Mount Prospect
Child Care Center, Inc

"Wee care" when you're not there!

406 – 408 E. Northwest Hwy.
Mt. Prospect, IL 60056

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APPLICATION FOR ENROLLMENT

Today's Date: _____

Child's Name: _____

Child's Date of Birth_____ Sex: ___M ___F

Child's Address: _____

City, State, Zip: _____

Home Phone Number: _____

Child's Pediatrician: _____

Pediatrician Address: _____

Pediatrician Phone: _____

Emergency Contact:

First contact person: Mother _____ Father _____ Other _____

Whom do we call if unable to contact above persons?

Name: _____ Relationship_____

Address _____

Home phone: _____ Cell: _____ Work: _____

Additional Emails:_____

Parents' Status: _____Single _____Married _____Separated _____Divorced

Child's Release:
Please list persons child may be released to:

1. **Primary**_____ **Relationship**_____ **Phone**_____
2. **Primary**_____ **Relationship**_____ **Phone**_____
3. **Contingency**_____ **Relationship**_____ **Phone**_____

Mother's Name: _____

Check here if same address as child _____

Home Address: _____

City, State, Zip: _____ **Cell Phone:** _____

Email Address: _____

Employer's Name: _____ **Work Phone:** _____

Employer's Address: _____

City, State, Zip: _____

Normal Working Hours: _____

Father's Name: _____

Check here if same address as child _____

Home Address: _____

City, State, Zip: _____ **Cell Phone:** _____

Email Address: _____

Employer's Name: _____ **Work Phone:** _____

Employer's Address: _____

City, State, Zip: _____

Normal Working Hours: _____

Name of previous Centers attended: _____

How did you learn of our Center?

Referral _____ Drive-By _____ Brochure _____ Newspaper _____ Yellow Book USA _____

Ameritech Pages _____ Internet Search (please specify) _____ Other _____

********** SCHOOL USE ONLY **********

School Admission Date: _____ Discharge Date: _____

Registration Fee: _____ Paid: _____

Class:_____ Weekly Fee: _____

Care: Day Care:_____ Days per Week: _____

Preschool:_____ Days per Week: _____

CHILD INFORMATION/DEVELOPMENTAL HISTORY

FAMILY AND SOCIAL HISTORY

Name of Child: _____

Marital Status of Parents: _____Single _____Married/Living Together

_____Separated _____How long?

_____Divorced _____How long? Remarks: _____

_____ Is there a Stepfather in the child's life _____ How Long?

_____ Is there a Stepmother in the child's life _____ How Long?

Custody/visiting arrangements: _____

_____

If Child is adopted, age at adoption: _____ Does child know he/she is adopted? _____

Siblings of Child:

Name_____ Date of Birth_____ Grade in School_____

Name_____ Date of Birth_____ Grade in School_____

Other members of the household (include relationship and age): _____

_____

DEVELOPMENTAL HISTORY

Age at which child

Sat alone_____ Walked alone_____ Slept through the night_____

Named simple objects_____ Repeated short sentences_____ Began toilet training_____

Is child toilet trained? Yes_____ No_____

Word child uses for urination:_____

Word child uses for bowel movement:_____

Usual time for bowel movement:_____

Does child dress self?_____ Undress self?_____

Is child right or left handed?_____

What time does the child usually eat breakfast?_____ lunch?_____ dinner?_____

Eating problems?_____ Is family vegetarian?_____

Other dietary restrictions_____

What time does child usually go to bed at night?_____ Awaken?_____

Does child sleep well?_____

What are child's favorite indoor play activities?_____

Outdoor play activities?_____

Does child like to play with water?_____ Go barefoot?_____

Does child have any speech problems?_____

Does child have any other problems that we should be aware of?_____

_____

What method of behavior control/discipline is used in your home? Please explain:

