe _____

Any special instructions?_____

ROUTINES

General Separation

Is this your child's first infant/toddler or preschool experience? ❍ Yes ❍ No

If no, what was previous experience?_____ Where?_____

How long did they participate? Days/Week_____Hours/Day_____

What was child's experience? _____

How did your child transition?_____

Why did experience end?_____

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FAMILY PROFILE FORM – PART FIVE

ROUTINES (CONTINUED)

Do they:

- ❍ Use a bottle
- ❍ Use a pacifier
- ❍ Thumb suck
- ❍ Sleep in a crib
- ❍ Sleep in a bed
- ❍ Sleep alone
- ❍ Sleep with toy
- ❍ Sleep with blanket

❍ Fall asleep easily? Are there routines that help your child fall asleep? _____

_____

_____

❍ Have nighttime fears _____

_____

How early retire? _____

How early awake? _____

❍ Still nap? What time/How long? _____

_____

TOILETING

At what age did they? Start B.M. Training_____Start bladder training_____

Method of training _____Do they tell you ❍ Before ❍ After

Needs reminding to go: In the day ❍ Yes ❍ No At night ❍ Yes ❍ No

Do they mind using toilets outside the home? ❍ Yes ❍ No If "accident" what reaction? _____

EATING

Are mealtimes: ❍ Pleasant ❍ Difficult Please describe _____

How do you handle it?_____

What are your child's favorite foods?_____

What foods does your child dislike?_____

When do they usually get hungry?_____

How often does your child eat during the day? _____

DEVELOPMENT

At what age did they? *(If you can't recall the age but your child has mastered the skill, just check it.)*

Crawl _____ Walk _____ Point _____ Babble _____

Use Single Words _____ What were first words? _____

Use Phrases _____ What were first phrases? _____

Are there any aspects of your child's development that are of concern to you?_____

_____

_____

Because we believe that early identification and intervention is key to long-term developmental growth and success, please answer the following question in an effort to share as much information as possible about your child's unique learning profile.

Does your child currently receive outside professional therapies such as: Speech, occupational, developmental, physical, Early Intervention, etc.? If so, please explain. _____

_____

_____

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2024-2025

FAMILY PROFILE FORM – PART SIX

EARLY CHILDHOOD EXPERIENCES

Has your child had any other group experiences? _____

Will your child participate in other programs this year? ❍ Yes ❍ No

Which ones? _____ With or without an adult? _____

Do they know other children coming to school? ❍ Yes ❍ No Names _____

_____

What experiences would you like your child to have in preschool? _____

_____

What are your goals for your child this year? _____

OTHER

Is there any other information you would like to provide? _____

_____

_____

Would you like to receive information about other JCC Chicago programs and services? Please check:

❍ Summer Camps ❍ Sports/Swimming ❍ Adult Fitness

❍ Family Events ❍ Parent/Child Programs ❍ Children's Programs

How did you learn about JCC Chicago Early Childhood? _____

_____

PARENT/GUARDIAN SIGNATURE

Omission and/or falsification of any information required in this profile is grounds for immediate dismissal from the program.

_____

Print Name

_____

Parent/Guardian Signature Date

Thank you for completing this form. The information you provided will allow JCC Chicago to provide caring, individualized attention to your child. If you have any questions about this form, please don't hesitate to call.

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State of Illinois
Certificate of Child Health Examination

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. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine / Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 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						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:** * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

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 (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies 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**

3. Laboratory Evidence of Immunity (check one) ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

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)	Yes No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**	
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. **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 if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

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		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**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 ☐ Modified ☐**

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

Address **Phone**

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE EVALUATED FOR LEAD POISONING (410 ILCS 45/6.2)

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area
- all Medicaid-eligible children should have a blood lead test prior to 12 months of age and 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If responses to all the questions are "No":

- re-evaluate at every well child visit or more often if deemed necessary

Child's name _____ Today's date _____

Age_____ Birthdate_____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**		
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes	No	Don't Know
2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	Yes	No	Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes	No	Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes	No	Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes	No	Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes	No	Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes	No	Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes	No	Don't Know
9. Does this child reside in a high-risk ZIP code area? (see reverse side of page for list)	Yes	No	Don't Know

If there is any **"Yes"** or **"Don't Know"** response; **and**

- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), **and**
- there has been no change in the child's living conditions, a blood lead test is not needed at this time.

