

Dear 2019 Families,

We are so excited to have you as part of our JCC family during the 2019-2020 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 (*six parts*)
2. DCFS Medical Form (*requires both physician and parent signature*)
3. DCFS Lead Risk Assessment Questionnaire and Guidelines (*requires physician signature*)
4. Program Permission Form
5. Authorization for Pick-Up Form
6. Receipt and Agreement to Policies Form
7. Insurance Form
8. Preferred E-mail Form
9. Friendship Request Form (*optional*)
10. Waiver for the Distribution of Medicine Form (*optional*)
11. Waiver for the Distribution of Sunscreen and Insect Repellent Form (*optional*)
12. 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, 2019.** 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.

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

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.

For Office Use Only

Date Entered Program _____

Site _____

Date Exited Program _____

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 _____

☐ **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 _____

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

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? _____

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? _____

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? _____

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. _____

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 programs and services? Please check:

- ☐ Summer Camps ☐ After School Recreation ☐ Sports/Swimming ☐ Adult Fitness
☐ Family Events ☐ Parent/Child Programs ☐ Children's Programs

How did you learn about JCC 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 to provide caring, individualized attention to your child. If you have any questions about this form, please don't hesitate to call.



State of Illinois Certificate of Child Health Examination

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



Student's Name				Birth Date		Sex	Race/Ethnicity		School /Grade Level/ID#									
Last		First		Middle		Month/Day/Year												
Address				Street		City		Zip Code		Parent/Guardian		Telephone # Home Work						
IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for <i>every</i> dose administered. The day and month is required if you cannot determine if the vaccine was given <i>after</i> 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)													COMMENTS:					
Varicella (Chickenpox)																		
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																			Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade																			
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																			
Hearing																			

Last First Middle			Birth Date Month/Day/ Year		Sex	School	Grade Level/ ID
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER							
ALLERGIES (Food, drug, insect, other)				MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No					
Birth defects?	Yes	No		Hospitalizations?	Yes	No	
Developmental delay?	Yes	No		When? What for?			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.)	Yes	No	
Diabetes?	Yes	No		When? What for?			
Head injury/Concussion/Passed out?	Yes	No		Serious injury or illness?	Yes	No	
Seizures? What are they like?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Heart problem/Shortness of breath?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart murmur/High blood pressure?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Alcohol/Drug use?	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____				Family history of sudden death before age 50? (Cause?)	Yes	No	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ •Bridge ☐ •Plate ☐ Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?	Yes	No		Parent/Guardian Signature Date			
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes ☐ No ☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes ☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ At Risk Yes ☐ No ☐							
LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)							
Questionnaire Administered ? Yes ☐ No ☐		Blood Test Indicated? Yes ☐ No ☐		Blood Test Date		Result	
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed ☐ Test performed ☐ Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____ Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____							
LAB TESTS (Recommended)	Date	Results			Date	Results	
Hemoglobin or Hematocrit				Sickle Cell (when indicated)			
Urinalysis				Developmental Screening Tool			
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs			Normal	Comments/Follow-up/Needs	
Skin				Endocrine			
Ears				Gastrointestinal			
Eyes		Amblyopia Yes ☐ No ☐		Genito-Urinary		LMP	
Nose				Neurological			
Throat				Musculoskeletal			
Mouth/Dental				Spinal Exam			
Cardiovascular/HTN				Nutritional status			
Respiratory		☐ Diagnosis of Asthma		Mental Health			
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)				Other			
NEEDS/MODIFICATIONS required in the school setting				DIETARY Needs/Restrictions			
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal							
EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes ☐ No ☐ If yes, please describe.							
On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)							
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐				INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Limited ☐			
Print Name		(MD,DO, APN, PA)		Signature		Date	
Address				Phone			

(Complete Both Sides)

Illinois Department of Public Health Childhood Lead Risk Assessment Questionnaire

(Revised May 2001)

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE SHOULD BE ASSESSED FOR LEAD POISONING.

