Skip-a-Long
CHILD DEVELOPMENT SERVICES
A program of SAL Family and Community Services

4800 60th St., Moline, IL 61265 | (309) 764-8110

Davenport, IA
Milan, IL
Moline, IL
Rock Island, IL
www.skip-a-long.org

www.skip-a-long.org

Dear Family,

Welcome to **Skip-a-Long Child Development Services!**

During this unprecedented time, Skip-a-Long will be providing Emergency Child Care for Illinois essential workers as listed in Governor Pritzker's Executive Order. Skip-a-Long has been issued an Emergency Child Care license by the Illinois Department of Child and Family Services to provide Emergency Child Care services.

We will open for Emergency Child Care on **Monday March 30, 2020** at the Moline location, located at 4800 60th Street, Moline, IL. We will provide child care for children ages 6 weeks to 12 years, Monday through Friday, from 6:00 am – 5:30 pm.

Your child's safety, development, and education are our top priority. Class sizes will remain small, with no more than 10 people per classroom at one time. The center and classrooms will be cleaned and disinfected frequently throughout the day, and all children and staff will follow stringent hand-washing guidelines.

Please return the completed Enrollment Packet to the Site Director, Mary at mrosagastaldo@skip-a-long.org at least one day prior to your requested start date. All information must be completed in full and we must be updated of any changes as soon as possible. The Site Director will then contact you to inform you of your application status/confirm your child's start date.

Our main concern will always be our responsiveness to you and your child's needs. If any questions or concerns come up, know that we are always willing to work with you to resolve issues as quickly as possible.

Once again, we are happy to welcome you to the Skip-a-Long family and thank you for trusting us with your child's care and education.

Respectfully,

Mary Rosa-Gastaldo
Site Director
mrosagastaldo@skip-a-long.org
(309) 764-8110

Deb Brownson
Chief Program Officer
dbrownson@salfcs.org
(309) 764-3724

EMERGENCY CHILD CARE POLICIES

These Emergency Child Care Policies have been created to supplement our Family Handbook as it relates to our Emergency Child Care program. All policies listed below will be followed throughout the duration of the Emergency Child Care license, and will supersede any conflicting policies in the Family Handbook.

Drop-Off and Pick-Up Times

All parents will submit their drop-off and pick-up times to the Site Director. Care for your child will be limited to these times – no early arrivals or late pick-ups will be allowed, due to staffing needs. If you are unable to pick-up your child at your intended time, please make arrangements for an authorized guardian to pick-up.

Drop-Off – Daily Admission Screening

All children will be dropped off at the main entrance of the building, where Skip-a-Long staff will conduct a daily pre-admission screening to determine if the child has a fever or any other obvious symptoms of illness. If signs of illness are present, the child will be excluded from care for that day, or longer.

If the child appears well, a Skip-a-Long staff member will usher them to their classroom. All parents or authorized guardians must stay at the main entrance of the building and will not be allowed to walk throughout the halls or into classrooms.

Sickness Policy

Children will be monitored throughout the day for any signs of illness. If they are showing signs of illness, or hove a fever of 100 or higher, they will be excluded from child care and a parent or authorized guardian will be asked to come pick them up.

Payments and Fees

All parents will sign a Family Fee Agreement listing their required payments. All payments will be due prior to the child attending. Payments must be made on the first day of the week, for that week. If payment is not received, the child will not be allowed to attend.

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FAMILY CHECKLIST

Below is a list of items that must be returned to the office.

REQUIRED

☐	Review Emergency Child Care Policies
☐	Complete the Enrollment Form
☐	Complete Child Profile
☐	Complete Emergency Card
☐	Complete Child and Adult Care Food Program Form
☐	Complete Certificate of Child Health Examination Form (physical, immunizations, lead and TB)
☐	Review and sign DCFS Handbook
☐	Review and sign Family Handbook
☐	Review, initial and sign Signature Page
☐	Review and sign Family Fee Agreement (when asked)
☐	Provide copy of official birth certificate
☐	Provide change of clothes for child (on first day)

IF APPLICABLE

☐	Complete Authorization to Exchange Information Form
☐	Complete Application for IL Child Care Assistance Program
☐	Provide three recent and consecutive check stubs
☐	Complete Physician Statement for Food Substitution
☐	Complete Infant Formula/Food Waiver
☐	Diapers
☐	Wipes
☐	Formula/Breastmilk

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ENROLLMENT FORM – EMERGENCY CHILD CARE

1. CHILD INFORMATION

CHILD'S NAME (first, middle, last) _____ GENDER _____
DATE OF BIRTH _____ AGE _____ SS # _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

