jccchicago

EARLY CHILDHOOD

CHILDCARE | PRESCHOOL

jccchicago.org/earlychildhood

FLORENCE G. HELLER JCC
524 W. Melrose Street
Chicago, IL 60657
773.938.8346

BERNARD HORWICH JCC
3003 W. Touhy Avenue
Chicago, IL 60645
773.516.5882

JCC AT AM SHALOM
840 Vernon Avenue
Glencoe, IL 60022
847.835.0008

BERNARD WEINGER JCC
300 Revere Drive
Northbrook ,IL 60062
224.406.9229

JCC "Z" FRANK APACHI
3050 Woodridge Lane
Northbrook, IL 60062
847.272.8707

JACOB DUMAN AT
LAKE COUNTY JCC
23280 N. Old McHenry Rd.
Lake Zurich, IL 60047
847.901.0620

Dear 2018 Families,

We are so excited to have you as part of our JCC family during the 2018–2019 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 through the internet. 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 **jccchicago.org** 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.
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. Friendship Request Form *(optional)*
9. Waiver for the Distribution of Medicine Form *(optional)*
10. Waiver for the Distribution of Sunscreen and Insect Repellent Form *(optional)*
11. Emergency Card (2) included electronically

You will also find these guidelines and policies online for your perusal at jccchicago.org/earlychildhood:

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, 2018.** Forms may be returned to:

- JCC EC location, c/o Director, Address, City, IL Zip Code *(EC contact information may be found on the following page)*
- 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 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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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 manual signature. If you complete your forms electronically, you must print them, sign them and mail/bring them to your Center. An electronic signature is not sufficient.

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

FAMILY PROFILE FORM – ANNUAL UPDATE PART ONE

Please complete this form in its entirety. Date Completed _____

CHILD

Child's Name _____ Nickname _____ Date of Birth _____
Gender ❍ 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 _____
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 _____

❍ Parent ❍ Guardian

Name _____
Age _____ Education _____
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 _____

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*
						❍ M ❍ F
						❍ M ❍ F
						❍ M ❍ F
						❍ M ❍ F

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FAMILY PROFILE FORM – ANNUAL UPDATE PART TWO

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 s/he 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		Yes	No	
❍	❍	Allergies _____	❍	❍	Coordination _____
❍	❍	Vision _____	❍	❍	Food Restrictions _____
❍	❍	Hearing _____	❍	❍	Diarrhea _____
❍	❍	Eating Difficulties _____	❍	❍	Seizures _____
❍	❍	Constipation _____	❍	❍	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? _____

Are there any professionals/agencies working with your child/family? ❍ Yes ❍ No

Collaboration is necessary for successful service delivery for your child. Please list professionals/agencies names and numbers for us to collaborate with them. _____

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

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

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. 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)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**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	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? Child wakes during night coughing?	Yes Yes	No No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	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** **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)

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REQUIRED

Program Permission Form

1. I give permission for my child _____ to receive appropriate medical attention from JCC 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 to transport him or her 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 staff to contact my pediatrician for any information needed about my child. I authorize my pediatrician to release such information to JCC.
3. I understand that JCC allows students of schools of education, nursing and other allied professions to observe JCC programs as part of their course of education.
4. I understand that to provide support to families and staff, consultants are engaged by JCC. 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 he or she is en route to and from JCC programs.
6. I hereby permit my child to accompany an authorized JCC staff member on excursions to places of interest (field trips) and release the JCC of all responsibilities other than reasonable care.
7. I hereby permit my child to participate in athletic activities and swimming as applicable.
8. I give my permission for my child's picture to be used for publicity purposes by JCC. JCC may videotape or photograph participants enrolled in programs, classes, and events or while enjoying JCC facilities. These photographs are for JCC publications, flyers, publicity efforts, brochures, web use, other electronic communications or video usage. All photos and videos are for JCC use and become the sole property of JCC. Please contact the Program Director for photographic exclusions for your child. I understand that parents are allowed to photograph and videotape classroom activities.
9. I understand that JCC programs contain Jewish content and I agree to allow my child to participate in this type of program.
10. 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.
11. I understand that should I wish to transfer my child to another JCC sponsored program, my child's financial records will be shared with the staff of that program.
12. I/We hereby give permission for the Early Childhood staff to use hypo-allergenic wipes on my child for diapering purposes, if needed.
13. I give my permission for all the foregoing. I have also read and understand the registration policies on the JCC Registration Policies page available at **jccchicago.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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REQUIRED

Receipt and Agreement to Policies

Please refer to EC Guidelines and Policies found at **jccchicago.org/policies.**

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 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 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 Early Childhood Policy on Late Pickup and agree to adhere to this policy.

_____
Print Name

_____
Parent/Guardian Signature Date

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REQUIRED

Insurance Form

As part of NAEYC (National Association for the Education of Young Children) criteria we must have health insurance information for all children enrolled in our JCC programs. 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.

_____
Print Name

_____
Parent/Guardian Signature Date

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REQUIRED

Preferred Email Address Form

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

Please fill out ALL fields below

Child's Name _____

Parent/Guardian's Name _____

Parent/Guardian's Name _____

JCC Location _____

Name of Child's Program _____

Preferred Email Address _____

_____
Print Name

_____
Parent/Guardian Signature Date

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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 Early Childhood location.

Location_____ Program _____

Child's Name _____ Home Phone _____

Doctor's Name_____ Phone _____

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

The undersigned further acknowledges that he or she has 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 he/she is under the supervision of JCC.

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, 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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OPTIONAL

Waiver for the Distribution of Sunscreen or Insect Repellent

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

Child's Name _____ Home Phone _____

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

The undersigned further acknowledges that he or she has requested that JCC, its employees and/or duly authorized agents administer or assist in administering sunscreen or insect repellent to _____ while he/she is under the supervision of JCC.

Now, in consideration of the administering or assistance in administering said sunscreen and/or insect repellent, the undersigned does hereby forever release, discharge, hold harmless and agree to indemnify JCC, 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 and/or insect repellent.

Will you be providing?

❍ Sunscreen–Name brand _____

❍ Insect repellent–Name brand _____

_____
Print Name

_____
Parent/Guardian Signature Date

Emergency Information 2018-19

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 Early Childhood to contact my pediatrician for any information needed about my child and authorize my pediatrician to release such information to JCC.

_____

Signature Parent/Guardian

_____

Date

Emergency Information 2018-19

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 Early Childhood to contact my pediatrician for any information needed about my child and authorize my pediatrician to release such information to JCC.

_____

Signature Parent/Guardian

_____

Date