Miss Mona's Child Care Rates

HMC

Age/Classroom	Rate (weekly/daily)
Infants (6 weeks to 15 months)	$185/$38
Toddlers (15 months to 2 years)	$171/$37
2's & 3's	$162/$34
4's & 5's	$150/$31

List Of Things To Bring

Bottles-Filled with water, and marked with child's name. Please mark bottle and cap.

Formula & Baby Food-If not using the centers.

Diapers-You may bring a large pack if you like. Only the package of diapers needs to be marked.

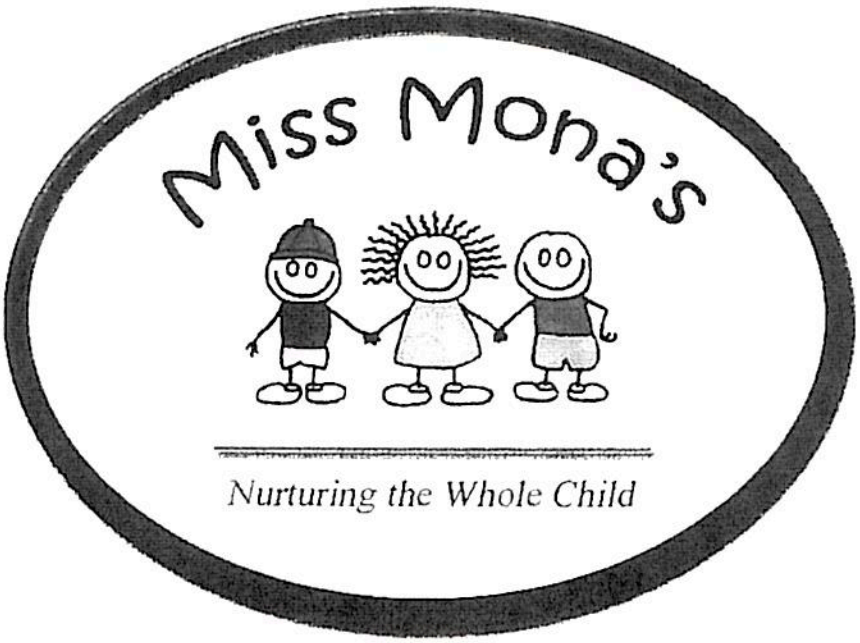
Pacifier

Blanket

Extra clothes for cubby

Shoes, coats, sweaters, hats, mittens, etc. for the appropriate season. We go outside to play and go for walks, when weather permits.

* Please mark everything with your child's name on it. This will help a lot when there is a sub in the room.



Parent Policies and Informational Packet

Miss Mona's Child Care Center
107 Tremont Street
Hopedale, IL 61747
(309) 449-4900

Introduction

Welcome to Miss Mona's Child Care Center! We feel that every child has the right to receive quality child care in a child-centered program. We offer a safe and nurturing environment in which your child can learn and have fun. Children are offered opportunities to develop cognitive, social, emotional and physical skills. Developmentally appropriate activities are planned for each age group and offer a wide range of hands-on experiences. Children develop skills that will be used all their lives through play experiences, and we consider "play" to be a child's "work".

We encourage parents to visit the classroom whenever they can. Daily sheets will be filled out for each child ages 6 weeks to two years. Teachers provide information about the child's activities, meals and naptime. Please feel free to speak with the teachers or director about any suggestions or concerns. Comments may also be left in the payment box. If you have confidential communications regarding the Director, or if problems are not getting resolved to your satisfaction, please contact the Hopedale Medical Complex Chief of Operation Office at 309-449-4296.

Admission

Our center is open to all children ages 6 weeks through 6 years. Beginning, June 2010, only children of Hopedale Medical Complex and siblings of current enrollees, ages 4 years of age and over. Unless granted pre-approval by the CEO. Hours of operation are 5:30 a.m. to 5:30 p.m.

Miss Mona's offers **all-day child care** available for children ages 6 weeks to kindergarten on a full-time or part-time basis. Days and times must be arranged in advance.

All children must be registered in advance and must comply with the Department of Children and Family Services regulations in regard to physical exams; immunizations, including a TB skin test and lead screening or waiver; and other appropriate paperwork. All enrollment paperwork must be completed before a child can receive services.

Tuition

- Tuition is determined according to current rates as from time to time determined by management. A rate sheet is included in the enrollment packet.
- Tuition is due weekly and no later than the child's first day of attendance.
- Checks made payable to **Hopedale Medical Complex** and can be placed in the payment box in the parent information area.
- Drop-in fees are due the day services are rendered.
- Families enrolling more than one child will receive a 10% discount.
- HMC employees may use payroll deduction.