START DATE _____ DISCHARGE DATE _____
DAYS OF CARE _____
HOURS OF CARE _____
DROP-OFF TIME _____ PICK-UP TIME _____

CCAP APPROVED (Y/N) _____ IF YES, REGULAR CARE PROVIDER _____
APPLYING FOR CCAP (Y/N)* _____ PRIVATE PAY (Y/N) _____

***If you need to apply for the IL Child Care Assistance Program, please also complete and submit the IL CCAP Application.**

2. CAREGIVER INFORMATION

PARENT/GUARDIAN _____ RELATIONSHIP TO CHILD _____
SS# _____
ADDRESS _____ HOME PHONE _____
CITY _____ STATE _____ ZIP _____
CELL PHONE _____ EMAIL ADDRESS _____
EMPLOYER _____ WORK HOURS _____
EMPLOYER ADDRESS _____ EMPLOYER PHONE _____
CITY _____ STATE _____ ZIP

2ND PARENT/GUARDIAN _____ RELATIONSHIP TO CHILD _____
SS# _____
ADDRESS (if different from above) _____ HOME PHONE _____
CITY _____ STATE _____ ZIP _____
CELL PHONE _____ EMAIL ADDRESS _____
EMPLOYER _____ WORK HOURS _____
EMPLOYER ADDRESS _____ EMPLOYER PHONE _____
CITY _____ STATE _____ ZIP

3. HEALTH INFORMATION

PHYSICIAN NAME _____ PHONE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
HOSPITAL OF CHOICE _____
INSURANCE PROVIDER _____ GROUP/ID# _____

IDHS Illinois Department of Human Services
Iowa Department of Human Services
United Way Community Partner
NAC Accredited

4. EMERGENCY CONTACTS (who to contact in an emergency if parents cannot be reached)

NAME _____ RELATIONSHIP TO CHILD _____
CELL PHONE _____ HOME PHONE _____

NAME _____ RELATIONSHIP TO CHILD _____
CELL PHONE _____ HOME PHONE _____

5. AUTHORIZED FOR PICK-UP – PRIMARY (will regularly be picking up child)*

NAME _____ RELATIONSHIP TO CHILD _____
CELL PHONE _____ HOME PHONE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

NAME _____ RELATIONSHIP TO CHILD _____
CELL PHONE _____ HOME PHONE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

6. AUTHORIZED FOR PICK-UP – SECONDARY (will only pick up child under certain conditions)*

NAME _____ RELATIONSHIP TO CHILD _____
CELL PHONE _____ HOME PHONE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
WHEN TO RELEASE CHILD TO THIS PERSON _____

NAME _____ RELATIONSHIP TO CHILD _____
CELL PHONE _____ HOME PHONE _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
WHEN TO RELEASE CHILD TO THIS PERSON _____

***Please Note: for Emergency Child Care, you are <u>required</u> to include at least one person, other than the parents, that is able to pick up your child in the event that the parents are unable to get to the center before close of business at 5:30 pm. We will be strictly enforcing our hours of operation, 6:00 am – 5:30 pm.**

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CHILD PROFILE

Child's Name _____ Gender _____
Parent/Guardian Name(s) _____
Enrollment Date _____
Race/Ethnicity _____ Date of Birth _____

What traditions, cultural or religious practices does your family celebrate that we could include?

Has your child been in child care before?

How would you describe your child's temperament?

What helps your child calm down?

What are your child's sleeping habits?

Is your child in diapers or underwear?

If diapers, has toilet training been introduced?

If underwear, does your child express his or her need to use the bathroom?

Is there any additional information you would like your child's teachers to know?

SPECIAL HEALTH CONDITIONS OF CHILD: *In order to substitute food, drinks, or administer medication we are required to have a doctor's note on file.*

Does your child have…	**Yes**	**No**	**If yes, please describe**
any allergies or dietary restrictions?			
any medications that must be administered?			
an Individual Education Plan (IEP) or Individual Family Service Plan (IFSP)?			
any medical or mental health diagnoses?			

IDHS Illinois Department of Human Services
Iowa Department of Human Services
United Way Community Partner
NAC Accredited

I/we,

_____
Print Name(s)

parent(s) of

_____
Print Name(s) of Child(ren)

hereby verify that all information submitted is true and up-to-date, and that I have read, reviewed, and agree to abide by the Emergency Child Care Policies.

I understand that I am enrolling in the Emergency Child Care program and will only be enrolled temporarily for as long as the Emergency Child Care license is in effect. When lifted, I will work with Skip-a-Long staff to determine if enrollment can be switched to permanent care at Skip-a-Long or if alternative child care will be secured.

