SUMMARY OF LICENSING STANDARDS FOR DAY CARE CENTERS

DCFS
Illinois Department of Children & Family Services

Introduction

The Department of Children and Family Services (DCFS) is responsible for licensing day care centers. When a day care center is licensed, it means that a DCFS licensing representative has inspected the facility and the facility was found to meet the minimum licensing requirements. A license is valid for three years. The day care center's license must be posted. It will indicate the maximum number of children allowed in the facility and the areas where children may receive care.

Licensed day care facilities are inspected annually by DCFS licensing staff. If a complaint has been received regarding a violation of the licensing standards of a day care center, a licensing representative will conduct a licensing complaint investigation to determine if the alleged violation should be substantiated or unsubstantiated. Individuals may contact the Day Care Information Line to learn of substantiated violations.

Day Care Information Line 1-877-746-0829

This statewide toll-free information line provides information to the public on the past history and record, including substantiated violations, of licensed day care homes, day care centers, and group day care homes. This number operates Monday through Friday from 8:30 a.m. to 5:00 p.m.

Summary of Licensing Standards for Day Care Centers

The following is a summary of the licensing standards for day care centers. It has been prepared for you so that you may monitor the care provided to your child. This is a summary and does not include all of the licensing standards for a day care center. State licensing standards are *minimum* standards. If you observe a violation of any of these standards, you are encouraged to discuss your concerns with the day care center operator. In most cases, parents and day care operators are able to resolve the parents' concerns and issues. If you believe the day care operator is not responding to your concerns and may not be meeting state licensing standards, you may make a complaint to the local DCFS Licensing Office or by calling the Child Abuse Hotline at 1-800-252-2873 and stating that you want to make a licensing complaint. A DCFS licensing representative will investigate

your complaint and report the results back to you. The day care center is required to provide a copy of its own written policies regarding the operation of the facility to each staff person and to parents of enrolled children.

Staffing

- The day care center must have a qualified child care director on site at all times. The director must be at least 21 years old, have completed two years of college or have equivalent experience and credentials.
- Early childhood teachers must be at least 19 years old, have two years of college or have equivalent experience and credentials.
- School-age workers must be at least 19 years of age and at least five years older than the oldest child in their care. They must have completed one year of college or have the equivalent experience and credentials.
- Early childhood assistants and school-age assistants must have a high school diploma or the equivalent and must work under direct supervision of an early childhood teacher or a school-age worker.
- Student and youth aides must be at least 14 years of age, at least five years older than the oldest child in their care, and must work under direct supervision of an early childhood teacher or a school-age worker.
- Student and youth aides are not generally counted for purposes of maintaining staff/child ratios.
- The director and all child care staff must have 15 hours of in-service training annually.
- All staff must have current medical reports on file and are subject to background checks for any record of criminal conviction or child abuse and neglect.
- A person certified in first aid, including CPR and the Heimlich maneuver, must be present at all times.

Group Size and Staff Requirements:

AGE OF CHILDREN	STAFF/CHILD RATIO	MAXIMUM GROUP SIZE
Infants (6 weeks through 14 months)	1 to 4	12
Toddlers (15 through 23 months)	1 to 5	15
Two years	1 to 8	16
Three years	1 to 10	20
Four years	1 to 10	20
Five years (preschool)	1 to 20	20
School-age: Kindergartners present	1 to 20	30

- Exception: One early childhood teacher and an assistant may supervise a group of up to 30 children if all of the children are at least five years of age.
- Whenever children of different ages are combined, the staff/child ratio and maximum group size must be based on the age of the youngest child in the group.

General Program Requirements

- Parents must be allowed to visit the center without an appointment any time during normal hours of operation.
- Staff must demonstrate respect for each child enrolled regardless of gender, ability, cultural, ethic or religious differences.
- There must be a balance of active and quiet activity. Daily indoor and outdoor activities are to be provided for children to make use of both large and small muscles.
- In pre-school programs where children receive care for less than three hours per day, outdoor activity is not required.
- Children may not be left unattended at any time.

Infants and Toddlers

- Infants and toddlers must be in separate space away from older children.
- A refrigerator and sink must be easily accessible.
- Toys and indoor equipment must be cleaned and disinfected daily. Safe, durable equipment and play materials must be provided.
- Either the day care center or the parent may provide food for infants not consuming table food. Feeding times and amounts consumed must be documented in writing.
- No food other than formula, milk, breast milk or water may be placed in a bottle for infant feeding. Microwaves are not to be used for bottle warming.
- Children who cannot turn over alone must be placed on their backs.
- The facility must have a clearly defined diaper changing area with the procedures for changing diapers clearly posted. A hand-washing sink must be accessible for hand washing.
- Staff changing diapers must wash their hands and the child's hands with soap and running water after diapering.
- Information about feeding, elimination and other important information must be recorded in writing and made available to parents when the child is picked up at the end of the day.
- Only new cribs manufactured on or after June 28, 2011 must be in place

School-Age Children

- The facility must have a designated area for school-age children so they do not interfere with the care of younger children.
- Clear definitions of responsibility and procedures are to be established among parent, day care center and school when children move to and from school.
- A variety of developmentally appropriate activities and materials must be available for children. Opportunities must be provided to do homework, if requested.

Evening, Night and Weekend Care

- Family-like groups of mixed ages are allowed.
- Staff must be awake at all times and in the sleeping area whenever children are sleeping.
- Each child must have an individual cot, bed or crib.
- An evening meal and a bedtime snack must be served.
- Breakfast must be served to all children who have been at the facility throughout the night and are present between 6:30 a.m. and 8:30 a.m.

Enrollment and Discharge

- Parents must be provided the names, business address and telephone number of persons legally responsible for the program.
- Parents must be provided, in writing, information on the program, fees, arrival and departure policies explaining to the parents and guardians what actions the caregiver will take if children are not pick up at the agreed upon time, and the guidance and discipline policies.
- Parents must complete an enrollment application, which includes, for first time enrolment, providing a certified copy of their child's birth certificate (which will be copied by the center and returned to the parent), emergency numbers, and persons authorized to pick up their child.
- A child may only be released to a parent or other responsible person designated by the parent.
- Daily arrival and departure logs must be kept by the center.

Guidance and Discipline

- Parents must be given a copy of the guidance and discipline policy.
- The following are prohibited:
  - corporal punishment
  - threatened or actual withdrawal of food, rest or use of the bathroom
  - abusive or profane language
  - public or private humiliation
  - emotional abuse, including shaming, rejecting, terrorizing or isolating a child

- "Time-out" is to be limited to one minute per year of age. "Time-out" may not be used for children less than two years of age.

Transportation

- The driver must be 21 years of age and hold a driver's license that has been continuously valid for three years.
- Children must not be allowed to stand or sit on the floor of the vehicle. Age appropriate safety restraints must be used when transporting children in vehicles other than school buses.
- The driver must make sure that a responsible person is present to take charge of a child when delivered to his or her destination.

Health Requirements for Children

- A medical report indicating that the child has been appropriately immunized must be on file for each child. Parents are encouraged to be informed about childhood immunizations by going to the following Web site: http://www.state.il.us/dcfs/daycare/Childhood_Immunizations.shtml. A tuberculin skin test is to be included in the initial exam unless waived by a physician.
- The medical report is valid for two years for infants and preschool children. Exams for school-age children are required consistent with the requirements of the public schools.
- The center will comply with the Illinois Department of Public Health's Hearing and Vision Screening Codes and the Illinois Child Vision and Hearing Test Act.
- Children aged one to six years must have either a lead risk assessment or a lead screening.
- Water must be freely available to all children.
- Children's hands must be washed with soap and water upon arrival at the center, before and after meals or using the toilet, after wiping or blowing their noses, after outdoor play and after coming into contact with any soiled objects.

- Prescription and non-prescription medication may be accepted only in its original container. The center must maintain a record of the dates, times administered, dosages, prescription number (if applicable) and the name of the person administering the medication.
- Medication must be kept in locked cabinets or other containers that are inaccessible to children.

Nutrition and Meals

- Menus must be posted.
- Meals and snacks must meet nutritional guidelines.
- Children in care two to five hours must be served a snack. Children in care five to 10 hours must be served a meal and two snacks or two meals and one snack. Children in care more than 10 hours must be served two meals and two snacks or one meal and three snacks.

Napping and Sleeping

- Children under six years of age who remain five or more hours must have the opportunity to rest or nap.
- Infants must sleep in safe, sturdy, freestanding cribs or portable cribs.
- Toddlers may use either stacking cots or full-size cribs.
- A cot or bed must be provided for each toddler or preschool child in attendance five or more hours. Each cot, bed or crib must be labeled with the name of the child.

Physical Space

- Infants and toddlers must be housed and cared for at ground level unless special approval has been granted from the Department.
- Indoor space must provide a safe, comfortable environment for the children. Floors and floor coverings must be washable and free from drafts and dampness.
- Toilets and lavatories must be readily accessible to the children.

- Hot and cold running water must be provided.
- Hazardous items must be inaccessible to children.
- Parents must be notified before pesticides are applied, unless in an emergency
- Exits must be unlocked and clear of equipment and debris.
- Drills for fire and tornado must be conducted. A floor plan must be posted in every room indicating the areas providing the most safety in the case of a tornado and the primary and secondary exit routes in case of fire.
- Smoking or the use of tobacco products in any form is prohibited in the child care center or in the presence of children while on the playground or on trips away from the center.
- Play materials must be durable and free from hazardous characteristics.
- The facility may not use or have on the premises any unsafe children's product as described in the Children's Product Safety Act. Lists of unsafe children's products and recalls from 1989 to now are available at: www.idph.state.il.us/webapp/SRSApp/pages/index.jsp.
- The facility must be cleaned daily and kept in sanitary condition at all times.
- First-aid kits must be maintained and readily available for use.

Outdoor Play Area

- Play space must be fenced or otherwise enclosed or protected from traffic and other hazards. There must be a shaded area in summer to protect children from excessive sun exposure.
- All areas of the outdoor play space must be visible to staff at all times.
- Equipment must be free of sharp points or corners, splinters, protruding nails or bolts, loose or rusty parts, the potential for entrapment and/or other hazards.
- Protective surfaces must be provided under equipment from which a child might fall

- All swimming pools must be fenced or otherwise inaccessible to children.
- During hours of operation and at all times that children are present there must be a means for parents of enrolled children to have direct telephone contact with a center staff person.

This summary has been developed to assist parents in monitoring the care provided by the day care center.

For a complete copy of the Licensing Standards, write or call

Department of Children and Family Services
Office of Child and Family Policy
406 East Monroe Street
Springfield, Illinois 62701
Telephone (217) 524-1983

Licensing Standards for Day Care Centers may also be accessed through the DCFS website: www.state.il.us/dcfs and following the links to Part 407, Licensing Standards for Day Care Centers. You may also contact your nearest DCFS office.