Test 1: Blood Lead Result _____mcg/dL Date _____ Test 2: Blood Lead Result _____mcg/dL Date _____

_____ _____

Signature of Doctor/Nurse *Date*

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

IOCI 15-678 IDCI Printed by Authority of the State of Illinois

State of Illinois
Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams
62301
62320
62324
62339
62346
62348
62349
62365

Alexander
62914
62988

Bond
62273

Boone
61038

Brown
62353
62375
62378

Bureau
61312
61314
61315
61322
61323
61328
61329
61330
61337
61338
61344
61345
61346
61349
61359
61361
61362
61368
61374
61376
61379

Calhoun
62006
62013
62036
62070

Carroll
61014
61051
61053
61074
61078

Cass
62611
62618
62627
62691

Champaign
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Christian
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Clark
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Clay
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Clinton
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Coles
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61943
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Cook
All Chicago
ZIP Codes
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Crawford
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Cumberland
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DeWitt
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DeKalb
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Douglas
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DuPage
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Edgar
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Edwards
62476
62806
62815
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Effingham
None

Fayette
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Ford
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Franklin
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Fulton
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Gallatin
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Greene
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Grundy
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Hamilton
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Hancock
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Hardin
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Henderson
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Henry
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Iroquois
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Jackson
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Jasper
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Jefferson
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Jersey
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Jo Daviess
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Johnson
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Kane
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Kankakee
60901
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Kendall
None

Knox
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Lake
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LaSalle
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Lawrence
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Lee
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Livingston
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Logan
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Macon
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Macoupin
62009
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Madison
62002
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Marion
None

Marshall
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Mason
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Massac
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McDonough
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McHenry
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McLean
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Menard
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Mercer
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Monroe
None

Montgomery
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Morgan
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Moultrie
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Ogle
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Peoria
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Perry
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Piatt
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Pike
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Pope
None

Pulaski
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Putnam
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Randolph
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Richland
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Rock Island
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St. Clair
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Saline
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Sangamon
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Schuyler
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Scott
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Shelby
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Stark
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Stephenson
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Tazewell
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Union
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Vermilion
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Wabash
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Warren
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Washington
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Wayne
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White
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Whiteside
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Will
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Williamson
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Winnebago
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Woodford
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IOCI 15-678

Printed by Authority of the State of Illinois

April 2015

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2024-2025

REQUIRED

Program Permission Form

1. I give permission for my child _____ to receive appropriate medical attention from JCC Chicago staff, such as first aid, CPR, Heimlich maneuver, etc., or, if it is determined that my child needs immediate professional medical care, I authorize JCC Chicago to transport them to the nearest emergency hospital. Parents will be contacted immediately. I understand that I will be responsible for all of his/her expenses in relation to emergency medical services.
2. I hereby give permission for JCC Chicago staff to contact my pediatrician for any information needed about my child. I authorize my pediatrician to release such information to JCC Chicago.
3. Dependent on DCFS recommendations regarding outside facilitators, I understand that JCC Chicago may allow allows students of schools of education, nursing and other allied professions to observe JCC Chicago programs as part of their course of education.
4. Dependent on DCFS recommendations regarding outside facilitators, I understand that consultants may be engaged by JCC Chicago to provide support to families and staff. These consultants may observe and make recommendations about children in the classroom. When necessary these consultants provide staff training on classroom management; materials and resources, observations and family support.
5. I understand that I am legally responsible for my child while they are en route to and from JCC Chicago programs.
6. I give my permission for my child's picture to be used for publicity purposes by JCC Chicago. JCC Chicago may videotape or photograph participants enrolled in programs, classes and events or while enjoying JCC Chicago facilities. These photographs are for JCC Chicago publications, flyers, publicity efforts, brochures, web use, other electronic communications or video usage. However, for Early Childhood, a program permission form must be signed to allow a child's picture and name to be used for publicity purposes by JCC Chicago. This policy is mandated by DCFS. All photos and videos are for JCC Chicago use and become the sole property of JCC Chicago. Please contact the Program Director for photographic exclusions.
7. I understand that JCC Chicago programs contain Jewish content and I agree to allow my child to participate in this type of program.
8. I/We hereby give permission for my name and my child's name, address and phone number to be included in a class roster information list.
9. I/We hereby give permission for the Early Childhood staff to use hypo-allergenic wipes on my child for diapering purposes, if needed.
10. I understand that should I wish to transfer my child to another JCC Chicago sponsored program, my child's financial records will be shared with the staff of that program.
11. I give permission for my child to participate in athletic activities such as swimming or gymnastics, if applicable.
12. I give my permission for all the foregoing. I have also read and understand the registration policies on the JCC Chicago Registration Policies page available at **jccchicagoearlychildhood.org/policies**.

