



# EARLY CHILDHOOD

DAYCARE | PRESCHOOL

Dear 2021-22 Families,

We are so excited to have you as part of our JCC Chicago family during the 2021-2022 school year! We look forward to a wonderful year of working with you and your children.

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

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

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

### The following forms are included:

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

You will also find these guidelines and documents online for your perusal at

### [jccchicagoearlychildhood.org/intake-forms](http://jccchicagoearlychildhood.org/intake-forms):

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

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

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

If you are unable to access the forms electronically, please contact your early childhood Director immediately. **All completed forms must be received by August 3, 2020.** Forms may be returned to:

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

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

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

### FLORENCE G. HELLER JCC

524 W. Melrose Street  
Chicago, IL 60657 773.938.8346  
Rachel Weber, Director  
rweber@jccchicago.org

### BERNARD HORWICH JCC

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

### JCC CHICAGO EARLY CHILDHOOD AT BETH EMET

1224 Dempster Street  
Evanston, IL 60202  
847.763.3571  
Nicole Correa, Director  
ncorrea@jccchicago.org

### JCC CHICAGO EARLY CHILDHOOD AT AM SHALOM

840 Vernon Avenue  
Glencoe, IL 60022  
847.835.0008  
Jody Benishay, Director  
jbenishay@jccchicago.org

### BERNARD WEINGER JCC

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

### JCC CHICAGO EARLY CHILDHOOD AT 'Z' FRANK APACHI

3050 Woodridge Lane  
Northbrook, IL 60062  
847.272.8707  
Leanne Nathan, Director  
lnathan@jccchicago.org

### JACOB DUMAN EARLY CHILDHOOD CENTER AT LAKE COUNTY JCC

23280 N. Old McHenry Rd.  
Lake Zurich, IL 60047  
847.901.0620  
Lisa Spewak, Director  
lspewak@jccchicago.org

[jccchicagoearlychildhood.org](http://jccchicagoearlychildhood.org)

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

JCC Chicago is a partner with the Jewish United Fund in serving our community. ©2020 JCC Chicago

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## Enrollment Forms Completion

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

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

### **Completing the enrollment forms is mandatory.**

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

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

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

### **Some tips to help you complete these forms.**

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

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

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

**Parent**    **Guardian**

Name \_\_\_\_\_  
 Age \_\_\_\_\_ Education \_\_\_\_\_  
 Are there any health issues that you feel are important for us to know? \_\_\_\_\_  
 \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Business Name \_\_\_\_\_  
 Business Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 Work Days/Hours    M \_\_\_\_\_  T \_\_\_\_\_  W \_\_\_\_\_  
     Th \_\_\_\_\_  F \_\_\_\_\_  Sa \_\_\_\_\_  Su \_\_\_\_\_  
 Do you travel for business?    Yes    No  
 How Often? \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Pager Number \_\_\_\_\_  
 Email \_\_\_\_\_

**Parent**    **Guardian**

Name \_\_\_\_\_  
 Age \_\_\_\_\_ Education \_\_\_\_\_  
 Are there any health issues that you feel are important for us to know? \_\_\_\_\_  
 \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Business Name \_\_\_\_\_  
 Business Phone \_\_\_\_\_  
 Business Address \_\_\_\_\_  
 Work Days/Hours    M \_\_\_\_\_  T \_\_\_\_\_  W \_\_\_\_\_  
     Th \_\_\_\_\_  F \_\_\_\_\_  Sa \_\_\_\_\_  Su \_\_\_\_\_  
 Do you travel for business?    Yes    No  
 How Often? \_\_\_\_\_  
 Cell Phone \_\_\_\_\_  
 Pager Number \_\_\_\_\_  
 Email \_\_\_\_\_

# EARLY CHILDHOOD

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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	D.O.B.	Gender	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:  Fall asleep easily? Are there routines that help your child fall asleep? \_\_\_\_\_

