



# EARLY CHILDHOOD EDUCATION

Dear 2025-26 Families,

We are so excited to have you as part of our JCC Chicago family during the 2025-26 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](http://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. DCFS Medical Form (*requires physician signature*)
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 important guidelines and policies online for your perusal at [jccchicagoearlychildhood.org/intake-forms](http://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 has mandated 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, 2025.** 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.

**BERNARD HORWICH JCC**  
3003 W. Touhy Avenue  
Chicago, IL 60645  
773.516.5882  
Miriam Aberman, Director  
maberman@jccchicago.org

**JCC CHICAGO EARLY  
CHILDHOOD AT BETH EMET**  
1224 Dempster Street  
Evanston, IL 60202  
847.763.3571  
Rebecca Anisfeld, Director  
kmcgahey@jccchicago.org

**JCC CHICAGO EARLY  
CHILDHOOD AT AM SHALOM**  
840 Vernon Avenue  
Glencoe, IL 60022  
847.835.0008  
Jody Benishay, Director  
jbenishay@jccchicago.org

**BERNARD WEINGER JCC**  
300 Revere Drive  
Northbrook, IL 60062  
224.406.9229  
Jen Rosenfeld, Director  
jrosenfeld@jccchicago.org

**JCC CHICAGO EARLY  
CHILDHOOD AT  
'Z' FRANK APACHI**  
3050 Woodridge Lane  
Northbrook, IL 60062  
847.272.8707  
Leanne Nathan, Director  
lnathan@jccchicago.orgs

**JACOB DUMAN EARLY  
CHILDHOOD CENTER AT  
LAKE COUNTY JCC**  
23280 N. Old McHenry Rd.  
Lake Zurich, IL 60047  
847.901.0620  
Lisa Spewak, Director  
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[jccchicagoearlychildhood.org](http://jccchicagoearlychildhood.org)

JCC Chicago is a nonprofit organization dedicated to ensuring a strong and vibrant Jewish life and community for generations to come.

JCC Chicago is a partner with the Jewish United Fund in serving our community. ©2025 JCC Chicago

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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.
- 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.

## 2025-2026

### FAMILY PROFILE FORM - ANNUAL UPDATE PART ONE

Please complete this form in its entirety.

Date Completed \_\_\_\_\_

#### CHILD

Child's Name \_\_\_\_\_ Hebrew Name, if any \_\_\_\_\_

Nickname \_\_\_\_\_ Date of Birth \_\_\_\_\_

Gender \_\_\_\_\_ Comments \_\_\_\_\_

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 \_\_\_\_\_

Health issues that you feel are important for us to know? \_\_\_\_\_

Occupation \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

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? \_\_\_\_\_

#### ☐ Parent ☐ Guardian

Name \_\_\_\_\_

Age \_\_\_\_\_ Education \_\_\_\_\_

Health issues that you feel are important for us to know? \_\_\_\_\_

Occupation \_\_\_\_\_

Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

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? \_\_\_\_\_

#### YOUR FAMILY

Marital Status of Parents ☐ Married/Date \_\_\_\_\_ ☐ Widowed/Date \_\_\_\_\_ ☐ Single  
☐ Separated/Date \_\_\_\_\_ ☐ Divorced/Date \_\_\_\_\_ ☐ Other \_\_\_\_\_

#### Other Children in Family

Name	Date of Birth	Resides With	Health	School	Grade	Gender
_____	_____	_____	_____	_____	_____	<input type="radio"/> M <input type="radio"/> F
_____	_____	_____	_____	_____	_____	<input type="radio"/> M <input type="radio"/> F
_____	_____	_____	_____	_____	_____	<input type="radio"/> M <input type="radio"/> F
_____	_____	_____	_____	_____	_____	<input type="radio"/> M <input type="radio"/> F

## FAMILY PROFILE FORM - ANNUAL UPDATE PART TWO

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

- |  |  |
|--|--|
| <input type="checkbox"/> Household Moves _____         | <input type="checkbox"/> Change in caregiver _____ |
| <input type="checkbox"/> Parental Job Changes _____    | <input type="checkbox"/> Death in Family _____     |
| <input type="checkbox"/> Parent Work Hours _____       | <input type="checkbox"/> Loss of Pet _____         |
| <input type="checkbox"/> New Baby _____                | <input type="checkbox"/> Other Loss _____          |
| <input type="checkbox"/> Serious Illness _____         | <input type="checkbox"/> Hospitalization _____     |
| <input type="checkbox"/> Operation _____               | <input type="checkbox"/> Accident _____            |
| <input type="checkbox"/> Serious Injury _____          | <input type="checkbox"/> Other _____               |
| <input type="checkbox"/> Parent Attending School _____ |  |