_____
Print Name

_____
Parent/Guardian Signature Date

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REQUIRED

Authorization for Pick-up

Child's Name _____

Parent/Guardian Name _____
Work Phone _____ Home Phone _____ Cell Phone _____

Parent/Guardian Name _____
Work Phone _____ Home Phone _____ Cell Phone _____

I understand that only those individuals listed on this page are authorized to pick up my child. If special circumstances arise, parents will provide written instructions for release of the child to another individual. That person should be prepared to present personal identification upon arrival.

Name	Address	Relationship	Work Phone	Home Phone
1.				
2.				
3.				
4.				

In case of emergency and I cannot be reached, please contact

Name	Address	Relationship	Work Phone	Home Phone
1.				
2.				
3.				
4.				

I am in a carpool with the following people

Name	Address	Relationship	Work Phone	Home Phone
1.				
2.				
3.				
4.				

_____
Print Name

_____
Parent/Guardian Signature Date

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EDUCATION

2024-2025

REQUIRED

Receipt and Agreement to Policies

Please refer to documents found at **jccchicagoearlychildhood.org/intake-forms**.

I/We _____
Please Print Name(s)

Parent(s) or Guardian(s) of _____
Name of Child

Please fill out the appropriate information below and provide your signature and date signed.

- ❍ I/We have received and read the JCC Chicago Early Childhood Parent Guide *(including the section on Guidance and Discipline)* and agree to adhere to all of the policies and procedures described.
- ❍ I/We hereby certify that I/we have received and read the JCC Chicago Early Childhood Code of Honor and agree to adhere to all the principles described therein.
- ❍ I/We hereby certify that I/we have received and read the ILDCFS Summary of Licensing Standards for Day Care Centers.
- ❍ I/We hereby certify that I/we have read the JCC Chicago Early Childhood Policy on Late Pickup and agree to adhere to this policy.

_____
Print Name

_____
Parent/Guardian Signature Date

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2024-2025

REQUIRED

Insurance Form

JCC Chicago requires health insurance information for all children enrolled in our programs unless waived below. Please complete the form below.

Please fill out ALL fields below

Child's Name _____

Insured Name _____

Insurance Carrier _____

Member # _____

Group # _____

Signature _____

Thank you for your cooperation.

Waived: _____

JCC Chicago

by _____

_____
Print Name

_____
Parent/Guardian Signature Date

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REQUIRED

Preferred Email Address Form

JCC Chicago Early Childhood is using email as an important mode of communication. JCC Chicago will never send spam/junk emails to our families. Emails will only be used for official JCC Chicago communications.