Fees

- **Late pick-up fee** – If your child is not picked up by the center's closing time, you will be charged $10.00 for the first 15 minutes and $1.00 per minute thereafter.
- **Late payment** – If payment is not received by your child's second day of attendance there will be a $5.00 fee added to the weekly tuition. Failure to provide payment for two weeks may result in refusal of admittance unless payment arrangements have been made with the child care director.

- **Insufficient funds** – A fee of $20.00 will be charged for each returned check. After two returned checks, you will be asked to make tuition payments in cash.
- **Responsible Party** – (parents and guardians) agree to pay collect on costs and reasonable attempts filed if sent to collections is required.

Vacation / Sick Days

- Each family receives two (2) weeks of tuition free for vacation or sick days based on the number of days the child is enrolled.
    - If your child is enrolled full-time, five (5) days per week, you will have ten (10) days.

  Therefore, if your child is enrolled two (2) days per week you will receive four (4) vacation days.
- Vacation / sick days are effective January 1st each year and may not be carried over from the previous year.
- Time may be used by the day.

Severe Weather

- In case of severe weather the Director will make the decision as to close the daycare for our children's safety, as well as our staff members. Announcements and notifications will be made at the time of the closing. All tune into NBC 25/WHOI 19/WEEK television channels, for update reports. We reserve the right not to adjust your tuition whether the center is open for all or part day due to severe weather.

Holidays

- The center will be closed on the following holidays: New Year's Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving Day and Christmas Day.
- There is no adjustment to your tuition unless you choose to use a vacation day.

Termination of Service

- We ask that a two-week notice be given, in writing, if you choose to end service. If possible, more notice would be appreciated.
- The center reserves the right to re-evaluate any child's continued participation in the program. The center may request withdrawal of the child and will recommend a suitable alternative that may better suit his or her needs. A two-week notice will be given unless the child is an immediate danger to himself or others.

Drop-off and Pick-up Procedures

- **When dropping off your child, please be sure to clock them in, and out when picking them up. An I.D. number will be assigned for you to do so. This number will also be your keyless entry number. We ask that your child be at the center by 9:30 a.m., if possible. When coming after 9:30 a.m., your child misses part of the morning routine and classroom involvement. This also helps us calculate staffing as well as meals. Please call the center if you know your child will be later than 9:30 a.m.**

Your child will only be released to persons listed on the Pick-up Authorization form. The center staff is only allowed to release your child only to those on the pickup list unless you notify the Director in advance. The pickup person must be at least 18 years of age or older, unless it is the child's parent.
Anyone with whom the staff is not familiar will be asked to present a photo I.D.

Illness

- All children attending the center should be well enough to participate comfortably in daily indoor and outdoor activities.
- Children with a fever of over 101 degrees Fahrenheit should be excluded from care while the fever persists.
- Children need not be excluded for minor illness unless any of the following exists, in which case exclusion from the center is required by DCFS Licensing Standards:
    - An illness which calls for greater care than staff can provide without compromising the health and safety of other children
    - Rash combined with fever over 101 degrees Fahrenheit
    - Rash with a fever or behavior change, unless a physician has determined the illness to be non-communicable
    - Unusual lethargy, difficulty breathing or other signs of possible severe illness
    - Diarrhea (child will be sent home after 3rd watery stools) or diarrhea combined with fever of 101 degrees or higher
    - Vomiting two or more times in the previous 24 hours
    - Mouth sores associated with the child's inability to control his or her saliva, until the child's physician or the local health department states (in writing) that the child is non-infectious
    - Purulent conjunctivitis until 24 hours after treatment has been initiated
    - Impetigo until 24 hours after treatment has been initiated
    - Strep throat until 24 hours after treatment has been initiated and until the child has been without fever for 24 hours
    - Head lice until the morning after the first treatment (the center may require proof of treatment) must be nit free.
    - Scabies until the morning after the first treatment
    - Chicken Pox until at least six (6) days after onset of the rash and all lesions are crusted over
    - Whooping cough until five (5) days of antibiotic treatment have been completed
    - Mumps until nine (9) days after the onset of parotid gland swelling
    - Measles until four (4) days after disappearance of the rash
    - Symptoms which may be indicative of one of the serious, communicable diseases identified in the Illinois Department of Public Health Control of Communicable Diseases Code

    - Children who have been absent due to a contagious disease (including, but not limited to, the above listed illnesses) must have prior written consent from a physician upon return to the center when the disease has not completely run its course

- The center reserves the right to require a physician's written consent to return to child care when a contagious disease is suspected.