Signature of Parent _____ Date _____

Signature of Parent _____ Date _____

SIGNATURE PAGE

I _____ HEREBY GIVE MY PERMISSION FOR _____

PARENT/GUARDIAN NAME *CHILD NAME*

PLEASE INITIAL IN THE BOXES BELOW FOR THOSE ITEMS YOU ARE GIVING PERMISSION

☐ TO ALLOW MY CHILD TO BE OBSERVED BY HEALTH PROFESSIONALS, INCLUDING CHILD CARE NURSE CONSULTANTS AND MENTAL HEALTH CONSULTANTS, CHILD DEVELOPMENT EXPERTS AND STUDENTS WHO'S PURPOSE WILL BE TO ASSESS ENVIRONMENT, PROVIDE EDUCATION AND OFFER REFERRALS FOR COMMUNITY RESOURCES AS NECESSARY;

☐ TO HAVE MEDICAL TREATMENT AND/OR FIRST AID FOR MY CHILD UNTIL I ARRIVE

THESE PERMISSIONS WILL BE IN AFFECT UNTIL REVOKED IN WRITING BY PARENT/GUARDIAN

_____

SIGNATURE OF PARENT/GUARDIAN *DATE*

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AUTHORIZATION TO EXCHANGE INFORMATION

Child Name:		**Birthdate (*mm/dd/yyyy*):**	
Address:		**Phone:**	

Parent/Legal Guardian: To ensure your child has the best possible care at Skip-a-Long, it is important for our staff to have updated information about your child in order to create a supportive environment. Your signature on this Authorization for the Exchange of Information will give the individuals, programs, organizations, and entities listed on the next page of this Authorization permission to exchange the information indicated below specific to your child.

The purpose for the exchange of information is:

- ☐ Regarding Special Needs
- ☐ Regarding Medical Needs
- ☐ Regarding Social-Emotional Needs
- ☐ Other:

Your signature will give your permission for the following specific information to be exchanged:

- ☐ Medical Status
- ☐ Recommendations
- ☐ Current Medications/treatments
- ☐ Other:

Per the Health Insurance Portability and Accountability Act (HIPAA) regulations, information in the following areas may not be exchanged without your special permission. Your signature will give special permission for the exchange of information in the areas indicated specific to your child:

- ☐ Mental health
- ☐ Sexually transmitted diseases
- ☐ Substance abuse/chemical dependence
- ☐ HIV/AIDS

Please review before signing: This authorization is good until the following date:___/___/____, or until one year after the date of signing, whichever occurs first. You may revoke this authorization, in writing, at any time, however, this does not affect information shared prior to your request for revocation. The Director, Family Service Provider, Mental Health Therapist and Teachers, as appropriate are identified as having legitimate educational and supportive interest in reviewing the information shared. Information will be shared on a limited or "need to know" basis. HIPAA and Family Educational Rights and Privacy Act (FERPA) both ensure child and family privacy protection of personally identifiable information as well as complaint procedures. Access to records will remain strictly confidential. I understand my rights related to this exchange of information. I consent to the exchange of information with the identified individuals, programs, organizations, and entities listed on the next page.

_____ _____

Signature of Parent/Legal Guardian Date

_____

IDHS Illinois Department of Human Services
Iowa Department of Human Services
United Way Community Partner
NAC Accredited

Printed Name of Parent/Legal Guardian

AUTHORIZATION TO EXCHANGE INFORMATION

1. Name:	2. Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

3. Name:	4. Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

5. Name:	6. Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

_____ _____

Signature of Parent/Legal Guardian Date

_____

Printed Name of Parent/Legal Guardian

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Start Date:	**Office Use**
Classroom:	
Media Release: Yes No	

Emergency Card

Child's First Name: _____ Middle: _____ Last: _____

Date of Birth: _____

Gender: _____

Hours of Attendance: _____ Days of Attendance: M T W TH F

Name of Parent/Guardian: _____ Relationship to Child: _____

Employer/School: _____ Work Phone: _____

Work/School Hours: _____ am/pm to _____ am/pm

Home Phone: _____ Email Address: _____

Cell Phone: _____

Home Address: _____ City/State/ZIP: _____

(if applicable)

Name or 2nd Parent/Guardian: _____ Relationship to Child: _____

Employer/School: _____ Work Phone: _____

Work/School Hours: _____ am/pm to _____ am/pm

Home Phone: _____ Email Address: _____

Cell Phone: _____

Home Address: _____ City/State/ZIP: _____

Marital Status of parents/guardians: _____

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Start Date:	**Office Use**
Classroom:	
Media Release: Yes No	