What was child told about family changes? \_\_\_\_\_

How did they react? \_\_\_\_\_

## GENERAL HEALTH

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_

Child's Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Affiliation \_\_\_\_\_

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 \_\_\_\_\_
- ☐ ☐ Eating Difficulties \_\_\_\_\_
- ☐ ☐ Constipation \_\_\_\_\_

### Yes No

- ☐ ☐ Coordination \_\_\_\_\_
- ☐ ☐ Food Restrictions \_\_\_\_\_
- ☐ ☐ Diarrhea \_\_\_\_\_
- ☐ ☐ Seizures \_\_\_\_\_
- ☐ ☐ Ear infections How often? \_\_\_\_\_ Fluid? ☐ Yes ☐ No

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? \_\_\_\_\_

## OTHER

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

What are your goals for your child this year? \_\_\_\_\_

Does your child have specific fears? \_\_\_\_\_

Is there any other information you would like to provide? \_\_\_\_\_

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. \_\_\_\_\_

## 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 \_\_\_\_\_



State of Illinois  
Certificate of Child Health Examination

<b>Student's Name</b>				<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>					
Last		First		Middle		Month/Day/Year						
Address				Parent/Guardian		Telephone # Home Work						
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> 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.</b>												
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>		<b>DOSE 2</b>		<b>DOSE 3</b>		<b>DOSE 4</b>		<b>DOSE 5</b>		<b>DOSE 6</b>	
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
<b>DTP or DTaP</b>												
<b>Tdap; Td or Pediatric DT</b> (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	
<b>Polio</b> (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	
<b>Hib</b> Haemophilus influenza type b												
<b>Pneumococcal Conjugate</b>												
<b>Hepatitis B</b>												
<b>MMR</b> Measles Mumps. Rubella							<b>Comments:</b> * indicates invalid dose					
<b>Varicella</b> (Chickenpox)												
<b>Meningococcal conjugate (MCV4)</b>												
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>												
<b>Hepatitis A</b>												
<b>HPV</b>												
<b>Influenza</b>												
<b>Other: Specify Immunization Administered/Dates</b>												
<b>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.</b>												
<b>Signature</b>				<b>Title</b>				<b>Date</b>				
<b>Signature</b>				<b>Title</b>				<b>Date</b>				
<b>ALTERNATIVE PROOF OF IMMUNITY</b>												
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b>												
<b>*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR</b>												
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b>												
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.												
<b>Date of Disease Signature Title</b>												
<b>3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/>Measles* <input type="checkbox"/>Mumps** <input type="checkbox"/>Rubella <input type="checkbox"/>Varicella Attach copy of lab result.</b>												
*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.												
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b>												
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
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes No	List:		<b>MEDICATION</b> (Prescribed or taken on a regular basis.)		Yes No
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		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 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				
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT	BMI	BMI PERCENTILE	B/P
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex 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. (Blood test required if resides in Chicago or high risk zip code.)							
Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/>		Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/>		Blood Test Date		Result	
<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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . 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 _____							
<b>LAB TESTS (Recommended)</b>		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		Screening Result:		Gastrointestinal			
Eyes		Screening Result:		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 Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				Other			
NEEDS/MODIFICATIONS required in the school setting				DIETARY Needs/Restrictions			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
<b>MENTAL HEALTH/OTHER</b> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal							
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> 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.) <b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>							
Print Name		(MD,DO, APN, PA)		Signature		Date	
Address				Phone			

**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, email 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 understand that I will be notified in advance of any excursions taken off campus and will provide written consent for those occasions.
12. I give permission for my child to participate in athletic activities such as swimming or gymnastics, if applicable.
13. 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](https://jccchicagoearlychildhood.org/policies).

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**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	Cell Phone
1. _____					
2. _____					
3. _____					
4. _____					

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

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

I am in a carpool with the following people

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



**REQUIRED**

## Receipt and Agreement to Policies

Please refer to documents found at [jccchicagoearlychildhood.org/intake-forms](https://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

**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

**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 \_\_\_\_\_

Secondary Email \_\_\_\_\_

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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

**PLEASE READ CAREFULLY. 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.

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Minor Name (print clearly)

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Date

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Parent/Guardian Signature

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Parent/Guardian Name (print clearly)

**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

**OPTIONAL**

## **Waiver for the Distribution of Sunscreen, Ointments or Insect Repellent**

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

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

## Emergency Information

Classroom Copy

2025-26

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

Office copy

2025-26

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