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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.

Toddler House

Code_____

Application Form

Date of Application _____

Name of Child _____ Sex _____
Last First Middle

Family Data

Child's Age _____ Date of Birth _____ Place of Birth _____

Mother's Name (Whether in home or not): _____

Address _____ Phone # _____
_____

Mother or Guardian's Employer: _____
Work Address: _____ Phone # _____
_____
Hours of work _____ Occupation _____

Hours of care: _____

Father's Name (Whether in home or not): _____

Address _____ Phone # _____
_____

Father or Guardian's Employer:
_____
Work Address: _____ Phone # _____
_____
Hours of work _____ Occupation _____

Whom should we contact in case of an emergency?
Name: _____ Relationship: _____
Address: _____ Phone # _____
_____

Name of doctor or clinic: _____ Phone # _____

Toddler House

Please list other children in household.
1. _____
2. _____
3. _____

Please list other adults in household.
1. _____
2. _____
3. _____

How would you describe your child's role in your family?

_____

_____

Please describe any alliances and frictions in the family that you think we should be aware of:

_____

_____

Have there been any major changes in the family constellation, such as divorce or death?

_____

Have there been any difficulties or crises in your family (such as accidents, problems with the law, medical problems) that may have affected the emotional well being of your child?

_____

CHILD'S BEHAVIOR PATTERNS AND HABITS

Please briefly describe an ordinary day in the life of your child, from his/her rising in the morning to going to bed: _____

_____

_____

_____

What is your child's favorite toy? _____ book? _____
pet? _____ person? _____

Does your child have any particular habits or mannerisms, such as thumb sucking or nail biting? Please describe: _____

_____

_____

Does your child have any particular fears, such as dogs or sirens? Does he/she have nightmares? Please describe:

_____

_____

_____

Does your child use any peculiar words or expressions (such as "wee-wee" for urine) that may not be understood by an outsider? Please describe:

_____

_____

In general, how does your child react to anxiety or a stressful situation? Does he cry, withdraw, throw tantrums? Please describe: _____

_____

Does your child have any allergies?

_____

Has your child had any previous school or playgroup experiences? _____

_____

How does your child relate to adults? _____

Has your child had the experiences of being cared for by adults other than members of your family? _____

_____

What is the accustomed mode of disciplining your child? What is your "philosophy" of discipline?

_____

_____

Does your child speak English? _____ Any other language? _____

Is he/she talkative, quiet, average?

_____

To the best of your knowledge does your child have any language problems or learning disabilities?

_____

Does your child have any emotional disturbances or physical handicaps?

_____

_____

How well do you anticipate your child will adjust to this day care program? _____

_____

Are there additional circumstances regarding your child's physical or emotional status that you would like us to be aware of? _____

_____

Child may be release to:

Name: _____

Address: _____

_____

Phone: _____Relationship: _____

Name: _____

Address: _____

_____

Phone: _____Relationship: _____

Name: _____

Address: _____

_____

Phone: _____Relationship: _____

Parent or Guardian's Signature: _____

CFS 593
Rev 7/2007

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD _____

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES.

Parent(s) or legal guardian placing the child may sign any or all of the following consents:

EMERGENCY MEDICAL CARE

This authorizes _____
to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement. _____ is the preferred doctor/clinic/hospital.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize _____ to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER OVER-THE-COUNTER MEDICINE

(Administer only in accord with the appropriate standards for licensure)

I/we authorize _____ to administer over-the-counter medicine to my/our child as specified in written instructions.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

- over -

CHILD PICKUP

(Use additional sheet of paper if more than 3 people are authorized to pick up child)

I/we authorize _____
Name Address Phone

and/or

_____
Name Address Phone

and/or

_____
Name Address Phone

to pick up my/our child when I am/we are unavailable.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES

I/we authorize _____ to take my/our child on walking trips, special excursions, and to nearby public park facilities. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the above-named person(s). I/we understand all such trips are under the supervision of the above-named person(s) and that health and safety precautions are taken in compliance with DCFS standards for licensure.

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

SWIMMING

I/we consent to my/our child using the swimming pool of _____
Name of Provider

at _____.
Address

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 1/2012

DCFS

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

COMMENTS:

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																			

Codes:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

IL444-4737 (R-01-12)

(COMPLETE BOTH SIDES)

Printed by Authority of the State of Illinois

5A

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	School	Grade Level/ ID #

HEALTH HISTORY — TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)				MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the night	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 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. Questionnaire Administered ? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date (Blood test required if resides in Chicago.)

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 Antagonist) ☐ 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 (for one year) Yes ☐ No ☐ Limited ☐

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

Address Phone

(Complete both sides)

5B

Toddler House Approach to Guiding Behavior

Infants

Until they are about six to eight months old, infants cannot control their own behavior. Adults need to step in and make sure they do not hurt themselves. Creating a safe environment is one of the ways we guide infants' behavior. Infants are guided in the following ways:

* Keep infants away from potential problems. If an infant is trying to climb up on a table, redirect the Infant to some pillows on the floor.

* Remove temptations or dangerous objects. For example, keep the bathroom door closed and put sharp objects out of reach.

* Offer an infant something interesting to play with if another child is playing with something the infant wants.

* Separate the infants who are hurting each other and show them ways to relate. For example, how to stroke hair instead of pulling it.

Mobile Infants

Between ten and twelve months of age infants realize that adults don't always approve of everything they do. A firm " Walk Away" can be quite effective in stopping and infant's behavior. Mobile infants are guided in the following ways:

* Use facial expressions and a dramatic tone of voice to convey your feelings rather than a lot of words.

* If no one will be hurt, give infants a chance to work things our for themselves. Only intervene when you have to.

* Resist the temptation to habitually say "NO!" Save

this word for dangerous situations so that it will be more effective.

* Always respond in ways that meet the needs of infants and help them feel good about themselves.

Toddlers

Toddlers, who are striving to be independent and want to do everything for themselves need to have their independence balanced by the need to learn limits. Although toddlers are very likely to forget what you tell them from one minute to the next, they are beginning to learn what is acceptable behavior and what is not. Firm positive statements about behaviors or redirection of behaviors shall be the accepted techniques for use with infants and toddlers. Removal from the group to help a child gain control shall not exceed one minute per year of age. Removal from the group shall not be used for children less than 24 months of age.
The following behaviors are prohibited in all child care setting:

* Corporal punishment, including hitting, spanking, swatting, beating, shaking, pinching and other measures intended to induce physical pain or fear.

* Threatened or actual withdrawal of food, rest or use of the bathroom.

* Abusive or profane language.

* Any form of public or private humiliation, including threats of physical punishment.

* Any form of emotional abuse, including shaming, rejecting, terrorizing, or isolating a child.

By this stage of development, toddlers are starting to use words to express their feelings. They can listen and usually understand what you say to them. The words you use and your tone of voice are powerful tools in guiding a toddler's behavior. A calm, but firm tone conveys that you care and mean what you say. Angry and loud words may startle children so they don't hear what you are saying and will not be used.

Here are some strategies for guiding the behavior of toddlers to promote self-discipline.

* Stop the behavior in ways that show respect and help toddlers feel good about themselves. "It seems hard for you to stop throwing sand, We'll find something else for you to do".

* Try to understand why a toddler is misbehaving. perhaps the child is tired or hungry.

* Acknowledge the toddler's feelings, but protect the child and others. "I know you are angry, but I can't let you hurt Molly".

* Anticipate dangerous situations and set up a safe environment to prevent problems. "You like to climb but this is too high. Let's try climbing over here on the climber".

* Explain what children can do. "You can drive the truck on the rug, Beth, not in the bathroom". Or "Use the crayons on the paper, not on the table". (Or cover the table with paper)

* Consequences should logically follow a toddler's action. "Uh-oh, the juice spilled. Let's get a sponge and wipe up the table".

I_____understand the guidance policies for the Infants/Mobile Infants/Toddlers. I am agreement with the methods used for the young.

_____signature_____date

6c

Dear Parents,

As with time, it is ever changing, and to improve our connections with school and home we are changing our discipline to reflect these changes. We have researched different disciplines as to what would be the best for our children, as well as keeping in touch with our families.

We have adopted "Conscious Discipline" By Dr. Becky Bailey. We feel that with our school climate we can help build co-operation, willingness and responsibility, as the teachers, students and the parents work together. The children will be working on self regulation, ie: using a "Safe Place", for when they are feeling, angry, sad or just out-of-sorts. They will learn they can go to the "Safe Place" on their own and rejoin the class when they are ready.

We have a staff member who has taken the training, and is now in the process of working with the staff. This is a process we will be sharing with you in the near future, during two evening sessions. While we work with the children on the steps and techniques to use, giving them the ability to manage their feelings, thoughts and actions. This will give them -a cornerstone for a successful life.

I, _____ have read the above on _____ and understand that a new discipline is now being introduced to my child/children at Toddle Town, Inc.

File copy

Toddle Town, Inc
208 E Lincoln St.
Belleville, IL 62220
618-234-3832

Administer Diaper Ointment/Sunscreen and Bug Spray

Please initial beside each item that authorize Toddle Town, Inc to administer to your child as specified on the label.

Child's Name_____

- Sun block_____
- Bug Spray_____
- Diaper Ointment_____

Signature of
Parent/Guardian_____
Date_____

Toddle Town, Inc.
208 S Jackson St
Belleville, IL 62220
618-234-3832

I/We Authorize Toddle Town, Inc to photograph my child for publicity purpose.

_____
Signature of parent/guardian

_____
Child's name

_____
Date

I/We authorize Toddle Town Inc, to photograph my child for in center use such as portfolios and pictures to be used in the center.