Please fill out ALL fields below

Child's Name _____

Parent/Guardian's Name _____

Parent/Guardian's Name _____

JCC Chicago Location _____

Name of Child's Program _____

Preferred Email Address _____

_____
Print Name

_____
Parent/Guardian Signature Date

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REQUIRED

2024-2025

Minor Participant Waiver, Release, Indemnification of All Claims & Covenant Not to Sue

PLEASE READ CARFULLY. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS AND IS LEGALLY BINDING. BY SIGNING THIS AGREEMENT, YOU ARE RELEASING JEWISH COMMUNITY CENTERS OF CHICAGO FROM ALL LIABILITY AND FOREVER GIVING UP ANY CLAIMS THEREFOR

Assumption of Risk

I, in my legal capacity as parent/guardian of the minor named below ("Minor"), acknowledge and agree that any use of Jewish Community Centers of Chicago facilities, services, equipment, premises and services provided offsite from Jewish Community Centers of Chicago premises, such as, but not limited to, at participants' homes and public parks ("Facilities") and any participation in Jewish Community Centers of Chicago programs and activities ("Programs") comes with inherent risks including, but in no way limited to: (1) moderate and severe personal injury, (2) property damage, (3) disability, (4) death, and (5) sickness or disease, including COVID 19, I voluntarily, for myself and Minor, accept and assume full responsibility for these risks as well as any and all other risks of the use of Facilities and participation in Programs. I agree that I have full knowledge of the nature and extent of all such risks and am not relying on all such risks being described in this document.

JCC Chicago requires health insurance coverage for all children enrolled in Programs, unless waived in writing. JCC Chicago does not maintain health insurance coverage.

Waiver, Release, Indemnification & Covenant Not to Sue

In consideration of Minor's use of Facilities and participation in Programs I, in my legal capacity as parent/guardian of Minor, agree on behalf of myself and Minor that Jewish Community Centers of Chicago its officers, directors, agents, employees, volunteers and representatives ("Releasees") will not be liable for any personal injury, property damage, disability, death, sickness or disease, including COVID 19 incurred by Minor, however occurring including, but not limited to, the negligence of Releasees. I understand that Minor and I will be solely responsible for any loss or damage, including personal injury, property damage, disability, death, sickness or disease, including COVID 19 sustained from the use of Facilities and participation in Programs.

I further agree, in my legal capacity as the parent/guardian of Minor, on behalf of Minor, myself, and any and all legal successors and proxies, to release and **HEREBY DO RELEASE, WAIVE AND COVENANT NOT TO SUE** Releasees from any causes of action, claims, suits, liabilities or demands of any nature whatsoever including, but in no way limited to, claims of negligence, force majeure, impossibility of performance, impracticability of performance and frustration of purpose, which Minor, myself, and any and all legal successors and proxies may have, now or in the future, against Releasees on account of personal injury, property damage, disability, death, sickness, disease, including COVID 19 or accident of any kind, arising out of or in any way related to the use of Facilities or participation in Programs, whether that participation is supervised or unsupervised, however the injury or damage occurs, including, but not limited to, the negligence of Releasees.

In further consideration of the use of Facilities and participation in Programs, I, in my legal capacity as parent/guardian of Minor, myself, and any and all legal successors and proxies, agree on behalf of myself and Minor to **INDEMNIFY AND HOLD HARMLESS** Releasees from any and all causes of action, claims, demands, losses, suits, liabilities or costs of any nature whatsoever, including claims of negligence, force majeure, impossibility of performance, impracticability of performance and frustration of purpose, arising out of or in any way related to the use of Facilities and participation in Programs.

I hereby further agree that this waiver of liability and hold harmless agreement shall be construed in accordance with the laws of the State of Illinois. If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

Minor Name (print clearly)	Date
Parent/Guardian Signature	Parent/Guardian Name (print clearly)

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2024-2025

OPTIONAL

Friendship Request Form

Are there children with whom you would like your child grouped? If the children are the same age as your child, **we will do our best to honor at least one request.** Please list the names of the children in order of preference.

Friendship requests must be mutual.

Please do not list more than two names.

Your child's name _____

#1 Friendship request

Name _____

#2 Friendship request

Name _____

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OPTIONAL

Waiver for the Distribution or Administration of Medicine

This form must accompany physician instructions for administering medication, including name of medicine, dosage, schedule, and duration. This form and instructions must be submitted to your JCC Chicago Early Childhood location.

Location_____ Program _____

Child's Name _____ Home Phone _____

Doctor's Name_____ Phone _____

The undersigned hereby acknowledges and represents that they are the parent, legal guardian or person legally responsible for _____ while they are under the supervision of the programs sponsored and operated by JCC Chicago.