Medication

- All medications must be signed in daily on the Medication Chart located in your child's room. Please include specific instructions on the administering of any medicine. We ask that you do not sign medicine in to be given "as needed". We feel strongly that "as needed" should be a decision made by a parent and not left to the discretion of the child care staff.
- Prescription and over-the-counter medications must be given to a teacher for proper storage.
- All medication must be in the original container. Prescription medication must display the proper pharmacy label with the child's name. Over-the-counter medication must be labeled with your child's name.
- Medicine will not be given before 9:30 a.m.

Medical Examinations and Immunizations

- All children enrolled in the centers' programs are required by DCFS regulations to have a physical exam on file completed no more than six (6) months prior to enrollment. The exam shall be updated every two (2) years. School-age children must provide a copy of their current school physical.
- In accordance with the Child Care Act of 1969, as amended, a parent may request that immunizations, physical examinations and/or medical treatment be waived on religious grounds. A request for such waiver shall be in writing and kept in the child's record.
- Exceptions made for children who should not be subject to immunizations or tuberculin tests for medical reasons shall be indicated by the physician on the child's medical form.
- The number of non-immunized children enrolled shall be available to parents on request.

Emergency Medical Treatment

All accidents occurring on the center's property must be reported to the Director. First aid will be administered by the staff for minor scrapes, cuts and bumps. In serious cases where immediate medical attention is required, the parents or emergency contacts will be notified. If the center is unable to reach anyone, the child will be treated in the Hopedale Medical Complex Emergency Room, and the parents/guardians are consenting thereto.

Personal Items

- All children will have a basket or cubby labeled with their name to store personal items such as extra clothes or a small stuffed animal for naptime.
- All items need to be labeled with your child's name.
- Please do not allow your child to bring toys or other "treasures" to the center. These items often get lost, broken or cause conflict between the children. Your child's teacher may choose to designate a special show-and-tell day when the children can bring a small item to share with the class. Absolutely no war toys will be allowed into

the center. Playing or acting violently as "Power Rangers", Ninjas, etc. will not be tolerated.

- Children are welcome to bring a book to share with the class occasionally. Please be sure to mark it with your child's name and be prepared to leave it for a couple of days as the teacher may not be able to read it the same day.

Field Trips

All classrooms take short walking field trips. The children may walk to the nearby park or pond.

The 3&4 year old classroom take outside fieldtrips periodically. The HMC bus is used for these fieldtrips. In order to allow your child to go on a fieldtrip, a permission slip must be signed, and a car seat available for the bus.

Meals and Snacks

- The center serves breakfast, lunch, and two snacks in accordance with the nutritional guidelines of the Department of Children and Family Services.
- Children are not allowed to bring food into the classroom. You may occasionally bring a snack for the entire class to celebrate a special day such as a birthday or holiday. Unfortunately, we are not allowed to serve homemade treats. All treats must be in unopened packages from the store or bakery.
- If your child eats on the way to the center, please have him/her finish eating before entering the classroom.

Dress Code

- Children will go outside daily except in extreme conditions. Your child's attire at the center should be chosen with regard to activity and comfort. Remember that spills, paint, dirt and glue happen!
- For safety and comfort reasons, we highly recommend that tennis shoes and socks be worn daily.
- Sandals are not recommended. Children often have difficulty running and climbing in sandals. Socks should be worn if your child must wear sandals.

Supplies and Extra Clothes

We ask that parents provide the following items:

- Blanket for naptime (child sized)
- Complete change of clothes including socks to be left in the child's basket (3 or 4 if potty training or prone to accidents)
- Disposable diapers or training pants (if needed)
- Pacifier (if needed)
- Weather appropriate outerwear

*Please remember to put your child's name on all items.

Donations

Miss Mona's Child Care Center accepts any clean, safe indoor or outdoor toy donations for appropriate age levels. Please check with the director before donations occur.

Guidance and Discipline Policy

Our child care staff will help individual children develop self-control and assume responsibility for their own actions.