_____
Signature of parent/guardian

_____
Child's name

_____
Date

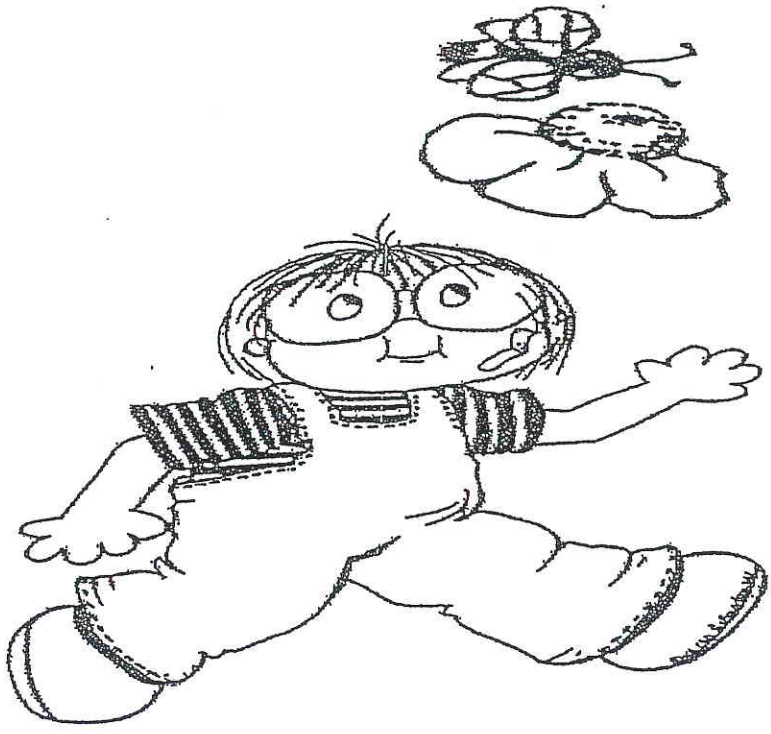
I/We authorize Toddle Town Inc. to have my child's photo or name published in the newspaper articles or website.

_____
Signature of Parent/guardian

_____
Child's Name

_____
Date

5/28/2009



Walking Trips / Buggy Rides

I/we authorize Toddler House/Toddle Town to take my/our child on walking trips to downtown Belleville in the buggy. I/we understand all such trips are under
the supervision of staff from Toddler House. A cell phone, first-aid kit and emergency cards are with us on the walks. Health and safety precautions are taken in compliance with DCFS standards for licensure.

Date_____

Signature or Parent or Guardian_____

Late Pickup Policy
Toddle Town/Toddler House/Learning Journey

Children who are not picked up by 6 P.M. will automatically be charged $1.00 for every minute per child, per occurrence. Fees begin to accrue at 6:05 P.M.

Steps to be taken to reach someone to pick up:

1. Parents will be called at 6:10 and 6:20 P.M. We will call parents - home, work and cell.
2. Emergency numbers will be called at 6:30 and 6:45.
3. Parents and emergency numbers will be called again at 7:00 and 7:30.
4. If a child is still at the center at 8:00 P.M. and we have not made contact with a parent or emergency. contact person, the Belleville Police Department will be called.
5. The Department of Children and Family Services will be called as a last resort.

We want to emphasize the importance of having updated information and correct phone numbers in your child's file so that you can be contacted when needed. Toddle Town, Inc. is responsible for your child's protection and well being until someone arrives for your child. The center staff will remain with the child until the child has been picked up and the child will not be responsible for the situation, nor will it be discussed with the child.

I have read the above and agree to keep my child's file updated with new phone and emergency numbers.

Parent Signature_____ Date_____

Toddle Town, Inc
208 S Jackson St
Belleville, Il 62220
(618) 234-3832

Toddle Town Inc will need a copy of your child's certified birth certificate or other reliable proof of identity and age of the child within 30 days of enrollment. This required by DCFS Section 407.250 I-4-A.

4) The day care center shall:

A) Provide a written notice to the parent or guardian of any child to be *enrolled for the first time that within 30 days* of enrollment the parent or guardian must *provide a certified copy of the child's birth certificate or other reliable proof of identity and age of the child.* The center shall make a duplicate and return the original certified copy to the parent or guardian no later than the end of the next business day after receipt. If a certified copy of the birth certificate is not available, the parent or guardian must submit *a passport, visa or other governmental documentation as proof of the child's identity and age and an affidavit* or notarized letter *explaining the inability to produce a certified copy of the birth certificate.* The center's notice to parent or guardian shall also indicate that the center is required by law to notify the Illinois State Police or local law enforcement agency if the parent or guardian fails to submit proof of the child's identity within the 30 day time frame;

B) Notify the Illinois State Police or local law enforcement agency of the parent's failure to submit a certified copy of the child's birth certificate or other reliable proof of identity. The center shall also *notify the parent or guardian in writing that the* Illinois State Police or *local law enforcement* has been notified as required by law, advising the parent or guardian that he or she *has 10 additional days to comply* by submitting the required documentation;

Signature of Parent/guardian Date

Toddle Town, Inc.
208 South Jackson
Belleville, Il 62220

Video/Audio Consent,

I hereby voluntarily grant my permission to Toddle Town, Inc. staff, their agents and licensees to photograph or video tape myself and or the child named below. I understand that the interests of the early childhood care and education field will be advanced by the use of the video, audio, and or photos covered by this consent. I understand that all rights, title, and interest in these video and photographic images belong exclusively to Toddle Town, Inc. and that this group reserves the right to edit the images.

Child's name in full(please print)_____

Name of parent or legal guardian(please print)_____

Address_____

City, State & Zip_____

Phone_____

Parent/Guardian
Signature:_____Date_____

Toddle Town, Inc
208 S Jackson St
Belleville, Il 62220
618-234-3832

Pest Control

To prevent infestation of our buildings, Toddle Town and Toddler House will be checked monthly by Orkin pest control. Orkin is a licensed pest control company and uses child safe materials. If there is an outbreak of mice or any other pest concerns, we will call Orkin and have them access the situation and take action. During the summer months, they spray for mosquitoes. They will come on Saturday to do this spraying. The dates that Orkin will be here will be posted in the monthly newsletter. If you have any further questions, you may contact the director.

Thank You

Beth Maloney

I _____ have read the above statement on
(Name)

_____.
Date

9.13.20

Toddle Town, Inc
208 E Lincoln St
Belleville, IL 62220
618-234-3832

December 4, 2012

Dear Parents

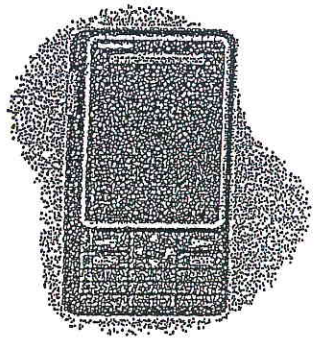
We are starting a new program. The teachers will be able to text you pictures of your child when they do something cute or funny. If you would like to participate in this program, please fill out the form below.

Parents Name _____

Child's Name _____

Cell Phone Number _____

Parent's signature _____



Dear Parents,

In the next few weeks we will begin to make "Sunshine" calls. There are just to keep in touch with you about special things your child may be doing at school or give you the opportunity to ask how your child is doing. Please let us know how and when it is convenient for you to get these.

E-Mail_____

Text_____

Phone _____Time_____

Thank You,

Toddle Town, Inc Teachers

Child and Adult Care Food Program

INFANT FORMULA/FOOD WAIVER NOTIFICATION

Toddle Town, Inc
(Name of Child Care Center/Home)

_____ (Infant's Name)

_____ (Birth Date)

For Parent/Guardian of Infants Age Birth Through 11 Months

This child care center/home participates in the Child and Adult Care Food Program (CACFP) and is required to follow the Infant Meal Pattern for infants ages birth through 11 months. Solid foods are introduced to infants when developmentally ready, a decision made by you and your infant's doctor. To better meet your personal preferences and your infant's needs, please complete this document.

(Instructions—The center/home must complete this section before giving to the parent/guardian.)

This center/home will provide:

Iron-fortified infant formula (list brand) Gerber Good Start ;

Iron-fortified infant cereal (list type such as baby rice cereal) Baby oatmeal & Baby rice ; and

Food appropriate for infants
- ☒ **Commercial baby food** and/or
- ☒ **Table food** offered at the appropriate consistency for the development of the infant

(Instructions— The parent/guardian must ANSWER THE FOLLOWING QUESTION and MARK ONE OF THE CHOICES FROM EACH OF THE THREE SECTIONS BELOW; then sign and date this form.

What do you currently feed your infant?
- ☐ Iron-fortified infant formula
- ☐ Breast milk
- ☐ Low-iron or another type of infant formula provided for medical reasons I will receive a *Medical Exception Statement for Food Substitutions.*

The parent or guardian would like their infant to be fed the following while in care.

Section 1—Infant Formula or Breast Milk

_____ **Choice 1**—I want my infant to **receive the child care center-/home-provided iron-fortified infant formula** identified above. I will not bring infant formula from home.

_____ **Choice 2**—I understand I am not required to bring infant formula that I purchase or receive from Women, Infants, and Children (WIC), however, I want to **bring my own formula/breast milk.** If I should forget to bring infant formula/breast milk, the child care center/home will contact me immediately and I may request they serve my infant the center-/home-provided iron-fortified infant formula that day.

Section 2—Infant Cereal

_____ **Choice 1**—I want my infant to **receive the child care center-/home-provided iron-fortified infant cereal,** identified above. I will not bring infant cereal from home.

_____ **Choice 2**—I understand I am not required to bring iron-fortified infant cereal that I purchase or receive from WIC, however, I want to **bring my own infant cereal.** If I should forget to bring the cereal, the child care center/home will contact me immediately and I may request they serve my infant the center-/home-provided iron-fortified infant cereal that day.

Section 3—Baby Food

_____ **Choice 1**—I want my infant to **receive the child care center-/home-provided baby food** identified above. I will not bring baby food from home

_____ **Choice 2**—I understand I am not required to bring baby food that I purchase, however, I want to **bring my own baby food.** If I should forget to bring the baby food, the child care center/home will contact me immediately and I may request they serve my infant the center-/home-provided baby food that day.

If I decide to change the selections I made above, I will be required to complete another form.

_____ (Parent's Signature)

_____ (Date)

PARENT LETTER
FOR CHILD CARE CENTERS
July 1, 2015, Through June 30, 2016

Parent or Guardian:

This child care center participates in the USDA Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information you provide on the attached Household Eligibility Application. Part of the USDA requirement is to ask you to complete the application. If your income is equal to or less than the income listed in the chart below for your household size, the center will receive a higher level of reimbursement. Read the attached instructions carefully and fill out all required information. We cannot approve an application that is not complete. Please return the completed application back to our center as soon as possible.

If a member of your family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits; or you care for a foster child that is the legal responsibility of the State through DCFS or the court, these children are eligible for meal benefits regardless of your household income.

If your income(s) is over the income guidelines listed below, you are not required to complete this application; however, it would be helpful if you would write your child's name on the application and return it to our center. Please notify us, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the income eligibility standards.