The undersigned further acknowledges that they have requested, or that a family physician has requested, that JCC Chicago, its employees and/or duly authorized agents, administer or assist in administering certain medication to _____ while they are under the supervision of JCC Chicago.

Now, in consideration of the administering or assistance in administering said medication, the undersigned does hereby forever release, discharge, hold harmless and agree to indemnify JCC Chicago, its employees and duly authorized agents of and from any and all claims, demands, suits, actions and liabilities or responsibilities of whatsoever kind or nature, arising out of or in connection with the administering or assistance in administering of said medication.

_____
Print Name

_____
Parent/Guardian Signature Date

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2024-2025

OPTIONAL

Waiver for the Distribution of Sunscreen, Ointments or Insect Repellent

This form gives JCC Chicago permission to apply oitments, sunscreen and/or insect repellent that is supplied from home. This form must be received in your JCC Chicago Early Childhood office before sunscreen or insect repellent can be applied.

Child's Name _____ Home Phone _____

The undersigned hereby acknowledges and represents that they are the parent, legal guardian or person legally responsible for _____ while they are under the supervision of the programs sponsored and operated by JCC Chicago.

The undersigned further acknowledges that they have requested that JCC Chicago, its employees and/or duly authorized agents administer or assist in administering sunscreen, ointments or insect repellent to _____ while they are under the supervision of JCC Chicago.

Now, in consideration of the administering or assistance in administering said ointment, sunscreen and/or insect repellent, the undersigned does hereby forever release, discharge, hold harmless and agree to indemnify JCC Chicago, its employees and duly authorized agents of and from any and all claims, demands, suits, actions and liabilities or responsibilities of whatsoever kind or nature, arising out of or in connection with the administering or assistance in administering of sunscreen, ointments and/or insect repellent.

Will you be providing?

- ❍ Sunscreen–Name brand _____
- ❍ Insect repellent–Name brand _____
- ❍ Ointment–Name brand _____

_____
Print Name

_____
Parent/Guardian Signature Date

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Emergency Information 2024-25

Classroom Copy

Child's Name _____

Birth date _____ Program _____

Address _____

City _____ Zip _____

Email _____

Parent(s)/Guardian(s) *please place asterisk next to preferred phone number*

#1 Name _____

Work Phone _____ Home Phone _____

Cell Phone _____

#2 Name _____

Work Phone _____ Home Phone _____

Cell Phone _____

Relative or Friend Alternative

#1 Name _____ Phone _____

#2 Name _____ Phone _____

Pediatrician _____ Phone _____

Allergies _____

Medication _____ Hospital _____

Other Significant Medical Info _____

Emergency Authorization

I hereby give permission to the medical personnel selected by JCC Chicago to order x-ray, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by JCC Chicago to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child.

I hereby give my permission for JCC Chicago Early Childhood to contact my pediatrician for any information needed about my child and authorize my pediatrician to release such information to JCC Chicago.

Signature Parent/Guardian

Date

Emergency Information 2024-25

Office copy

Child's Name _____

Birth date _____ Program _____

Address _____

City _____ Zip _____

Email _____

Parent(s)/Guardian(s) *please place asterisk next to preferred phone number*

#1 Name _____

Work Phone _____ Home Phone _____

Cell Phone _____

#2 Name _____

Work Phone _____ Home Phone _____

Cell Phone _____

Relative or Friend Alternative

#1 Name _____ Phone _____

#2 Name _____ Phone _____

Pediatrician _____ Phone _____

Allergies _____

Medication _____ Hospital _____

Other Significant Medical Info _____

Emergency Authorization

I hereby give permission to the medical personnel selected by JCC Chicago to order x-ray, routine tests and treatment for my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by JCC Chicago to hospitalize, secure proper treatment for, and to order injections and/or anesthesia and/or surgery for my child.

I hereby give my permission for JCC Chicago Early Childhood to contact my pediatrician for any information needed about my child and authorize my pediatrician to release such information to JCC Chicago.

Signature Parent/Guardian

Date