Use a bottle \_\_\_\_\_

Use a pacifier \_\_\_\_\_

Thumb suck  Have nighttime fears \_\_\_\_\_

Sleep in a crib \_\_\_\_\_

Sleep in a bed How early retire? \_\_\_\_\_

Sleep alone How early awake? \_\_\_\_\_

Sleep with toy  Still nap? What time/How long? \_\_\_\_\_

Sleep with blanket \_\_\_\_\_

### TOILETING

At what age did they? Start B.M. Training \_\_\_\_\_ Start bladder training \_\_\_\_\_

Method of training \_\_\_\_\_ Do they tell you  Before  After

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

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

### EATING

Are mealtimes:  Pleasant  Difficult Please describe \_\_\_\_\_

How do you handle it? \_\_\_\_\_

What are your child's favorite foods? \_\_\_\_\_

What foods does your child dislike? \_\_\_\_\_

When do they usually get hungry? \_\_\_\_\_

How often does your child eat during the day? \_\_\_\_\_

### DEVELOPMENT

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

Crawl \_\_\_\_\_ Walk \_\_\_\_\_ Point \_\_\_\_\_ Babble \_\_\_\_\_

Use Single Words \_\_\_\_\_ What were first words? \_\_\_\_\_

Use Phrases \_\_\_\_\_ What were first phrases? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

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## FAMILY PROFILE FORM - PART SIX

### EARLY CHILDHOOD EXPERIENCES

Has your child had any other group experiences? \_\_\_\_\_

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

Which ones? \_\_\_\_\_ With or without an adult? \_\_\_\_\_

Do they know other children coming to school?  Yes  No Names \_\_\_\_\_

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

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

### OTHER

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

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

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

How did you learn about JCC Chicago Early Childhood? \_\_\_\_\_

### PARENT/GUARDIAN SIGNATURE

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

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

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

\_\_\_\_\_  
Date

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





## State of Illinois Certificate of Child Health Examination

<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>						
Last	First	Middle	Month/Day/Year									
<b>Address</b>			<b>Parent/Guardian</b>			<b>Telephone # Home</b>						
Street	City	Zip Code			Home	Work						
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.</b>												
REQUIRED Vaccine / Dose	DOSE 1		DOSE 2		DOSE 3		DOSE 4		DOSE 5		DOSE 6	
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
<b>DTP or DTaP</b>												
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV	
<b>Hib</b> Haemophilus influenza type b												
<b>Pneumococcal Conjugate</b>												
<b>Hepatitis B</b>												
<b>MMR</b> Measles Mumps. Rubella							<b>Comments:</b> * indicates invalid dose					
<b>Varicella</b> (Chickenpox)												
<b>Meningococcal conjugate (MCV4)</b>												
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>												
<b>Hepatitis A</b>												
<b>HPV</b>												
<b>Influenza</b>												
<b>Other: Specify Immunization Administered/Dates</b>												
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.												
<b>Signature</b>			<b>Title</b>				<b>Date</b>					
<b>Signature</b>			<b>Title</b>				<b>Date</b>					
<b>ALTERNATIVE PROOF OF IMMUNITY</b>												
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR												
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.												
<b>Date of Disease</b>			<b>Signature</b>				<b>Title</b>					
<b>3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/>Measles* <input type="checkbox"/>Mumps** <input type="checkbox"/>Rubella <input type="checkbox"/>Varicella Attach copy of lab result.</b>												
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.												
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b> Physician Statements of Immunity MUST be submitted to IDPH for review.												