Income Eligibility Guidelines
Effective from July 1, 2015, to June 30, 2016

	Reduced-Price Meals 185% Federal Poverty Guideline				
Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	21,775	1,815	908	838	419
2	29,471	2,456	1,228	1,134	567
3	37,167	3,098	1,549	1,430	715
4	44,863	3,739	1,870	1,726	863
5	52,559	4,380	2,190	2,022	1,011
6	60,255	5,022	2,511	2,318	1,159
7	67,951	5,663	2,832	2,614	1,307
8	75,647	6,304	3,152	2,910	1,455
For each additional family member, add	7,696	642	321	296	148

The information you provide on the application will be used to determine your child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

By signing the section on the application for the Illinois All Kids Health Insurance, you are stating you do not want your information shared with the Illinois Department of Healthcare and Family Services. If you agree to disclose the application information, it may be used to identify your child(ren) for the health insurance program. If you would like more information on All Kids, call toll-free 866/255-5437 or 877/204-1012 (TTY).

If you have any questions or need help, please contact our center.

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.)

If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov.

Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish).

USDA is an equal opportunity provider and employer

HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS
CHILD AND ADULT CARE FOOD PROGRAM

1. All Household Members | **2.** | **3.**

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to #6.	SNAP OR TANF CASE NUMBER Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.
		☐	- - -
		☐	- - -
		☐	- - -
		☐	- - -
		☐	- - -
		☐	- - -

4. Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway

Signature of School Homeless Liaison or Migrant Coordinator _____ Date _____

5. Total Household Gross Income (before deductions) You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Part 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits his or her social security number or mark the *I do not have a social security number* box.

X X X - X X - _ _ _ _ Social Security Number

☐ I do not have a social security number.

I certify all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date _____ *Printed Name of Adult Household Member* _____ *Signature of Adult Household Member* _____

7. Contact Information (Optional)

Work Telephone Number (Include Area Code) _____ *Home Telephone Number (Include Area Code)* _____ *Home Address (Number, Street, City, State, Zip Code)* _____

8. Optional – Sharing Information With All Kids Insurance Program

May we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If *yes*, do not sign below.
☐ No, I do not want my information from this application shared with the *All Kids Insurance Program*.

Date: _____ Sign here: _____

PRIVACY ACT STATEMENT: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

CHILD CARE REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION - COMPLETE SECTIONS A, B and C BELOW
Follow the *Instructions for Institutions to Process Household Eligibility Applications* available at www.isbe.net/nutrition.

SECTION A Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 *Convert income only if different frequencies of pay are reported.*

TOTAL INCOME $ _____ Per: ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year NUMBER IN HOUSEHOLD: _____

☐ **Free based on:**
- ☐ foster child
- ☐ SNAP or TANF
- ☐ homeless
- ☐ migrant
- ☐ runaway
- ☐ household's income

☐ **Reduced based on:**
- ☐ household's income

☐ **Denied—Reason:**
- ☐ income too high
- ☐ incomplete application
- ☐ Non-qualifying SNAP/TANF

SECTION B Signature of Determining Official _____ Date _____

SECTION C Effective Date of this application: _____

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which the child's eligibility is certified.

PARENT INSTRUCTIONS
HOUSEHOLD ELIGIBILITY APPLICATION

Follow These Instructions and Return the Completed form to your Center. Once approved for meal benefits, a child's Household Eligibility Application is effective for 12 months.

FOSTER CHILD(REN)

A foster child remains the legal responsibility of the State through a foster care agency or the court. If you submit documentation from the state or local agency that the child is in foster care, that documentation replaces completing a household eligibility application.

1) If all children in your household (who attend this center) are foster children that are the legal responsibility of a foster care agency or court, provide the following:
   - Part 1—List the name(s) and age(s) of your foster child(ren) attending this center.
   - Part 2—Check the box(es) indicating a foster child(ren).
   - Part 3—5 Skip
   - Part 6—Provide a signature of an adult household member and date the application.
   - Part 7-8 (OPTIONAL)

2) If you have some foster children that are the legal responsibility of a foster care agency or court along with other children attending this center, please provide the following:
   - Part 1—List ALL household members, including the foster child(ren), and the age(s) of the child(ren) attending the center.
   - Part 2—Check the box(es) identifying the foster child(ren).
   - Part 3—Record a valid SNAP/TANF case number if applicable
   - Part 4—Skip
   - Complete Parts 5 and 6 if applicable. See the instructions for INCOME–HOUSEHOLDS REPORTING section.
   - Part 7-8 (OPTIONAL)

SNAP OR TANF BENEFITS - HOUSEHOLDS RECEIVING

If any member (child or adult) of your household receives SNAP or TANF benefits, provide the following:
- Part 1—List ALL people in your household (including grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the center.
- Part 2—Skip
- Part 3—Record a valid SNAP or TANF case number for any member (child or adult) of this household. You will find your SNAP or TANF case number on your letter of eligibility for benefits.
- Part 4—5 Skip
- Part 6—Provide a signature of an adult household member and date the application.
- Part 7-8 (OPTIONAL)

HOMELESS, MIGRANT, OR RUNAWAY

If no one in your household receives SNAP or TANF benefits and if any child is homeless, a migrant or runaway, follow these instructions.
- Part 1—List ALL household members, and the age(s) of the child(ren) attending the center.
- Part 2—3 Skip
- Part 4—If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your local school.
- Part 5—Complete only if a child in your household isn't eligible under Part 4. See instructions for INCOME–HOUSEHOLDS REPORTING section below and complete Part 5 and 6.
- Part 6—Provide a signature of an adult household member and date the application.
- Part 7-8 (OPTIONAL)

INCOME - HOUSEHOLDS REPORTING

If no one in your household receives SNAP or TANF benefits, please report all household income. The Household Eligibility Application must include the following information:
- Part 1—List the names of ALL household members and the age(s) of the child(ren) attending the child care center.
- Part 2—4 Skip
- Part 5—List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for last month. If the income last month was not the usual amount you normally receive, you may provide a projected amount that better represents your gross income.
  - For ONLY the self-employed, list income after expenses. This is for your business, farm, or rental property.
  - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
  - If you have no income, list zero in the earnings from work column.
- Part 6—Provide a signature of an adult household member and date the application. Also, provide the last four digits of the social social security number for the adult signing the application. If you refuse to provide the last four digits of the social security number, the application cannot be approved. If the adult does not have a social security number, mark the box, I do not have a social security number.
- Part 7-8 (OPTIONAL)

ILLINOIS STATE BOARD OF EDUCATION

Annual Enrollment Form

Child and Adult Care Food Program

This form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs.

This form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters.

Parents/Centers: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. If parent does not complete Section 5, center staff should complete to the best of their ability (by observation) and initial the section. The center will review completed enrollment form.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS DURING WEEK								4 MEALS RECEIVED
		TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center	
First Child	☐ Monday									☐ Breakfast
Name	☐ Tuesday									☐ A.M. Snack
Birth Date	☐ Wednesday									☐ Lunch
Age	☐ Thursday									☐ P.M. Snack
	☐ Friday	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
	☐ Saturday									
	☐ Sunday									
Second Child	☐ ***Same Days as Above***	☐ ***Same Times as Child Above***								☐ ***Same Meals as Above***
Name	☐ Monday									☐ Breakfast
Birth Date	☐ Tuesday									☐ A.M. Snack
Age	☐ Wednesday									☐ Lunch
	☐ Thursday									☐ P.M. Snack
	☐ Friday	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
	☐ Saturday									
	☐ Sunday									
Third Child	☐ ***Same Days as Above***	☐ ***Same Times as Child Above***								☐ ***Same Meals as Above***
Name	☐ Monday									☐ Breakfast
Birth Date	☐ Tuesday									☐ A.M. Snack
Age	☐ Wednesday									☐ Lunch
	☐ Thursday									☐ P.M. Snack
	☐ Friday	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours								
	☐ Saturday									
	☐ Sunday									

Please answer both questions. This information is voluntary.

5 ETHNIC/RACIAL CATEGORIES—

A. Ethnic data of child(ren) — Mark only one. ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren) — Mark one or more that apply. ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

6 SIGNATURE

I certify the information above is correct. _____ *Signature of Parent or Guardian* _____ *Date* _____ *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY

Effective Date of this enrollment form: _____

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which this form is received.

National Accreditation Commission
For Early Care and Education Programs

An Accreditation Program
Committed to Excellence

Dear Families,

On 6/30/2009, Toddle Town, Inc. was awarded accreditation by the National Accreditation Commission for Early Care and Education Programs (NAC).

As a NAC accredited center, Toddle Town, Inc. has been recognized as an early care and education program that exemplifies excellence in the care of young children. Toddle Town, Inc. ensures a high quality program for children that is conducive to their individual growth and development, provides professional training opportunities for staff, and demonstrates that the center exceeds minimum state licensing requirements for child care programs.

The accreditation process included a self-study in which administrators, staff and parents evaluated the program in accordance with NAC standards. A validation visit and thorough review of all program materials by a national commission concluded the process and a decision to award accreditation was reached. All parents, staff members and administrators at Toddle Town, Inc. are to be congratulated for achieving this level of excellence. ***As a parent you can rest comfortably knowing you have chosen an outstanding program for your child!***

About NAC

The National Accreditation Commission for Early Care and Education Programs (NAC) is sponsored by the National Association of Child Care Professionals (NACCP). NACCP is the nation's leader among associations serving child care owners, directors and administrators. The organization's goal is to strengthen and enhance the credibility of leaders in the field of early child care and education by providing membership services and benefits. For more information about NACCP and NAC, please visit www.naccp.org.

NAC is managed by
National Association of Child Care Professionals
7608 Highway 71 West, Suite E
Austin, Texas 78735
1.800.537.1118
512.301.5557 512.301.5080 FAX
www.naccp.org

Toddle Town, Inc
208 E Lincoln St.
Belleville, IL 62220
618-234-3832

Dear Parent,

Welcome to our screening and monitoring program. Because your child's first 5 years of life are so important, we want to help you provide the best start for your child. As part of this service, we provide the Ages & Stages Questionnaires, Third Edition (ASQ-3), to help you keep track of your child's development. A questionnaire will be provided every 2, 4, or 6 months period. You will be asked to answer questions about some things your child can and cannot do. The questionnaire includes questions about your child's communication, gross motor, fine motor, problem solving, and personal-social skills.

If the questionnaire shows that your child is developing without concerns, we will provide some activities designed for use with ASQ-3 to encourage your child's development and will provide the next questionnaire at the appropriate time.

If the questionnaire shows some possible concerns, we will contact you about getting a more involved assessment for you child. Information will only be shared with other agencies with your written consent.

