jccchicago

EARLY CHILDHOOD

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

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.

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 – 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 _____
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 _____

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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	*Date of Birth*	*Resides With*	*Health*	*School*	*Grade*	*Gender*
						❍ M ❍ F
						❍ M ❍ F
						❍ M ❍ F
						❍ M ❍ F
						❍ M ❍ F

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 s/he react? _____

_____

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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 his/her 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 s/he enjoys? _____

_____

_____

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FAMILY PROFILE FORM – PART FOUR

PRENATAL & POSTNATAL

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

_____

Any complications with pregnancy/delivery? _____

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

Complications after birth? _____

Did you have any anesthesia or medication during delivery? _____

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

GENERAL HEALTH

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

Yes No

❍ ❍ Allergies_____

❍ ❍ Vision _____

❍ ❍ Hearing_____

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

❍ ❍ Coordination_____

❍ ❍ Food Restrictions_____

❍ ❍ Eating Difficulties_____

❍ ❍ Constipation _____

❍ ❍ Diarrhea _____

❍ ❍ Seizures _____

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

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

Any special instructions?_____

ROUTINES

General Separation

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

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

How long did s/he participate? Days/Week_____ Hours/Day_____

What was child's experience? _____

How did your child transition?_____

Why did experience end?_____

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FAMILY PROFILE FORM – PART FIVE

ROUTINES (CONTINUED)

Does s/he:

- ❍ 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 s/he?

Start B.M. Training _____ Start bladder training _____

Method of training _____ Does s/he tell you ❍ Before ❍ After

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

Does s/he 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 does s/he usually get hungry? _____

How often does your child eat during the day? _____

DEVELOPMENT

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

Crawl _____ Walk _____ Point _____ Babble _____

Use Single Words _____ What were first words? _____

Use Phrases _____ What were first phrases? _____

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

_____

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

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

_____

_____

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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? _____

Does s/he 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.

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)

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

Printed by Authority of the State of Illinois
P.O. #373466 2M 8/02

Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams
62301
62320
62324
62339
62346
62348
62349
62365

Alexander
62914
62988

Bond
62273

Boone
61038

Brown
62353
62375
62378

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

Calhoun
62006
62013
62036
62070

Carroll
61014
61051
61053
61074
61078

Cass
62611
62618
62627
62691

Champaign
61815
61816
61845
61849
61851
61852
61862
61872

Christian
62083
62510
62517
62540
62546
62555
62556
62557
62567
62570

Clark
62420
62442
62474
62477
62478

Clay
62824
62879

Clinton
62219

Coles
61931
61938
61943
62469

Cook
All Chicago
ZIP Codes
60043
60104
60153
60201
60202
60301
60302
60304
60305
60402
60406
60456
60501
60513
60534
60546
60804

Crawford
62433
62449
62451

Cumberland
62428

De Witt
61727
61735
61749
61750
61777
61778
61882

DeKalb
60111
60129
60146
60550

Douglas
61930
61941
61942

DuPage
60519

Edgar
61917
61924
61932
61933
61940
61944
61949

Edwards
62476
62806
62815
62818

Effingham
None

Fayette
62458
62880
62885

Ford
60919
60933
60936
60946
60952
60957
60959
60962
61773

Franklin
62812
62819
62822
62825
62874
62884
62891
62896
62983
62999

Fulton
61415
61427
61431
61432
61441
61477
61482
61484
61501
61519
61520
61524
61531
61542
61543
61544
61563

Gallatin
62934

Greene
62016
62027
62044
62050
62054
62078
62081
62082
62092

Grundy
60437
60474

Hamilton
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Hancock
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62321
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Hardin
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Henderson
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61469
61471
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Henry
61234
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61274
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61443
61468
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Iroquois
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Jackson
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Jasper
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Jefferson
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Jersey
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Jo Daviess
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61085
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Johnson
62908
62923

Kane
60120
60505

Kankakee
60901
60910
60917
60954
60969

Kendall
None

Knox
61401
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Lake
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La Salle
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61301
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Lawrence
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Lee
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61006
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Livingston
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Logan
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Macon
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Macoupin
62009
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62649
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Madison
62002
62048
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62084
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Marion
None

Marshall
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61377
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Mason
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62644
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Massac
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McDonough
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McHenry
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McLean
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Menard
62642
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62688

Mercer
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Monroe
None

Montgomery
62015
62019
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Morgan
62601
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Moultrie
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Ogle
61007
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Peoria
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Perry
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Piatt
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Pike
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Pope
None

Pulaski
62956
62963
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62976
62992

Putnam
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Randolph
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62242
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Richland
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Rock Island
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St. Clair
62201
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Saline
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Sangamon
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Schuyler
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Scott
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Shelby
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Stark
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Stephenson
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Tazewell
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Union
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Vermilion
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Wabash
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Warren
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Washington
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Wayne
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White
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Whiteside
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Will
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Williamson
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Winnebago
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61101
61102
61103
61104

Woodford
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jccchicago
EARLY CHILDHOOD
DAYCARE | PRESCHOOL

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 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

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EARLY CHILDHOOD
DAYCARE | PRESCHOOL

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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EARLY CHILDHOOD
DAYCARE | PRESCHOOL

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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DAYCARE | PRESCHOOL

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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DAYCARE | PRESCHOOL

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 2019-20

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 2019-20

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