- Limits and consequences shall be clear and understandable to the child, consistently enforced and explained to the child before and as part of any disciplinary action.
- 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 and will be used if the child cannot be redirected. Removal from the group shall not be used for children less than 24 months of age.
- Children shall not be disciplined or shamed for toilet accidents.
- Discipline shall be the responsibility of the adults who have an ongoing relationship with the child.
- When there is a specific plan for responding to a child's pattern of behavior, all staff who affects the child shall be aware of the plan and cooperate with its implementation.

The following behaviors by staff and children are prohibited in all child care settings.

- Corporal punishment or threats of 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 private or public humiliation including threats of physical punishment.
- Any form of emotional abuse including shaming, rejecting, terrorizing or isolating a child.

Parents/guardians are seen as partners in the guidance and discipline process. On occasion children may exhibit some behavioral challenges. Child care staff will openly share concerns and suggestions regarding the child's behavioral challenges and parents are encouraged to do the same. By working together, parents and staff can provide consistent guidance and discipline. Should challenging behaviors persist; parents will be asked to attend a conference with the classroom teacher and child care director in order to discuss additional strategies to assist the child in managing his or her behavior in the classroom. In the case of extreme or serious behavioral issues, the parent may be asked to remove the child from the center for the day. If behavioral issues cannot be resolved satisfactorily, parents may be asked to withdraw their child from the center. Parents will be given a two-week notice unless the behaviors are so disruptive they seriously impact the classroom activities.

Mandated Reporter

The Abused and Neglected Child Reporting Act requires a wide range of professionals to report suspected child maltreatment. Under this law, all child care staff is considered to be mandated reporters and are required to report suspected child abuse or neglect immediately to the Department of Children and Family Services. Willful failure to report suspected incidents of child abuse or neglect is a misdemeanor. State law protects the identity of all mandated reporters, and they are given immunity from legal liability as a result of reports they make in good faith. State law does not require that the mandated reporter notify parents of the report.

Pest Control

If the need for use of pest control arises, there will be a note posted at the center 48 hours beforehand. It will only be done after hours and/or on the weekend. If you wish to be notified verbally, please let the director know.

Policy Sign-off

I/we, the parent/guardians of _____, have received and read a copy of Miss Mona's Child Care Policies and Informational Packet, understand it including the Guidance and Discipline Policy, and agree to its terms.

Signature_____ Date_____

Signature_____ Date_____

**Please sign and return to child care director.

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.

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 TAF 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.

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. 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: _____

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

CFS 428
Rev. 4/2001

State of Illinois
Department of Children and Family Services

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child _____ Birthdate _____ Sex _____

Address _____

Date Child Received _____ Date Child Left _____

PARENT OR OTHER PERSONS(S) PLACING THE CHILD

Name _____ Name _____

Relation to child _____ Relation to child _____

Home address _____ Home address _____

_____ _____

Phone Number _____ Phone Number _____

Place of employment _____ Place of employment _____

_____ _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Working hours _____ Working hours _____

OTHER PERSON TO NOTIFY IF PERSON PLACING THE CHILD CANNOT BE REACHED

Name _____ Address _____

Phone Number _____ Relationship _____

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name _____ Address _____

Phone Number _____ Hospital or Clinic _____

PROGRAM

Days per week_____ Hours of care _____

Rate of pay (optional) _____

_____ _____ _____

Signature of parent or other person placing child | Signature of caregiver | Date

A completely filled in form must be kept by the licensee for each child not related to the licensee. Please have this form available at all times to licensing representatives of the Department of Children and Family Services. Contact the Area Office for supplies of this form

If the child has any of the following, please explaining:

Medical problems _____

_____

Physical handicaps _____

_____

Restrictions for play—outdoors _____

_____

Restrictions for play—indoors _____

_____

Allergies _____

_____

Food likes _____

_____

Food dislikes _____

_____

Fears _____

_____

Does the child take a nap? _____ Time _____ Length _____

Is the child toilet trained? _____

Does the child have special names for objects? (potty, cookies, drinks, etc.) _____

_____

Does the child regularly take medication? _____ If so, what kind and directions _____

_____

If the child is an infant, what are the feeding instructions? _____

Time _____ Amount _____ Temperature _____

Diaper changes: Powder _____ Ointment _____

Other information that will help in caring for the child _____

_____

_____

Comments:

_____

_____

_____

_____

_____

_____

_____

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY

AUTHORIZATION FOR PICK UP

Please list all persons, including parents and guardians, authorized to pick up your child along with a 4 digit ID code that will allow them to sign in and/or out your child. The 4 digit code cannot start with a 0.

