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)	Yes No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	List:	
Diagnosis of asthma?	Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Child wakes during night coughing?	Yes No						
Birth defects?	Yes No			Hospitalizations? 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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

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		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	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 ☐ Modified ☐

Print Name (MD,DO, APN, PA) Signature Date

Address Phone

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.

PERMISSION AGREEMENT FORM

PHOTOGRAPHS:

I give consent for my child,_____ to be photographed. I understand that these photographs may be displayed at Polka Dot Dragon Preschool or on Facebook.

The center will ask for written permission on a photo release if your child can be photographed for other purposes, such as publicity outside the center.

_____ _____

Parent/Guardian Signature Date

PERMISSION AGREEMENT FORM

FIELD TRIPS

I give my consent for my child to participate in Polka Dot Dragon Preschool field trips or excursions, including walking trips and other activities in the neighborhood, under supervision of the authorized personnel of the Polka Dot Dragon. All precautions will be taken to insure the safety and well-being of each child. I understand that separate notices will be distributed for special field trips.

PARENT SIGNATURE_____ DATE___/___/___

Polka Dot Dragon Preschool
PICK-UP PERMISSION FORM

Name of child:_____

I hereby give permission for my child to leave the school with the following persons named below. It is the responsibility of the parents to notify the school, in writing, of any change. Even Mother and Father's name need to be listed!

Date	Name	Relationship
1.		
2.		
3.		
4.		
5.		
6.		

I also give my permission for my child to leave the above named facility for field trips or on walks. I understand that I will be notified before each such activity. I also give permission for my child's photo or video image to be taken and used in promotional or training applications.

Date_____ X_____
Signature of Parent or Guardian

If there is a separation or divorce custody problem of which we should be aware, please explain.

_____

_____

Names of persons who may not pick up the child:

_____

_____

What time does the child usually go to bed? _____ Awaken? _____
Does the child sleep well? _____
What are the child's favorite indoor activities?

_____

_____

What are the child's favorite outdoor activities?

_____

_____

Does the child play with water? Y / N Go barefoot? Y / N
Does the child have any special fears that you are aware of? (Please specify)

_____

_____

Does the child have speech problems? Y / N Any other problems/impediments? _____
What method of behavior control is used at home? _____
What is the child's usual reaction? _____
How would you describe your child's personality? _____

_____

Health History of the Child
What past illness has the child had and at what age? Chicken Pox _____ Scarlet Fever _____
Diabetes_____ Mumps_____ Hepatitis_____ other _____
Does your child have frequent colds? Y / N Explain: _____
Tonsillitis? Y / N Earaches? Y / N Stomachaches? Y / N Does the child vomit easily? Y / N
Does the child run high fevers easily? Y / N Has the child had any serious accidents? Y / N
Explain: _____
Is the child allergic? Y / N If so, how does it manifest itself? _____
Asthma? Y / N Hay fever? Y / N Hives? Y / N Other _____
What is the allergy caused by? _____
Has child ever been to the dentist? Y / N Has the child's vision been checked? Y / N
Hearing tested? Y / N Does the child wear corrective shoes? Y / N
Please give a statement of the child's overall health. _____

_____

FOR SCHOOL USE ONLY **********
Illness _____ Date _____ Illness _____ Date _____
Illness _____ Date _____ Illness _____ Date _____
Illness _____ Date _____ Illness _____ Date _____
Illness _____ Date _____ Illness _____ Date _____
Accidents:

_____

_____

Other health information:

Cumulative Record:

Polk Dot Dragon Preschool
11 S. Lincoln Way
North Aurora, IL 60502
O: (630) 801-4868
Fax: (630) 801-4868

Policy Consent Form
Financial Agreement

I understand the policies set forth in the Parent Handbook and agree to comply with the rules/regulations, and procedures therein.

Parent/Guardian: _____
Signature

Director: _____ Date: _____
Signature

The policy regarding fees is as follows:

1. The fee is based on enrollment and **not** on attendance. *The weekly fee agreed upon as stated below is the same whether or not your child actually attends any day during the week, up to and including just one day.*
2. If your child is only enrolled for a couple days a week or "part-time" then the fee will be assessed per day per week.
3. *All fees are due on the Friday preceding the week of your child' attendance.* A $55.00 late pay fee will be applied to your account if your tuition is not paid by Monday at 6:00pm. Any checks that are returned will be assessed a processing fee of $25.00 that will be added to your account.
4. Full tuition is due unless a full week is missed, and then one-half the regular tuition will be required to hold your child's place until he/she returns in the case of illness.
5. ***Vacations:*** One half of the "regular" weekly tuition will be charged when a full calendar week is missed.
6. Snow/bad weather days and days in which Polka Dot Dragon is closed temporarily for emergency closing; full tuition for that day(s) will be charged.
7. Two weeks written noticed, dated and signed must be given in all cases of withdrawal.
8. Polka Dot Dragon's operating hours are 6:30am to 6:00pm. If your child/children are picked up after closing time of 6:00pm a late fee of $5.oo per 5 minutes per child will be charged to your account.

Paid Holidays at Polka Dot Dragon

New Year's (January)
Memorial Day (May)
Labor Day (September)
Thanksgiving (November)
Friday after Thanksgiving (November)
Christmas (December)

Polka Dot closes down the week between Christmas and New Years –There is not tuition charged for this week.

9. There is a limit of four weeks per year on half tuition allotment. If the family has used the four weeks, full tuition will be charged whether or not the child is in attendance.

The fee for your child _____, for _____ days a week, will be $_____ each Friday, beginning _____.

I have read and understand the above policies and agree to adhere to them.

Parent/Guardian _____ Date_____
Signature