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

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



# Childhood Lead Risk Questionnaire

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

**A blood lead test should be performed on children:**

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

**If responses to all the questions are "No":**

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

Child's name \_\_\_\_\_ Today's date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ ZIP Code \_\_\_\_\_

**Respond to the following questions by circling the appropriate answer.**

**RESPONSE**

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

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

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

Test 1: Blood Lead Result \_\_\_\_\_mcg/dL Date \_\_\_\_\_ Test 2: Blood Lead Result \_\_\_\_\_mcg/dL Date \_\_\_\_\_

\_\_\_\_\_  
*Signature of Doctor/Nurse*

\_\_\_\_\_  
*Date*

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



# Pediatric Lead Poisoning High-Risk ZIP Code Areas

<b>Adams</b> 62301 62320 62324 62339 62346 62348 62349 62365	<b>Christian</b> 62083 62510 62517 62540 62546 62555 62556 62557 62570	<b>DuPage</b> 60519 <b>Edgar</b> 61917 61924 61932 61933 61940 61944 61949	<b>Grundy</b> 60437 60474 <b>Hamilton</b> 62817 62828 62829 62859 <b>Hancock</b> 61450 62311 62313 62316 62318 62321 62330 62334 62336 62354 62367 62458 62373 62379 <b>Clinton</b> 62219 62885	<b>Jefferson</b> 62883 Jersey 62030 62063 <b>Jo Daviess</b> 61028 61075 61085 61087 <b>Johnson</b> 62908 62923 Kane 60120 60505 <b>Kankakee</b> 60901 60910 60917 60954 60969 <b>Kendall</b> None	<b>Livingston</b> 60420 60460 60920 60921 60929 60934 61311 61313 61333 61740 61741 61743 61769 61775 <b>Logan</b> 62512 62518 62519 62548 62543 62635 62643 62666 62671 <b>Macon</b> 62514 62521 62522 62523 62526 62537 62551 <b>Macoupin</b> 62009 62033 62069 62085 62088 62093 62626 62630 62640 62649 62672 62674 62685 62686 62690 <b>Madison</b> 62002 62048 62058 62060 62084 62090 62095 <b>Marion</b> None <b>Marshall</b> 61369 61377 61424 61537 61541 <b>Mason</b> 62617 62633 62644 62655 62664 62682	<b>Massac</b> 62953 <b>McDonough</b> 61411 61416 61420 61422 61438 61440 61470 61475 62374 <b>McHenry</b> 60034 <b>McLean</b> 61701 61720 61722 61724 61728 61730 61731 61737 61770 <b>Menard</b> 62642 62673 62688 <b>Mercer</b> 61231 61260 61263 61276 61465 61466 61476 61486 <b>Monroe</b> None <b>Montgomery</b> 62015 62019 62032 62049 62051 62056 62075 62077 62089 62091 62094 62538 <b>Morgan</b> 62601 62628 62631 62692 <b>Moultrie</b> 61937 <b>Ogle</b> 61007 61030 61047 61049 61054 61064 61091	<b>Peoria</b> 61451 61529 61539 61552 61602 61603 61604 61605 61606 <b>Perry</b> 62832 62997 <b>Piatt</b> 61813 61830 61839 61855 61929 61936 <b>Pike</b> 62312 62314 62323 62340 62343 62345 62352 62355 62356 62357 62361 62362 62363 62366 62370 <b>Pope</b> None <b>Pulaski</b> 62956 62963 62964 62976 62992 <b>Putnam</b> 61336 61340 61363 <b>Randolph</b> 62217 62242 62272 <b>Richland</b> 62419 62425 <b>Rock Island</b> 61201 61236 61239 61259 61265 61279 <b>St. Clair</b> 62201 62203 62204 62205 62220 62289	<b>Saline</b> 62930 62946 <b>Sangamon</b> 62625 62689 62703 <b>Schuyler</b> 61452 62319 62344 62624 62639 <b>Scott</b> 62621 62663 62694 <b>Shelby</b> 62438 62534 62553 <b>Stark</b> 61421 61426 61449 61479 61483 61491 <b>Stephenson</b> 61018 61032 61039 61044 61050 61060 61062 61067 61089 <b>Tazewell</b> 61564 61721 61734 <b>Union</b> 62905 62906 62920 62926 <b>Vermilion</b> 60932 60942 60960 60963 61810 61831 61832 61833 61844 61848 61857 61865 61870 61876 61883 <b>Wabash</b> 62410 62852 62863	<b>Warren</b> 61412 61417 61423 61435 61447 61453 61462 61473 61478 <b>Washington</b> 62803 <b>Wayne</b> 62446 62823 62843 62886 <b>White</b> 62438 62821 62835 62844 62887 <b>Whiteside</b> 61037 61243 61251 61261 61270 61277 61283 <b>Will</b> 60432 60433 60436 <b>Williamson</b> 62921 62948 62949 62951 <b>Winnebago</b> 61077 61101 61102 61103 61104 <b>Woodford</b> 61516 61545 61570 61760 61771
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## REQUIRED