Name	Address	Phone #	Relationship to Child	ID Code

Parent Signature: _____ Date:_____

MISS MONA'S EMERGENCY INFORMATION FORM

Child's Name: _____ Age: _____ Birth Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Mother's Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Father's Name: _____ Home Phone: _____ Work Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

Emergency Contact: _____

Relationship to Child: _____ Phone: _____

List Authorized Adults Allowed to Pick Up Child:

Name	Address	Phone

List Any Medical Conditions: _____

_____

Allergies: _____

Name of Physician: _____ Phone: _____

Address: _____

Choice of Hospital: _____

My Child May View Movies Rated: (Please circle): G PG PG13

If I cannot be reached in an emergency, please seek medical attention: Yes No

Signature of Parent/Guardian: _____ Date: _____

FOR USE IN DCFS CHILD CARE FACILITIES

Please Print

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	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	1 DA	1 YR	2 MO	2 DA	2 YR	3 MO	3 DA	3 YR	4 MO	4 DA	4 YR	5 MO	5 DA	5 YR	6 MO	6 DA	6 YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										Comments								
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23		
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature _____ Title _____ Date _____

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) Title _____ Date _____

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) 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 report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

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

Printed by Authority of the State of Illinois
(Complete Both Sides)

444-4737 (R-01-05)

FS 600
ev 1/2005

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	Indicate Severity	
Child wakes during the 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		

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		

Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Dental ☐Braces ☐Bridge ☐Plate Other

Other concerns?

Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

Information may be shared with appropriate personnel for health and educational purposes
Parent/Guardian Signature Date

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS HEIGHT WEIGHT BMI B/P

DIABETES SCREENING 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 Indicated? Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** (Blood test required in Chicago and other high risk zip codes)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** mm

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal examination		
Cardiovascular/HTN			Nutritional status		
Respiratory			Mental Health		

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?
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
PHYSICAL EDUCATION Yes ☐ No ☐ **Modified** ☐ (If No or Modified, please attach explanation.) **INTERSCHOLASTIC SPORTS** (for one year) Yes ☐ No ☐ Limited ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name Signature Date

Address Phone

(Complete both sides)

Late Pick Up Policy Amendment
June 2005

The late pick-up policy of Miss Mona's Child Care Center states that if your child is here past the center's closing time, you will be charged the late pick-up fee of $10.00 for 15 minutes or any part of thereof and $1.00 per minute thereafter. This policy remains in effect with the following additions:

1. The staff member in charge will attempt to reach the parents via emergency contact information, which has been provided by the parent. After a reasonable amount of time as passed, if the parents have not been contacted, staff member would contact authorities for help in contacting parents.

2. The director will periodically check emergency information as to accuracy for this exact purpose.

3. The staff member in charge will be certain at all times to be responsible for the child's well-being and at no time will the staff member make the child feel responsible for the situation.

I _____
parent/guardian

of _____
child

Have read and understand this amendment to the Late Pick Up Policy of Miss Mona's Child Care Center.

_____ _____
Signed Date

Miss Mona's Child Care Center

Hopedale Medical Complex

Consent to Treat/Wavier and Release

Minor Child's Name: _____

Waiver & Release

Miss Mona's, LLC, d/b/a Miss Mona's Childcare Center, and the Hopedale Medical Foundation, d/b/a Hopedale Medical Complex, hereinafter referred to individually and collectively as "Miss Mona's", is committed to conducting its programs and activities in a safe manner and holds the safety of our children in high regard. The parents/guardians and custodians of minors enrolled in our program(s)/activity(ies) understand that although child safety is Miss Mona's number one concern, there is still an inherent risk of injury to children when they participate in our programs/activities, especially when playing or engaging in physical activity.

In light of the above, in consideration of Miss Mona's providing its services to the minor child/children, the undersigned on his/her behalf and on behalf of the minor child/children, does hereby fully release and forever discharge Miss Mona's , LLC and the Hopedale Medical Foundation, d/b/a the Hopedale Medical Complex, and their respective managers, officers, directors, employees, agents, successors and assigns, from and against any and all claims for injuries, damages or losses and liability that the undersigned or the minor child/children may sustain or which may accrue to the undersigned or the minor child/children, which arises out of, or is connected with Miss Mona's program and activities, unless said losses/liability or damages are the result of willful and wanton conduct.