We look forward to your participation in our program.
Sincerely,
Beth Maloney
Director

Demographic Information Sheet

Today's date: _____

Child's name (first /middle/last): _____

Child's date of birth (MM/DD/YYYY): _____ /_____ /_____

If child was born prematurely, # of weeks premature: _____

Child's gender: ◯ Male ◯ Female

Child's ethnicity: _____

Child's birth weight (pounds/ounces): _____

Parent/primary caregiver's name (first/middle/last): _____

Relationship to child: _____

Street address: _____

City: _____

State/Province: _____ ZIP/Postal code: _____

Home telephone: _____ Work telephone: _____

Cell/other telephone: _____

E-mail address: _____

Child's primary language: _____

Language(s) spoken in the home: _____

Child's primary care physician: _____

Clinic/location/practice name: _____

Clinic/practice mailing address: _____

City: _____

State/Province: _____ ZIP/Postal code: _____

Telephone: _____ Fax: _____

E-mail address: _____

Please list any medical conditions that your child has: _____

Please list any other agencies that are involved with your child/family: _____

_____

_____

Program Information

Child ID #: _____

Date of admission to program: _____

Child's adjusted age in months and days (if applicable): _____

Program ID #: _____

Program name: _____

ASQ-3™

Consent Form

The first 5 years of life are very important for your child because this time sets the stage for success in school and later life. During infancy and early childhood, your child will gain many experiences and learn many skills. It is important to ensure that each child's development proceeds well during this period.

Please read the text below and mark the desired space to indicate whether you will participate in the screening/monitoring program.

○ I have read the information provided about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and I wish to have my child participate in the screening/monitoring program. I will fill out questionnaires about my child's development and will promptly return the completed questionnaires.

○ I do not wish to participate in the screening/monitoring program. I have read the provided information about the Ages & Stages Questionnaires®, Third Edition (ASQ-3™), and understand the purpose of this program.

_____

Parent's or guardian's signature

_____

Date

Child's name: _____

Child's date of birth: _____

If child was born 3 or more weeks prematurely, # of weeks premature: _____

Child's primary physician: _____

Toddle Town – Toddler House – Learning Journey Rate Schedule and Policies

weekly rates are as follows:

6 weeks to 24 months	$210.00
2 year old	156.00
Part time 2 year old	105.00
Preschool (3,4 & 5 year old)	136.00
Part time preschool	94.00
Registration Fee for one child	20.00
Registration Fee for family	30.00

1. Registration fee is payable upon enrollment and again each year on September 1. Registration fees are non-refundable. Fees paid after May 1 will not need to be repaid in September.

2. All fees are non-refundable. Never send money in with a child. Please pay by check and place in mailbox in entry hall or office. Please give cash to a teacher or director. A receipt will be provided upon request.

3. Weekly rates are payable on Friday for the week to come. We cannot give tuition refunds for days your child is absent. An exception may be made if your child is absent due to an extended illness. If the center is not notified that the child is out due to vacation or illness the full rate of tuition will be charged.

4. A late charge of $25.00 per week will be assessed for payments not made on a timely basis. If payments are 2 weeks late the child may not attend the center.

5. A fee of $25.00 will be assessed for non-sufficient funds check.

6. If a child remains at the center past 6:00 pm an overtime fee of $5.00 is charged after 5 minutes or part there of. An additional $1.00 per minute will be charged after that. The fee is due immediately upon arrival. Your child would appreciate a message from you if you are going to be late.

7. Full rates are due every week with no exceptions for holidays. New Year's Day, Memorial Day, July 4th, Labor Day, Thanksgiving Day and the day after, Christmas Eve and Christmas Day.

8. Two weeks notice must be given if your child is to be withdrawn.

9. After full time enrollment of 6 months the child may be out for a 1-week vacation with credit for the week. Maximum of 2 weeks per year will be allowed for full time children. Children enrolled on a part-time basis will be given 1-week vacation (example: 3 days enrolled = 3 days vacation)

10. If your child is out for the summer, no vacation is given during the year.

Late Fee Policy

By signing this document I understand that in the event monies are owed for a period of time, in excess of thirty days, Toddle Town, Toddler House and Learning Journey reserve the right to demand payment in full. If the outstanding balance is not paid in full upon demand the undersigned agrees to pay reasonable interest on the balance plus all costs incurred by Toddle Town, Toddler House and Learning Journey in collecting the outstanding balance, including all reasonable attorney fees and all court costs.

My child_____is enrolled in Learning Journey (Toddle Town, Inc.) Child Care Program. The weekly tuition for my child is _____.

I have read the policies regarding tuition payment procedures and agree to abide by the

Parent/Guardian:_____Date:_____

Parent/Guardian:_____Date:_____

Director of Child Care:_____Date:_____

Toddle Town, Inc.
208 S Jackson St.
Belleville, IL 62220
618-234-3832

Dear Parents,

We are attempting to streamline and make our billing more effective. We will begin the new system on April 1, 2015.

Because of this, we are offering two ways to keep you informed on your tuition. A statement will be issued on the 1st of every month by your preferred method.

1) If you want to receive a paper statement in your child's cubby please initial here _____.
2) If you want to receive an email, please initial here _____. Please provide us with your email address.

_____.

We appreciate your cooperation in this matter. If you have any questions in the future, please contact Toddler House @ 618-234-3832 and speak with Jackie, Beth or Becky.

Thank You

Becky Fudge

Becky Fudge

2015-2016 Head Start/Early Head Start Enrollment Application

Applicant & Family Member Information

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient

Primary Health Coverage	Other Health Coverage	Insurance #	Medicaid	Medicaid #
			☐ Not Eligible ☐ On Medicaid ☐ Potentially Eligible	

Adult 1

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED	☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed	☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled	☐ Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent If teen parent, subsidized? ☐ Yes ☐ No

E-mail Address:

Adult 2

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient

Highest Grade Completed		Employment Status		Child's Relationship	Custody	Check all that apply:
☐ Associate's ☐ Bachelor's ☐ Col Deg/Train ☐ Col or Adv Train ☐ GED	☐ Grade 10 ☐ Grade 11 ☐ Grade 12 ☐ < Grade 9 ☐ HS Graduate ☐ Master's	☐ Full Time ☐ Part Time ☐ Seasonal ☐ Unemployed	☐ Full Time & Training ☐ Part Time & Training ☐ Training or School ☐ Retired or Disabled	☐ Natural/Adopted/Step ☐ Grandchild ☐ Niece/Nephew ☐ Foster ☐ Other	☐ Yes ☐ No	☐ Lives with Family ☐ Provides Financial Support ☐ Teen Parent If teen parent, subsidized? ☐ Yes ☐ No

E-mail Address:

Additional Child (Non-Applicant) *

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient

Additional Child (Non-Applicant) *

First	Middle	Last	Birthday	Gender

Race	Hispanic	English Proficiency	Other Language	Other Language Proficiency
☐ Asian ☐ American Indian/Alaska Native ☐ Black ☐ Hawaiian/Pacific Islander ☐ White ☐ Multi-Racial ☐ Other: _____	☐ Yes ☐ No	☐ None ☐ Little ☐ Moderate ☐ Proficient		☐ Poor ☐ Moderate ☐ Proficient

** If a family has more than one child applying for services, please complete a separate copy of this form for each applicant.*

2015-2016 Head Start/Early Head Start Enrollment Application

Doctor/Dentist of Applicant			
Physician's Name	Address	Phone ( )	
	City	State	Zip
Dentist's Name	Address	Phone ( )	
	City	State	Zip

Eligibility

Program	Program Term	Agency	Site	Classroom
☐ EHS ☐ HS	2015/2016	SIUE Head Start/Early Head Start		

Application Status		Application Date	Waitlisted Date	Accepted Date
☐ Complete & Verified ☐ Incomplete	☐ Incomplete, info not returned ☐ Other - specify in notes			

Releases Signed	Date Signed	Birth Verified?
☐ Yes ☐ No		☐ Yes ☐ No

Enrollment Notes

Eligibility Date	Eligibility Income	Number in Family	Income Status	Participation Year	Eligibility Criteria Total Points	Eligible Sibling Next Year
	$		☐ Eligible (0-100%) ☐ Over Income ☐ Foster child ☐ Public assistance ☐ Homeless			☐ Yes ☐ No

CACFP Date	CACFP Income	Per	CACFP Status
	$	☐ week ☐ month ☐ year	☑ Free ☐ Paid ☐ Reduced

Additional Information

Was child referred to program? ☐ No ☐ Yes If yes, by whom? Why?:

Any specific family need or crisis? ☐ No ☐ Yes If yes, describe:

Child has special need(s) or an Individualized Education Plan? ☐ No ☐ Suspected ☐ Yes
Describe (if disability has been diagnosed, give date/source.):

Releases Signed? ☐ No ☐ Yes

Date Signed:

For Expectant Families use only

Is this applicant an Expectant Family? ☐ Yes ☐ No If yes, complete and attach the Pregnancy Data form for Expectant Families.

CONFIDENTIALITY POLICY

In accordance with the Head Start Performance Standards, all information obtained about children and families is confidential. Files are kept in locked file cabinets and Head Start staff access is controlled on a "need to know" basis. A file control system is used to ensure confidentiality. Parents can make a written request to review their own child(ren)'s file(s) ONLY at any point during the program year. Professionals serving on federal and internal review teams are allowed to review files in their capacity as monitors of federal funding. Other agencies or organizations must obtain written parent/guardian consent to review information in a child/family file.

Certification: I certify that this information is true. If any part is false, my participation in this agency's programs may be terminated and I may be subject to legal action. I have read and understand the SIUE Head Start Confidentiality Policy.

Parent/guardian's signature: Date:

Verifying Staff Signature: _____ Date: _____

Site Manager's Signature: _____ Date: _____

SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

NO INCOME STATEMENT

SIUE Head Start/Early Head Start
Southern Illinois University Edwardsville

Child's Name: _____

I, _____ attest that I have no source
Parent/Guardian/Caregiver Name
of income.

☐ I have or ☐ I have not applied for TANF benefits.

_____ _____
Parent/Guardian/Caregiver Signature *Date*

SIUE Head Start/Early Head Start
2015-2016 Family Needs Assessment

Child's Name _____ DOB _____ Center _____

The Family Assessment will help you identify your family's strengths, address any concerns your family may have, indicate topics of information that interest you, and deal with challenges that affect your family.

I would like information presented at the Parent Committee Meetings on the following topics:

☐ Nutrition	☐ ADH/ADD	☐ Kindergarten Readiness	☐ Communication
☐ Family Strengths	☐ Healthy Pregnancy	☐ Parent/Child Activities	☐ Job Readiness
☐ Health Care (Adult)	☐ Positive Discipline	☐ Drug/Alcohol Education	☐ Support Groups
☐ Kids &Self Esteem	☐ First Aid	☐ Money Matters	☐ Financial Literacy
☐ Managing Stress	☐ Domestic Violence	☐ Transitions	☐ Dental health
☐ Food and Fitness	☐ Establishing Credit	☐ Other Topics_____	

I am available for meetings at the following times:

☐ Morning ☐ Afternoon ☐ My talents and hobbies are_____

Parents can get involved in Head Start in many ways:

- **Get involved with your child's school** — get to know the staff, join your center's policy/parent committee, attend Family Fun Day, Literacy Night ,male involvement activities, volunteer at your child's center, or sign up for educational events or help prepare activities at home
- **Keep a learning culture in your home** — Use household materials, family routines and conversations to help your children learn concepts, develop language and other skills, and explore feelings.
- **Spend quality time with your child** — eat meals together, talk during bath time, read together at bed time, do family activities on weekends, take home activities.