Today's date _____ Child's name _____

Child's age _____ In what ZIP code does the child currently live? _____

If the child has moved within the last 12 months, in what ZIP code(s) did he/she previously live?

Respond to the following questions by circling the appropriate answer.

RESPONSE

- | | | | |
|---|-----|----|------------|
| 1. Are any of the above ZIP codes listed on the back of this questionnaire? | Yes | No | Don't Know |
| 2. Does this child live in or regularly visit a home that was built before 1950 (older than 50 years)? | Yes | No | Don't Know |
| Has the child ever lived in or regularly visited a home that was built before 1950 (older than 50 years)? | Yes | No | Don't Know |
| 3. If this child lives in or regularly visits a home, school or day care center built before 1978 (older than 20 years) - | | | |
| Does it have peeling or chipping paint? | Yes | No | Don't Know |
| Is it being repaired or remodeled? | Yes | No | Don't Know |
| 4. Is this child eligible for or enrolled in Medicaid, Head Start, Kid Care or WIC? | Yes | No | Don't Know |
| 5. Does this child live with someone who has a job or hobby that may involve lead (for example, 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 |
| 6. 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 |
| 7. Has this child ever been to Mexico, Central or South America, Asia or any country where exposure to lead from certain items (for example, cosmetics, home remedies, folk medicines or glazed pottery) could have occurred? | Yes | No | Don't Know |

Please discuss any questions or concerns with your health care provider.

Children with brothers or sisters who have elevated blood levels should have a blood lead test.

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 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 you need more information, call

**Illinois Department of Public Health
Childhood Lead Poisoning Prevention Program
800-545-2200 or 217-782-0403
TTY (hearing impaired use only) 800-547-0466**