The undersigned has read and fully understands the above waiver and release of all claims. The undersigned's signature below is on his/her behalf of any and all minor child/children enrolled in or participating in Miss Mona's programs and activities, even if said minor child/children's names are not specifically listed below. If both parents/guardians have not signed this document, the undersigned states that he/she is authorized to sign on behalf of the other parent/guardian, and the undersigned agrees to indemnify and hold harmless Miss Mona's, LLC and the Hopedale Medical Foundation and the released entities from and against any and all liability, losses, claims/demands made against said entities by the non-signing parent/guardian.

Consent to Treat:

In the event of an accidental injury or sudden acute illness to the minor child participant, the undersigned, for himself/herself and on behalf of the minor child participant, HEREBY CONSENTS and permits the Miss Mona's and Hopedale Medical Complex personnel to administer First Aid or contact local EMS to care for and treat the minor child and to transport said child to the hospital Emergency Room if deemed necessary by EMS, HMC or Miss Mona's personnel. If Hopedale Medical Complex or Miss Mona's personnel are unable to immediately reach the parent/guardian of the minor child participant to obtain verbal consent, said permission to treat and transport by HMC and/or EMS personnel is granted. Note: Miss Mona's personnel will always attempt to immediately contact a parent/guardian/authorized person in an emergency.

This release and consent also applies to any other related programs conducted at or by Miss Mona's, regardless of location, whether on site or off premises, and shall remain in force and effect for 5 years or until revoked by the undersigned in writing by delivering a copy to the C.O.O of Hopedale Medical Complex, whichever occurs first. This consent may not be retroactively evoked.

_____

Parent/Guardian (Signature) Date

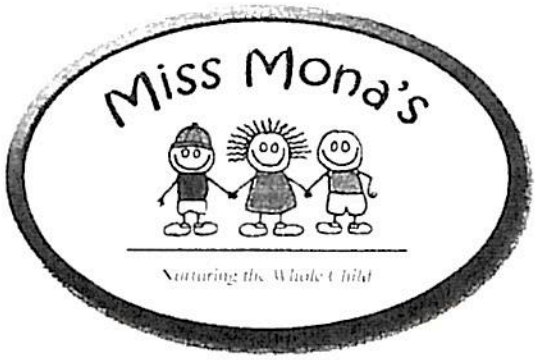
_____

Name of Minor Child (Please Print) Age

Emergency number where parent/guardian/authorized person can be reached if minor child participant is in need of Emergency medical treatment or in an emergency:

Authorized Contact No. 1:_____ Phone # _____

Authorized Contact No 2:_____ Phone # _____



PO Box 267

Hopedale, IL 61747

CONSENT TO PHOTOGRAPH AND USE IMAGES

The undersigned parent/guardian hereby consents to the photographing of his/her minor child doing activities at Miss Mona's. These photos will be taken by an agent of Hopedale Medical Complex (HMC) and Miss Mona's Childcare. In consideration of the above the undersigned will be provided a free copy of any photographs taken by HMC of his/her child/ward and **the undersigned hereby gives consent** to Miss Mona's and HMC to publish and display said photographs on site at Miss Mona's, on HMC or Miss Mona's advertising or brochures. No further consideration will be paid for the use of said photos.

Signed_____

Minor Child's name_____

Date_____

MISS MONA'S AUTHORIZATION FORM

EMERGENCY MEDICAL TREATMENT

This authorizes the staff at Miss Mona's Child Care Center to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. In the event of an emergency a staff member will take your child to be treated at the Hopedale Medical Complex Emergency Room. I/we will be responsible for the emergency medical charges upon receipt of the statement.

Signature of Parent/Guardian **Date**

ADMINISTER PRESCRIPTION MEDICATION

I/we authorize Miss Mona's Child Care Center to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Signature of Parent/Guardian **Date**

ADMINISTER OVER THE COUNTER MEDICATION

I/we authorize Miss Mona's Child Care Center to administer over the counter medication to my/our child as specified in written instructions.

Signature of Parent/Guardian **Date**

FIELD TRIPS

I/we authorize Miss Mona's Child Care Center to take my/our child on walking trips, special excursions, and to nearby public park facilities.

Signature of Parent/Guardian **Date**

PUBLICITY

I/we authorize Miss Mona's Child Care Center to photograph/video tape my/our child with the understanding that such photos or videos may be used for publicity.

Signature of Parent/Guardian **Date**

Policy Sign-off

I/we, the parent/guardians of _____,
have received and read a copy of Miss Mona's Child Care Policies and Informational Packet, understand it including the Guidance and Discipline Policy, and agree to its terms.

Signature_____ Date_____

Signature_____ Date_____

** Please sign and return to Child Care Director.

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.