How would you like to participate in the Head Start/Early Head Start Program?:

- _____
- _____
- _____

These statements are true to the best of my knowledge. Additionally, I may additionally ask Head Start staff for assistance or information at any time.

Parent Signature: _____ **Staff Signature:** _____

Date:_____

Family Needs Assessment (15-16)

Participant Name: _____ **ChildPlus ID:** _____

Date Completed: _____ **Case Worker:** L. Jackson **School Year:** 2015/2016

Scoring Legend: 3.0 Strength 1.0 Needs Assistance
2.0 Making Progress

Assessment Item	Preliminary Score	Midyear Score	End of Year Score
Family Well-Being			
Safety			
Budget and financial help (Budget, financial literacy, credit counseling, child support enforcement) What area?			
Employment (information, resume writing, job skills etc.)			
Food and Nutrition			
Housing Stability			
Utility assistance			
Physical & mental wellness			
Health/medical/dental care for my child and family			
Transportation			
Positive Parent-Child Relationship			
Spending Quality Time with my Child			
Learning new ways to understand and respond to child's behavior			
Using positive parenting practices			
Overcoming Behavioral challenges			
Learning New ways to ensure the health and safety of the child			
Families as Lifelong Educators			
Understanding of how my child is developing and learning			
How to partner with Head Start to support child's learning			
Communicating with my Child's Teachers			
Supporting Learning at Home/supporting IEP/IFSP or therapy goals at home			
Family as Learners			
My own education (basic life skills, budgeting, socialization, time management)			
Do you need to get your GED			
Do you want to attend college			
Do you need to take English as a Second Language (ESL) classes			
Job training and career goals			

Assessment Notes:

SIUE Head Start/Early Head Start
2015-2016 Family Partnership Agreement

The Family Partnership Agreement was explained to me and I am willing to participate in this agreement at this time. This tool will be utilized as we partner together to identify and meet my goals. Information shared with SIUE HS/EHS staff will be kept confidential unless a release form is signed by the family.

Child's Name: _____ Parent/Guardian: _____ Center: _____

Goal: _____

_____

Strengths & resources to meet goal: _____

_____

Date	Task/Strategy	By Whom	Expected Completion	Date Attained	Comments/Progress

_____ _____
Parent/Guardian Signature *Date*

_____ _____
Staff Signature *Date*

➢ ➢ ➢ **Always give a copy of the plan to the family** ➣ ➣ ➣

GUIDANCE & DISCIPLINE POLICY

Discipline problems are to be handled by staff in a way that encourages children to develop self-control.

Positive Guidance Approaches Implemented By Staff-

- Anticipate and plan ahead so that you can head off problems
- Look for reasons why a child is misbehaving. Discuss the situation with the Center Coordinator & the child's parent(s)
- Focus on the child's behavior, not on the child's value as a person
- Help children understand the consequences of their actions
- Explain the choices available
- Help children use problem-solving skills to develop solutions
- Help children refrain from dwelling on mistakes so they can learn to move on
- Watch for restlessness
- Tell children what to do, rather than what not to do. For example, "Let's get some paper to write on." Rather than, "Don't write in the book."
- Adults make a point to talk about children's positive behavior. For example, "You remembered to give the truck to Daniel when you were finished with it. Good remembering!
- Adults offer reasons for rules. For example, "I'm concerned you will slip and hurt yourself when you run in our room. We walk inside."
- Rules are focused around safety, respect for property and for others.
- Adults model valued behaviors that they wish children to use. For example, adults are courteous to children and are good listeners.
- Adults redirect children to more acceptable activity.

Acceptable Corrective Discipline Methods- Judgments concerning acceptable methods of corrective discipline will have to be made daily by Head Start staff, and these decisions will be subjective in many cases. Staff persons should select a method of corrective discipline they feel will be effective with a particular child and situation. If a staff person has doubts or concerns about the acceptability of a discipline method, the Center Coordinator/Home-Based Supervisor must be consulted before the method is implemented. The Special Services staff is also available for consultation on matters of discipline.

1. THE CHILD(REN) SHOULD:
   a. Be asked to stop the behavior and given an explanation of why.
   b. Be given a demonstration of appropriate behavior through modeling and guidance.

Infant/Toddler caregivers should provide an environment which permits the children to explore and experiment with their environment while being safe from accidents/things that will hurt them. As the children reach the toddler age they begin to understand directions better and are able to follow simple directions.

- Rules should be short and simple.
- Inappropriate behaviors should be handled in a way that allows the child to maintain their dignity.
- State rules as suggestions, not mandates
- Focus on the child's behavior, and don't make judgments about a child's character.
- Be consistent
- Talk and act simultaneously
- Use Redirection

Termination Policy Due To Disciplinary Issues- Any child who, after attempts have been made to meet the child's individual needs, demonstrates an inability to benefit from the services offered by the facility, or whose presence is detrimental to the group, shall be eligible for discharge from the facility. Prior to the decision to terminate a child from SIUE Head Start/Early Head Start being made, a conference will be held with the parent(s) to discuss the issue(s) and develop a behavior modification plan. Designated staff will be responsible for implementing positive, appropriate discipline methods on a consistent basis, evaluating outcomes, making modifications, and communicating with parents on a daily basis. If there is no improvement within set time lines, a staffing will be held which will include both Head Start center and central office staff. A recommendation will be made and presented to the SIUE Head Start/Early Head Start Program Director and Assistant Program Director. Only the Head Start Program Director can make the decision to terminate a Head Start child due to disciplinary issues.

Parents/staff, after reading the above GUIDANCE & DISCIPLINE POLICY, please sign and date below.

Check one:
☑ Parent
☐ Staff

Signature _____ Date _____

Parent's copy -kept in child's file *Staff's copy – kept in staff file*

SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE
EAST ST. LOUIS CENTER

CONSENT TO RELEASE OR OBTAIN INFORMATION

SIUE Head Start/Early Head Start

TO: _____ DATE: _____

_____ RE: _____

_____
Child's Date of Birth

_____

_____
Telephone Number

The parent/guardian of the above mentioned child gives his/her permission to SIUE Head Start to ☑ Obtain ☐ Release (check only one) information regarding diagnostics and/or other relevant materials that have been completed on his/her child, which would assist in providing a continuum of service. The specific information requested is:

BloodPressure/GrowthAssessment/Hemoglobin/Hematocrit/LeadAssessment/Physical Exam/Tuberculosis/ Well-Baby Checks

PLEASE FORWARD INFORMATION TO:

SIUE HEAD START
Agency Name
Kimberly Granger
Contact Person
601 James R. Thompson Blvd. Bldg. C, Suite 103
Address
East St. Louis Illinois 62201
City/State/Zip Code
618-482-8339
Telephone Number

PARENT AUTHORIZATION:

_____ _____
Parent/Guardian Signature *Date*

_____ _____
Head Start Staff/Witness Signature *Date*

Distribution: *Original - Agency (To)* *Copies - Child/Family File*

HOME VISIT FORM **VISIT #____**

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

SIUE Head Start/Early Head Start

☐ **Teacher Home Visit** ☑ **Social Service Home Visit**
☐ **Expectant Families Home Visit** ☐ **FCCH Home Visit**

Date of Visit: _____ Length of Visit: _____

Participant's Name: _____ HS/EHS Site: _____

Location of Home Visit/Address: _____ Telephone: _____

_____
City, State and Zip

I. Purpose of Visit: _____

II. Referrals/Follow-up (social services, education, health concerns, behavioral health, etc.) Needed: _____

III. Parent/Participant: Comments: _____

IV. Outcome of Visit: _____

_____ _____
Parent/Guardian/Participant's Signature Date

_____ _____
Staff Signature Date

2015-2016

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE
EAST ST. LOUIS CENTER

GENERAL CONSENT FOR SERVICES

SIUE Head Start/Early Head Start

(To be used at initial enrollment)

I, _____ hereby give permission for my child
(Parent/Guardian's Name)

_____ to receive the following services
(Child's Name)
through the SIUE Head Start/Early Head Start program:

- Behavioral Observations
- Blood Pressure Screening
- Developmental Screenings
- Height/Weight/BMI Screenings*
- Speech & Language Screenings
- Vision & Hearing Screenings*

***Temperature, pulse, respirations and blood pressure will be done routinely with these procedures.**

Please initial the following:

___ I understand that my TANF (I.D.P.A.) number, if applicable, listed on my child's enrollment application form, may be used when obtaining services.

This consent form and the service(s)/item(s) marked above have been explained in full to me and I understand it. I understand that this consent is valid for the 2015 – 2016 Head Start/Early Head Start program year.

_____ _____
*Parent/Guardian Signature** *Date**

_____ _____
*Head Start Staff/Witness Signature** *Date**

***Signatures are invalid if signed prior to June 1st of the current program year.**

Distribution: Original-file; Copies-providers

Rev. 5/15

SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

(PLEASE PRINT)

Today's Date	Primary Care Provider		
PATIENT INFORMATION			
Last Name	First Name	Middle Name	Birthdate
Sex: ☐ M ☐ F	Email	Allergies:	
Street Address:			
City:	State:	ZIP Code:	Phone number:
Race/Ethnicity: ☐ African American ☐White ☐Asian/Pacific Islander ☐Native American ☐Hispanic ☐Other/Unknown			
Parent/legal guardians name:	Address (if different from above):	Phone:	
INSURANCE INFORMATION			
(If no medical insurance information is given, the patient or guardian will be responsible for the charges.)			
Person insured (if different from above):	Birthdate:	Address (if different from above):	
Name of insurance:	Group/Medicaid/Medicare#	Policy #	
IN CASE OF EMERGENCY			
Name of friend/relative (not living in same location)	Relationship	Phone Number	

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to Southern Illinois University Edwardsville (SIUE) WE CARE Clinic. I understand that I am financially responsible for any balance. I also authorize SIUE WE CARE Clinic or insurance company to release any information required to process my claims. I authorize patient information be shared with the Illinois State wide immunizations registry (I-CARE). I understand that this consent will be in effect July 1 of this year to June 30 of the following year. I understand that de-identified medical data may be used for research purposes. Only aggregate data will be used.