Emergency Card

Child's First Name: _____ Middle: _____ Last: _____

Date of Birth: _____

Gender: _____

Hours of Attendance: _____ Days of Attendance: M T W TH F

Name of Parent/Guardian: _____ Relationship to Child: _____

Employer/School: _____ Work Phone: _____

Work/School Hours: _____ am/pm to _____ am/pm

Home Phone: _____ Email Address: _____

Cell Phone: _____

Home Address: _____ City/State/ZIP: _____

(if applicable)

Name or 2nd Parent/Guardian: _____ Relationship to Child: _____

Employer/School: _____ Work Phone: _____

Work/School Hours: _____ am/pm to _____ am/pm

Home Phone: _____ Email Address: _____

Cell Phone: _____

Home Address: _____ City/State/ZIP: _____

Marital Status of parents/guardians: _____

PARENT LETTER
FOR CHILD CARE CENTERS
July 1, 2019 Through June 30, 2020

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, 2019 to June 30, 2020

Reduced-Price Meals
185% Federal Poverty Guideline

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	23,107	1,926	963	889	445
2	31,284	2,607	1,304	1,204	602
3	39,461	3,289	1,645	1,518	759
4	47,638	3,970	1,985	1,833	917
5	55,815	4,652	2,326	2,147	1,074
6	63,992	5,333	2,667	2,462	1,231
7	72,169	6,015	3,008	2,776	1,388
8	80,346	6,696	3,348	3,091	1,546
For each additional family member, add	8,177	682	341	315	158

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 USDA Household Income Eligibility Guidelines are listed for families who do not receive TANF or SNAP benefits. If a household's income falls within or below the listed guidelines, they should contact their child care center or day care home provider for the benefits of the program. They may be required to complete an application and provide income, TANF, or SNAP information.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider. (10/15)

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**

First Child

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Second Child

☐ Same Days as Above ☐ Same Times as Child Above ☐ Same Meals as Above

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

Third Child

☐ Same Days as Above ☐ Same Times as Child Above ☐ Same Meals as Above

Name

Birth Date

Age

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack ☐ Breakfast ☐ A.M. Snack ☐ Lunch ☐ P.M. Snack ☐ Supper ☐ Evening Snack

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.

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

1. All Household Members

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	2. FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6	3. 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 ☐ Head Start

Signature of Homeless Liason, Migrant Coordinator, or Head Start Director _____ 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 Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "*I do not have a Social Security Number*" box.

__ __ __ - __ __ - __ __ __ __
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. Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Mark one or more racial identities:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

9. 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: _____

CHILD CARE REPRESENTATIVE USE ONLY

Eligibility Determination - Complete Sections A and B Below

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
- ☐ Head Start

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

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

SECTION B **Signature of Determining Official:** _____ **Date:** _____

INSTRUCTIONS FOR APPLYING - COMPLETE ONE APPLICATION PER HOUSEHOLD

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.
   - Parts 7-9 — (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.
   - Parts 7-9 — (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.
- Parts 7-9 — (OPTIONAL)

HOMELESS, MIGRANT, RUNAWAY, OR HEAD START

If no one in your household receives SNAP or TANF benefits and if any child is homeless, a migrant, a runaway, or head start, 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 Parts 5 and 6.
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (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.
  - o For ONLY the self-employed, list income after expenses. This is for your business, farm, or rental property.
  - o If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
  - o 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 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.
- Parts 7-9 — (OPTIONAL)

PRIVACY AND DISCRIMINATION 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.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 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						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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 (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

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

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

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

ALLERGIES (Food, drug, insect, other)	Yes No	List:

Diagnosis of asthma?	Yes	No	
Child wakes during night coughing?	Yes	No	
Birth defects?	Yes	No	
Developmental delay?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	
Diabetes?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No	
Seizures? What are they like?	Yes	No	
Heart problem/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			
Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

MEDICATION (Prescribed or taken on a regular basis.)	Yes No	**List:**

Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List all.) When? What for?	Yes	No	
Serious injury or illness?	Yes	No	
TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
TB disease (past or present)?	Yes*	No	
Tobacco use (type, frequency)?	Yes	No	
Alcohol/Drug use?	Yes	No	
Family history of sudden death before age 50? (Cause?)	Yes	No	

Dental ☐ Braces ☐ Bridge ☐ Plate Other

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signature **Date**

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____

Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS Yes** ☐ **No** ☐ **Modified** ☐

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

Address **Phone**