_____

_____

_____

What is the child's usual reaction to being disciplined?_____

_____

HEALTH HISTORY

Does child have frequent colds?_____ Explain:_____

_____

Sore throats/tonsillitis?_____ Ear infections?_____

Stomachaches?_____ Does child vomit easily?_____

Does child run high fevers easily?_____

Has child has any serious accidents? Explain:_____

_____

Does child have any seasonal allergies?_____

Does child have asthma or episodes of wheezing?_____

Does child have any food allergies?_____To what foods?_____

_____

How does the reaction usually manifest (ie. Hives, anaphylaxis, etc)?_____

_____

Does child have any other allergies (such as bee stings, lotions, etc)?_____

Has child ever been to a dentist?_____

Has child had vision tested?_____ Hearing tested?_____

Does child wear corrective shoes?_____

SOCIAL HISTORY

Has child had experience playing with other children?_____

By nature, is child: Friendly?_____ Self Assertive?_____ Shy?_____

Withdrawn?_____

With what age does child prefer to play?_____

Does child know any children currently enrolled in the child care center?_____

Does child enjoy being alone?_____

Does child demand a lot of adult attention?_____

What makes child upset?_____

What frightens your child? Animals?___ Storms?___ Darkness?___ Loud noises?____ Strange people?____

Favorite toys and activities at home?_____

Does child like to be read to?_____

Does child like to listen to music?_____

Can child ride a tricycle?_____

In what particular ways can we help your child?_____

_____

What are your expectations of our program?_____

_____

What is the purpose of formal education today in early childhood settings? Socializing, self-esteem, enhance critical thinking skills, prepare for adulthood… what are your views?_____

_____

_____

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

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

Name _____ Today's Date_____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes No Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher?	Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area?	Yes No Don't Know

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A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

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

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

Test 1: Blood Lead Result_____mcg/dL Date _____ Test 2: Blood Lead Result_____mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_____ _____

Signature of Doctor/Nurse Date

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

AUTHORIZATION

We authorize the directors and/or teachers of the Mt. Prospect Child Care Center to undertake necessary emergency first aid for our child, including but not limited to: transporting our child to the emergency room of the nearest hospital, clinic, or private doctor for treatment. We understand every effort will be made to reach us before such action is taken. We further authorize the staff of the Mt. Prospect Child Care Center to administer medicine which is provided by us in accordance with our verbal instructions.

We authorize the Mt. Prospect Child Care Center to, during the course of their enrollment, take our child on field trips and excursions and to use public parks and library facilities with the understanding that such trips are under the supervision of authorized personnel of the School and that all possible precautions are taken to ensure the safety and health of my child. We further authorize the Mt. Prospect Child Care Center to use pictures of our child for parent programs, displays, newspapers articles, brochures, and our web-site.

We agree to release Mt. Prospect Child Care Center directors, teachers, and staff from all liability in case of accidents. We understand that the Mt. Prospect Child Care Center meets all state requirements and is licensed by the State of Illinois.

We have read, understand, and agree to the above authorizations:
Child's Name:_____

Father's Signature:_____

Mother's Signature:_____

Date:_____ Home Phone:_____

Doctor:_____ Dr's Phone:_____

Mother's Work Phone:_____

Father's Work Phone:_____

PARENTAL CONSENT FOR EMERGENCY TREATMENT OF MINOR

To Whom It May Concern:
As a parent and/or guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the following minor in the even of a medical emergency which, in the opinion of the attending physician, may endanger his or her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me. This release form is completed with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signed: _____

Father ~ Mother ~ Legal Guardian

Name of Minor:_____ Birthdate:_____

Relationship:_____ Effective Date of Release:_____

Home Address: _____ Phone:_____

Pediatrician/Family Physician:_____ Phone:_____

Specific medical allergies, chronic illnesses, or other conditions:_____

_____

Parents' Cell Phone #s: Mother_____ Father_____

Parents' Work Phone #s: Mother_____ Father_____

Other contact in case of emergency: Name:_____ Phone:_____

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