# Program Permission Form

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

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

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

\_\_\_\_\_  
Date

**REQUIRED**

# Authorization for Pick-up

Child's Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

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

Name	Address	Relationship	Work Phone	Home Phone
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 documents found at [jccchicagoearlychildhood.org/intake-forms](http://jccchicagoearlychildhood.org/intake-forms).

I/We \_\_\_\_\_  
*Please Print Name(s)*

Parent(s) or Guardian(s) of \_\_\_\_\_  
*Name of Child*

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

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

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

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

\_\_\_\_\_  
Date

**REQUIRED**

## Insurance Form

JCC Chicago requires health insurance information for all children enrolled in our Early Childhood 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 Chicago Early Childhood is using email as an important mode of communication. JCC Chicago will never send spam/junk emails to our families. Emails will only be used for official JCC Chicago communications.

### Please fill out ALL fields below

Child's Name \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

JCC Chicago Location \_\_\_\_\_

Name of Child's Program \_\_\_\_\_

Preferred Email Address \_\_\_\_\_

Yes, I'd like to receive Journey, the weekly JCC Chicago Newsletter featuring community news and events for all ages.

Please subscribe me to this edition:

- Suburban: covering North, West and South Suburbs
- City: covering Chicago, Skokie, Evanston
- Both

Yes, I'd like to receive Chai Life, the monthly JCC Chicago Newsletter covering arts and cultural events.

No, I do not wish to subscribe at this time.

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

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

\_\_\_\_\_  
Date

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

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

### **Assumption of Risk**

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

### **Waiver, Release, Indemnification & Covenant Not to Sue**

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

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

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

---

Minor Name (print clearly)

---

Date

---

Parent/Guardian Signature

---

Parent/Guardian Name (print clearly)

**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 JCC Chicago Early Childhood location.

Location \_\_\_\_\_ Program \_\_\_\_\_

Child's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

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

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

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

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

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

\_\_\_\_\_  
Date

## OPTIONAL

# Waiver for the Distribution of Sunscreen or Insect Repellent

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

Child's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

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

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

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

2021-22

Child's Name \_\_\_\_\_  
Birth date \_\_\_\_\_ Program \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_

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

#1 Name \_\_\_\_\_  
Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
#2 Name \_\_\_\_\_  
Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**Relative or Friend Alternative**

#1 Name \_\_\_\_\_ Phone \_\_\_\_\_  
#2 Name \_\_\_\_\_ Phone \_\_\_\_\_  
Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_  
Allergies \_\_\_\_\_  
Medication \_\_\_\_\_ Hospital \_\_\_\_\_  
Other Significant Medical Info \_\_\_\_\_

## Emergency Authorization

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

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

Signature Parent/Guardian

Date

# Emergency Information

Office copy

2021-22

Child's Name \_\_\_\_\_  
Birth date \_\_\_\_\_ Program \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_

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

#1 Name \_\_\_\_\_  
Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
#2 Name \_\_\_\_\_  
Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**Relative or Friend Alternative**

#1 Name \_\_\_\_\_ Phone \_\_\_\_\_  
#2 Name \_\_\_\_\_ Phone \_\_\_\_\_  
Pediatrician \_\_\_\_\_ Phone \_\_\_\_\_  
Allergies \_\_\_\_\_  
Medication \_\_\_\_\_ Hospital \_\_\_\_\_  
Other Significant Medical Info \_\_\_\_\_

## Emergency Authorization

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

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

Signature Parent/Guardian

Date