This is also consent for any other emergency care WE CARE Clinic may provide.

☐ **I decline access to electronic personal health records (PHR)**

_____ _____

Patient/Guardian signature Date

SEE REVERSE SIDE

SIUE WE CARE Clinic
601 James R. Thompson Blvd., Bldg. D, Ste. 2015, East St. Louis, IL 62201

Center:_____ 2015-2016

HEALTHY KIDS EXPRESS CONSENT AND MEDICAL HISTORY FORM

Please complete a form for each child and return to his/her program

CHILD'S NAME LAST FIRST MIDDLE INITIAL ☐ MALE ☐ FEMALE DATE OF BIRTH

SCHOOL GRADE/AGE

RACE (optional-check all that apply):
☐ American Indian/Alaskan Native ☐ Asian ☐ Bi or Multi-Racial ☐ Black/African American ☐ Middle Eastern
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Unknown ☐ Other _____ ☐ Decline to Answer

ETHNICITY: ☐ Hispanic or Latino ☐ Non- Hispanic or Latino ☐ Unknown ☐ Decline to Answer

PARENT/GUARDIAN NAME LANGUAGE SPOKEN IN HOME PREFERRED WRITTEN LANGUAGE

HOME ADDRESS STREET APT # CITY STATE ZIP CODE

HOME PHONE (INCLUDE AREA CODE) CELL/PAGER WORK PHONE EMAIL ADDRESS (optional)

NAME OF EMERGENCY CONTACT CELL/HOME PHONE WORK PHONE RELATIONSHIP TO CHILD

NAME OF DOCTOR/CLINIC PHONE NAME OF DENTIST/CLINIC PHONE

DOES YOUR CHILD HAVE HEALTH INSURANCE: ☐ NO ☐ YES...NAME OF INSURANCE PROVIDER: _____

DOES YOUR CHILD RECEIVE FREE OR REDUCED SCHOOL LUNCH: ☐ NO ☐ YES

I have read and understand the nature of the screening services offered to my child and have completed all blanks and/or sought answers to my questions (if any) related to the screenings. I authorize and consent for my child to participate in the indicated screening(s) by my signature below.

PARENT/GUARDIAN SIGNATURE **DATE** (CONSENT IS VALID FOR ONE YEAR)

IF YOU ***DO NOT*** WANT SCREENINGS FOR YOUR CHILD, PLEASE CHECK THIS BOX. ☐ *[No signature needed]*

PLEASE CHECK THE SCREENING SERVICES YOU WOULD LIKE FOR YOUR CHILD:

☐ **HEARING** ☐ **VISION** ☐ **DENTAL EXAM*** with fluoride varnish if applicable (3 years and up)
☐ **LEAD**** (2-5 years) ☐ **ANEMIA**** (Low iron) ☐ **CHOLESTEROL/GLUCOSE testing**

Hearing and Vision for Head Start children only.

*** For Dental - PERMISSION TO GIVE IBUPROFEN** ☐ Yes ☐ No

**** For Lead and Anemia: Blood may need to be drawn from your child's vein if the finger stick results are abnormal. The results from the blood draw may be shared with the Department of Health and your child's primary care provider.**

NOTE: Release is <u>not</u> required for your child to obtain a screening but assists in coordinating care/treatment of your child with other providers

MEDICAL HISTORY - PLEASE CHECK IF YOUR CHILD HAS ANY OF THE FOLLOWING:

☐ ANEMIC (Low iron in blood) ☐ EYE PROBLEMS/SURGERY ☐ FREQUENT EAR INFECTIONS ☐ ASTHMA ☐ CONGENITAL HEART DEFECT
☐ LEAD (History of high levels) ☐ WEARS GLASSES ☐ EAR SURGERY (TUBES PLACED) ☐ HIV/AIDS ☐ MENTAL/PHYSICAL DISABILITY
☐ HIGH BLOOD PRESSURE ☐ SICKLE CELL DISEASE ☐ HEARING PROBLEMS/HEARING AIDS ☐ BLEEDING DISORDER ☐ PREGNANT
☐ NONE OF THE ABOVE ☐ OTHER: _____

PLEASE EXPLAIN ANY ITEM CHECKED ABOVE: _____

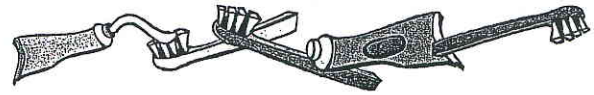
HOSPITALIZATIONS: _____ SURGERIES: _____

LIST ANY MEDICATIONS YOUR CHILD TAKES: _____

LIST ANY ALLERGIES YOUR CHILD HAS: ☐ LATEX ☐ SEASONAL ☐ FOOD: _____ ☐ DRUG: _____

PLEASE LIST ADDITIONAL CONCERNS YOU MAY HAVE ABOUT YOUR CHILD: _____

SIUE Head Start
DENTAL CONSENT FORM



PERMISSION FORM GOOD FROM
July 1, 2015 –June 30, 2016

PLEASE PRINT IN INK!!! DO NOT STAPLE

NAME OF CENTER _____ TEACHER _____

Dear Parent or Guardian,
SIUE Head Start has arranged for dental services for your child, which will include an exam, cleaning, fluoride treatment, and may include sealants. A licensed, experience dentist, hygienists, and assistant will come to your child's school with portable equipment to provide these services. These services are available for all children. In order for your child to receive these services: YOU MUST PROVIDE ALL INFORMATION REQUESTED BELOW AND SIGN IN THE AREA INDICATED. The information provided will be in compliance with HIPPA. Rules and regulations are available at the Board office. By signing below allows IDPH to perform sealant retention checks for 1 year after sealants were placed.

Child's Name _____ Birth Date _____ Home Telephone _____

Address _____ City _____ Zip _____ Sex: M / F

DOES YOUR CHILD HAVE PRIVATE INSURANCE? Y/N IF YES, INCLUDE INSURANCE NAME AND ID# _____

IS YOUR CHILD ON PUBLIC AID/MEDICAL CARD? Y/N CHILD ON "ALL KIDS" INSURANCE? Y/N

MOLINA HEALTH CARE PLAN? Y/N HARMONY HEALTH PLAN? Y/N MERIDIAN HEALTH PLAN? Y/N

**********IF YOUR CHILD IS ELIGIBLE **********

FOR PULIC AID, ALL KIDS, MOLINA, MERIDINA OR HARMONY (FHP) INCLUDE CHILD'S ID NUMBER _____
(9-digit id number across from child's name on medical card)

PLEASE CHECK IF YOUR CHILD HAS ANY OF THE FOLLOWING MEDICAL HISTORY THAT MAY COMPLICATE DENTAL TREATMENT:

Heart Murmur _____ Latex Glove Allergy _____ Hepatitis _____ Bleeding Disorder _____
Epilepsy _____ Seizures _____ Other _____

PARENT'S SIGNATURE _____ DATE _____

**********DO NOT WRITE BELOW THIS LINE. TO BE COMPLETED BY DENTIST**********

PREVIOUS DENTAL TX

_____ _____
_____ _____
_____ _____
_____ _____

PATHOLOGY PRESENT

Oral Hygiene Status: _____ Good ____ Fair _____Poor
Periodontal Status: _____ Good ____Fair _____Poor

_____ _____ _____

TREATMENT NEEDED

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

__ Urgent
__ Simple Restorative (less than five fillings)
__ Complex Restorative (Five or more fillings)
Space maintenance, crowns, etc.
__ Preventative Dental Care Only (sealants, prophylaxis, etc.)
__ No Treatment Required

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Treatment Date _____ Dentist's Signature _____ Treatment Date _____

D0601 _____ D0602 _____ D0603 _____
Treatment completed _____
Perioscale Treatment Provided _____

D0601 _____ D0602 _____ D0603 _____
Treatment completed _____
Perioscale Treatment Provided _____

SIUE Head Start/Early Head Start
Health History/*Historial de Salud del Hijo*
2015-2016
Complete if your child has NEVER attended SIUE Head Start/Early Head Start

Child's Name/*Nombre del Niño*: _____

D.O.B./*Fecha de Nacimiento* _____ **Gender/*Sexo*:** ☐ M/*Varón* ☐ F/*Hembra*

CHILD'S HEALTH HISTORY/ *HISTORIAL DE INFORMACIÓN DE SALUD DEL NIÑO*

	Yes/*Sí*	No	
1.	☐	☐	**Does your child have medical coverage?/*¿Su hijo tiene cobertura médica?*** **If yes, what type?** *En caso afirmativo, ¿que tipo?* ☐**Medical Card/*Carta Médico*** ☐**Private Insurance/*Seguro Privado*** ☐ **Other/*Otro*** _____
2.	☐	☐	**Does your child have a primary care doctor/clinic?*/*¿Su hijo tiene un doctor/clínica principal?*** **Name of doctor/clinic/*Nombre del doctor/clínica*** _____ **Date of child's last physical exam/*Fecha del último examen físico del niño*** ___/___/___ **Date of next appointment/*Fecha de la próxima cita*** ___/___/___
3.	☐	☐	**Was your child born premature?/*¿Su hijo nació prematuro?*** **If yes, how many weeks premature?/*En caso afirmativo, ¿cuántas semanas prematuro?*** _____ **Baby birth weight/*Peso del bebé al nacer*** _____
4.	☐	☐	**Were there any significant problems during the pregnancy or birth?/*¿Había cualquier problema significante durante el embarazo o el nacimiento?* If yes, please describe/*en caso afirmativo, por favor describe*** _____
5.	☐	☐	**Has your child had surgery or been hospitalized?/*¿Su hijo ha tenido una cirugía o ha sido hospitalizado?*** **Date and Reason/*Fecha y razón*:** _____

Does your child have or has your child had the following?/*¿Su hijo tiene o ha tenido las siguientes condiciones?*

	Yes/*Sí*	No	
6.*	☐	☐	**Asthma or respiratory problems*/*Asma o problema respiratorio**** ***If yes, please describe*/*En caso afirmativo por favor describe*** _____
7.*	☐	☐	**Seizures or other neurological problems*/*Convulsiones u otro problema neurológico**** ***If yes, please describe/ *En caso afirmativo por favor describe*** _____
8.*	☐	☐	**Heart or other cardiovascular problems*/*Problema con el corazón u otro problema cardiovascular**** ***If yes, please describe/*En caso afirmativo, por favor describe*** _____

Does your child have or has your child had the following?/*¿Su hijo tiene o ha tenido las siguientes condiciones?*