Reviewed by _____ Date _____
Signature of Doctor/Nurse

Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams	Christian	DuPage	Grundy	Jefferson	Livingston	Massac	Peoria	Saline	Warren
62301	62083	60519	60437	62883	60420	62953	61451	62930	61412
62320	62510		60474		60460		61529	62946	61417
62324	62517	Edgar		Jersey	60920	McDonough	61552		61423
62339	62540	61917	Hamilton	62030	60921	61411	61602	Sangamon	61435
62346	62546	61924	62817	62063	60929	61416	61603	62625	61447
62348	62555	61932	62828		60934	61420	61604	62689	61453
62349	62556	61933	62829	Jo Daviess	61311	61422	61605	62703	61462
62365	62557	61940	62859	61028	61313	61438	61606		61473
	62567	61944		61075	61333	61440		Schuyler	61478
Alexander	62570	61949	Hancock	61085	61740	61470	Perry	61452	
62914			61450	61087	61741	61475	62832	62319	Washington
62988	Clark	Edwards	62311		61743	62374	62997	62344	62214
	62420	62476	62313	Johnson	61769			62624	62803
Bond	62442	62806	62316	62908	61775	McHenry	Piatt	62639	
62273	62474	62815	62318	62923		60034	61813		Wayne
	62477	62818	62321		Logan		61830	Scott	62446
Boone	62478		62330	Kane	62512	McLean	61839	62621	62823
61038		Effingham	62334	60120	62518	61701	61855	62663	62843
	Clay	None	62336	60505	62519	61720	61929	62694	62886
Brown	62824	Fayette	62354		62548	61722	61936		
62353	62879	62458	62367	Kankakee	62543	61724		Shelby	White
62375		62880	62373	60901	62635	61728	Pike	62438	62820
62378	Clinton	62885	62379	60910	62643	61730	62312	62534	62821
	62219		62380	60917	62666	61731	62314	62553	62835
Bureau				60954	62671	61737	62323		62844
61312	Coles	Ford	Hardin	60969		61770	62340	Stark	62887
61314	61931	60919	62919		Macon		62343	61421	
61315	61938	60933	62982	Kendall	62514	Menard	62345	61426	Whiteside
61322	61943	60936		None	62521	62642	62352	61449	61037
61323	62469	60946	Henderson		62522	62673	62355	61479	61243
61328		60952	61418	Knox	62523	62688	62356	61483	61251
61329	Cook	60957	61425	61401	62526		62357	61491	61261
61330	All Chicago	60959	61454	61410	62537	Mercer	62361		61270
61337	ZIP Codes	60962	61460	61414	62551	61231	62362	Stephenson	61277
61338	60043	61773	61469	61436		61260	62363	61018	61283
61344	60104		61471	61439	Macoupin	61263	62366	61032	
61345	60153	Franklin	61480	61458	62009	61276	62370	61039	Will
61346	60201	62812		61467	62033	61465		61044	60432
61349	60202	62819	Henry	61474	62069	61466	Pope	61050	60433
61359	60301	62822	61234	61485	62085	61476	None	61060	60436
61361	60302	62825	61235	61489	62088	61486		61062	
61362	60304	62874	61238	61572	62093		Pulaski	61067	Williamson
61368	60305	62884	61274		62626	Monroe	62956	61089	62921
61374	60402	62891	61413	Lake	62630	None	62963		62948
61376	60406	62896	61419	60040	62640		62964	Tazewell	62949
61379	60456	62983	61434		62649	Montgomery	62976	61539	62951
	60501	62999	61443	La Salle	62672		62015	61564	
Calhoun	60513		61468	60470	62674		62019	61721	Winnebago
62006	60534	Fulton	61490	60518	62685		62032	61734	61077
62013	60546	61415		60531	62686		62049	61336	61101
62036	60804	61427	Iroquois	61301	62690		62051	61340	61102
62070		61431	60911	61316			62056	61363	61103
	Crawford	61432	60912	61321	Madison		62075		62906
Carroll	62433	61441	60924	61325	62002		62077	Randolph	62920
61014	62449	61477	60926	61332	62048		62089	62217	62926
61051	62451	61482	60930	61334	62058		62091	62242	Woodford
61053		61484	60931	61342	62060		62094	62272	61516
61074	Cumberland	61501	60938	61348	62084		62538	Vermilion	61545
61078	62428	61519	60945	61354	62090			60932	61570
		61520	60951	61358	62095	Morgan		60942	61760
Cass	De Witt	61524	60953	61364		62601	62419	60960	61771
62611	61727	61531	60955	61370	Marion	62628	62425	60963	
62618	61735	61542	60966	61372	None	62631		61810	
62627	61749	61543	60967			62692	Rock Island	61831	61832
62691	61750	61544	60968	Lawrence	Marshall	62695	61201	61236	61833
	61777	61563	60973	62439	61369		61239	61239	61844
Champaign	61778			62460	61377	Moultrie	61259	61848	61857
61815	61882	Gallatin	Jackson	62466	61424	61937	61265	61857	
61816		62934	62927		61537		61279	61865	
61845	DeKalb		62940	Lee	61541	Ogle		61870	
61849	60111	Greene	62950	60553		61007	St. Clair	61876	
61851	60129	62016		61006	Mason	61030	62201	61883	
61852	60146	62027	Jasper	61031	62617	61047	62203		
61862	60550	62044	62432	61042	62633	61049	62204	Wabash	
61872		62050	62434	61310	62644	61054	62205	62410	
	Douglas	62054	62459	61318	62655	61064	62220	62852	
	61930	62078	62475	61324	62664	61091	62289	62863	
	61941	62081	62480	61331	62682				
	61942	62082		61353					
		62092		61378					

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 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 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 during field trips.
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/We hereby give permission for the Early Childhood staff to use hypo-allergenic wipes on my child for diapering purposes, if needed.
12. 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.
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

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

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

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

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

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 _____

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 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.

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.

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

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 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.

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

Classroom Copy

2019-20

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

Office copy

2019-20

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