	Yes/*Sí*	No	
9.	☐	☐	**Bowel or other Gastro-Intestinal problems/*Problemas intestinales u otras problemas gastrointestinales***
10.*	☐	☐	**Eczema or skin problems/*Eczema o problemas con la piel***
11.	☐	☐	**Frequent ear infections or tubes/*Infecciónes del oído frecuentes o tubos*** **If yes, what date were tubes put in?/*En caso afirmativo, ¿en qué fecha le pusieron los tubos?*** _____
12.*	☐	☐	**Diabetes or other endocrine problems/ *Diabetes u otro problema endocrino***
13.	☐	☐	**Blood Disorder or Disease/*Desorden o enfermedad de sangre***
14.	☐	☐	**Has your child ever been screened for tuberculosis (TB)?/*¿Su hijo ha tenido un examen de tuberculosis(TB) alguna vez?*** **If yes, what were the results?/*En caso afirmativo, ¿qué fue el resultado?*** ☐**Positive/*Positivo*** ☐**Negative/*Negativo*** **Was medication taken?/*¿Tomó medicamento?*** ☐**Yes/*Sí*** ☐**No**
15.	☐	☐	**Has anyone in your child's home been screened for tuberculosis (TB)?/** *¿Alguien en la casa de su hijo ha tenido un examen de tuberculosis (TB)?* **If yes, has anyone tested positive?/*En caso afirmativo, ¿alguien tuvo un resultado positivo?*** ☐**Yes/*Sí*** ☐**No** **If yes, who and when?/*¿En caso afirmativo, ¿quién y cuándo?*** _____

All shaded areas with an asterisk requires a referral to be forwarded to Health Services

SIUE Head Start/Early Head Start
Health History/*Historial de Salud del Hijo*
2015-2016
Complete if your child has NEVER attended SIUE Head Start/Early Head Start

			¿Su hijo está recibiendo fluoruro por medio del agua que toma o por un suplemento de fluoruro recetado?
27.	☐	☐	**Does this infant have his or her gums or teeth wiped twice per day?/** *¿Su bebé se le limpian los dientes o las encías dos veces por día?*
28.	**How would you rate your child's dental health?/***¿Cómo se describe usted la salud dental de su hijo?* ☐**Very Good/***Muy bien* ☐**Somewhat Good/** *Bien* ☐**Fair/***más o menos bien* ☐**Somewhat bad/** *no muy bien* ☐**Very Bad/** *muy mal*		

NUTRITION/*NUTRICIÓN*

	Yes/*Sí*	No	
29.	☐	☐	**Is your child receiving WIC?/** *¿Su hijo está recibiendo WIC?* ☐East Side Health District. ☐St. Clair County Health Dept.
30. *	☐	☐	**Do you avoid feeding your child any foods for health, religious or other reasons?/** *¿Evita usted darle a su hijo caulquier comida por razones de salud, religión, u otra razón?* **If yes, please describe/** *En caso afirmativo, favor de describir* _____
31.	☐	☐	**Does your child take iron supplements? /** *¿Su hijo toma suplementos de hierro?*
32. *	☐	☐	**Is your child on a special diet?*/** *¿Su hijo tiene una dieta especial?** **If yes what kind?/** *En caso afirmativo, ¿qué tipo?* _____
33. *	☐	☐	**Does your child eat non food items such as dirt, clay, paint chips, or starch?/** *¿Su hijo come objetos que no sean comida tales como tierra, arcilla, pedacitos de pintura, o harinas?* **If yes, please describe/** *En caso afirmativo, favor de describir* _____
34. *	☐	☐	**Does your child have?/** *¿Su hijo tiene?* ☐**trouble chewing/***problemas al masticar* ☐**trouble swallowing/***problemas al tragar* ☐**a gag reflex/***reflejo de mordaza* **If yes, please describe/** *En caso afirmativo, favor de describir* _____
35.	☐	☐	**Does your child take a bottle?/***¿Su hijo toma de biberón?* **If yes, when?/***En caso afirmativo, ¿cuándo?* _____ **What is in the bottle?/***¿Qué contiene el biberón?* _____
36. *	☐	☐	**Do you put your infant to bed with a bottle? If yes, what is in the bottle?/** *¿Se le da el biberón su bebé cuando se le acuesta? En caso afirmativo, ¿que contiene el biberón?* _____
37. *	☐	☐	**Do you put food or cereal in the bottle?/** *¿Pone usted comida o cereal en el biberón?*
38.	☐	☐	**Can he/she use a sippy cup by him/herself?/** *¿Él/ella puede usar una taza con tapa sin ayuda?*
39.	**How often does your child use a sippy cup?/***¿Con qué frecuencia usa una taza con tapa para niños pequeños?* ☐**Never/***Nunca* ☐**Occasionally/***De vez en cuando* ☐**Several times a day/***Varias veces al día*		
40.	**Do you have these things where you live?/***¿Tiene usted las siguientes cosas donde vive?* Check all that you have/ *marque todas que aplican* ☐**Tables and chairs/** *mesa y sillas* ☐**Running water/** *agua corriente* ☐**Microwave/** *microonda* ☐**High Chair/** *silla alta* ☐**Refrigerator/** *refrigeradora* ☐**Freezer/** *congelador* ☐**Stove/***estufa*		

All shaded areas with an asterisk requires a referral to be forwarded to Health Services

Returning Child Health Update 2015-2016

Effective 7/1/2015-6/30/2016

Child's Name: _____

Person Providing this Information: _____ Relationship: _____

Dear Parent/Legal Guardian:

Your child's health history continues to be important to us at Head Start. The SIUE Head Start/Early Head Start Health Services program provides health screenings for vision, hearing and height & weight. If there has been any new or changes to an existing health condition which affects your child's ability to participate in activities, it is your responsibility to notify the Head Start staff.

Within the time your child has been away from Head Start, has any concerns develop regarding:

	Yes	No		Yes	No
ADD (Attention Deficit Disorder)			Heart/Congenital Heart Defect/Heart Murmur)		
Allergies			Headaches or Migraines		
Asthma/Reactive Airway Disease			Hormone Deficiency (thyroid, growth, adrenal)		
Austism Spectrum Disorder			Immune Deficiency		
Behavior/Emotional Concerns			Metabolic Disorder		
Bleeding Disorders			Neurological Disorder		
Bone/joint/Muscle Concerns			Respiratory Infections Frequently		
Bladder or Kidney			Seizure (febrile or otherwise)		
Bowel Concerns (constipation/loose stools)			Sickle Cell Anemia		
Chicken Pox Disease			Sleep Concerns		
Concussion (Head Injuries)			Strep Throat		
Diabetes			Surgeries/Hospitalizations		
Digestive Concerns/Special			Tourette's Syndrome		
Emotional Concerns			Other		
Ear or Hearing Concerns					
Eye or Vision Concerns					
Gastro esophageal Reflux					
Genetic Disorders					
Growth Concerns (over/underweight, short stature)					

If you answered YES to any of the above, please explain:

_____

_____

_____

_____

_____

children's home + aid

SOUTHERN REGION

Regional Office
2133 Johnson Rd.
Granite City, IL
62040-3986
P: 618.452.8900
F: 618.452.9062

#6 Crossroads Ct.
Alton, IL
62002-4100
P: 618.462.2714
F: 618.462.1303

120 East A Street
Belleville, IL
62220
P: 618.235.5335
F: 618.235.5960

807 Martin Luther King Dr.
Suite C
East St. Louis, IL
62201-1704
P: 618.874.0216
F: 618.874.7340

Dear Families,

We are very pleased to announce that Children's Home + Aid in collaboration with Toddle Town has received a Prevention Initiative Grant from the Illinois State Board of Education. Through this funding, the Stronger Beginnings for Families program will continue to provide services to families with children age birth through 36 months.

These services are all designed to support you in fostering your child's development. Sherri O'Toole, who has years of experience working with young children and their families, has been hired as the Family Coach. The following services will be offered through this grant:

Individual visits by the Family Coach, which will include: parent education, information about child development, community resource referrals and fun interactive activities. These visits may take place in your home or at the center. Mrs. O'Toole will have daytime, evening and weekend hours at your convenience.
Parenting Workshops and Support Groups on a variety of topics
Child Development Screenings using the Ages and Stages Questionnaire (ASQ)
Referrals to community resources
Newsletters covering topics related to parenting and child development

Additionally, Mrs. O'Toole will be available at our center each week to answer questions and offer support to families with children 0-36 months. At Toddle Town, Mrs. O'Toole will be available on Tuesdays.

If you have questions or would like additional information, please contact Sherri O'Toole at 452-8900 x118.

We are looking forward to continuing Stronger Beginnings for Families!

Sherri O'Toole
Family Coach
Children's Home + Aid

Beth Maloney
Director
Toddle Town

Kim Hunt
Director of Child Care Services
Children's Home + Aid

Rebecca Fudge
Executive Director
Toddle Town

Stronger Beginnings For Families
Interest Survey

Yes! I would like to learn more about the Stronger Beginnings For Families Program offered by Children's Home + Aid at Toddler House and Toddle Town for families with children ages birth – 36 months.

I would like to know more about (check all that apply):

___ ASQ developmental screenings
___ Individual Visits
___ Classroom consultation
___ Support groups for parents
___ Parent education workshops
___ Referrals to community resources.

The best way to contact me is:
___ by phone.
___ at Toddle Town or Toddler House when I drop off or pick up (circle) my child.
___ in my home.

Please PRINT contact information:

Parent/Guardian Name: _____

Child's Name: _____

Child's Age and Date of Birth: _____
*Children must be between birth and 36 months of age to participate.

Phone number: _____
May a message be left at this number?
___ yes ___ no

Address: _____

***Please return this form to the center Director within one (1) week.**

ASQ Screening Response Form

I, _____ (parent/guardian), the parent/guardian of _____ (child) born on _____ (DOB) understand that a free child development screening is being offered at my child care center by Sherri O'Toole, Family Coach from Children's Home + Aid.

I understand that The Ages and Stages Questionnaire (ASQ) is filled out by parents and supplies information about how my child is developing in the areas of language, social skills, cognition and motor skills. The ASQ is used to track children's progress and identify strengths and areas in which they may need support. According to program guidelines, if I agree to participate I further understand that:

- I will receive feedback/information on my child's screening results from Mrs. O'Toole.
- Should the ASQ reveal areas in which my child may need developmental support, Mrs. O'Toole will assist my family by showing us ways to enhance our child's development, locating services, and sharing information with my child's teachers and pediatrician, with my written permission. I may also continue to complete ASQs to track my child's developmental progress.
- I may choose to discontinue at any time.
- The screening is free and voluntary.

At this time (initial one line):

_____ Yes, I would like my son/daughter to participate in the ASQ screening.
_____ I do not want my son/daughter to participate in the ASQ screening.

_____
Signed

_____
Date

**Please return this form to your childcare director within 1 week. **