Parents:
I need the following for your child's file.

_____ Packet of enrollment forms

_____ Completed physical form (your child's physical is valid for two years)

_____ Immunization record (bring updated records as your child gets shots)

_____ TB test or written waiver from your doctor (We ask for this at 12 mos.)

_____ Lead blood test results (We ask for this at 12 months)

_____ Standards handbook signature page

_____ Contract signature pages from school handbook

_____ CACFP food program form

_____ Certified copy of child's birth certificate

_____ Other

Your child is subject to dismissal if these forms are not in your child's file.

1311 Vandalia Road Hillsboro, IL 62049 *Hillsboro Community Unit School District #3* 217-532-2942

Today's Date : _____/_____/_____

HCUSD #3 STUDENT ENROLLMENT FORM

Student's: Last Name | First Name | Middle Name | Preferred or Nick Name

Sex: | Birthdate: | Birth Certificate: (County/State) | Social Security: | Has this child attended a Hillsboro School before? YES ____ NO ____

Grade _____

Teacher _____

School Bus #_____

Please indicate who the student is living with:
1-father & mother
2-father
3-mother
4-guardian
5-other _____

Parent/Guardian Information:

Name _____

Street: _____P.O. Box_____

City & Zip _____, IL _____

Home Phone: _____

Cell Phone: _____

Email address: _____

Does this student have an Individualized Education Plan? YES _____ NO _____

Mother's Name | Mother's Occupation & Place of Employment | Mother's Work Phone Number

Father's Name | Father's Occupation & Place of Employment | Father's Work Phone Number

Please check the box next to any above phone number you DO NOT wish to have called as part of the Instant Messaging phone system.

Emergency Information: In order to safeguard your child in case of early dismissal, illness, or accident: If you do not have a phone or cannot be reached, whom shall we contact and where shall we send your child?

Relative/Friend #1 :	Name:	Relationship:	Phone:
Relative/Friend #2 :	Name:	Relationship:	Phone:

Doctor's Info :	Doctor:	Doctor's Phone:
Hospital's Info:	Hospital's Name:	Hospital's Phone:

Child covered by: (Mark one) _____ Insurance _____ Medical Card _____ All Kids _____ Not covered

Health History	Yes	No
ADD/ADHD		
Heart		
Seizures		
Asthma		
Diabetes		
Glasses		
Hearing aid		

Allergies (food or medicine): _____

Please state all medications being taken:

1.

2.

3.

Ethnic Code: (Check one)

Asian _____ Hispanic _____

Black_____ White_____

American Indian_____ Multi-Racial_____

Other:_____

Is a language other than English spoken in the student's home? Yes ____ No ____
If yes, which language?_____

Does the student speak a language other than English? Yes ____ No ____
If yes, which language? _____

ADDITIONAL COMMENTS:

Consent of Parent/Guardian: I agree to the release of health information on my child to appropriate school or health authorities and to Medicaid as needed for reimbursement.

Signature: _____ X Date:_____ X

Beckemeyer Elementary	Coffeen Elementary	Hillsboro Junior High	Hillsboro High School
532-6994	534-2314	532-3742	532-2841

Pat Quinn, *Governor*

Illinois Department of Human Services

Michelle R.B. Saddler, *Secretary*

100 South Grand Avenue, East • Springfield, Illinois 62762
401 South Clinton Street • Chicago, Illinois 60607

Dear Parent,

I am pleased to announce that Hillsboro Community Child Development Center has earned a Star Level 2 Award from the Illinois Quality Counts - Quality Rating System. This means that your child's program has gone the extra mile to make sure your child is receiving an enhanced learning and care experience. This can help prepare your child for success in school and in life. The Quality Rating System (QRS) is a voluntary process and recognizes a program's effort in going beyond the minimum state licensing requirements when caring for your child.

QRS certification is a detailed process and takes many hours of preparation by the director, teachers and staff. Independent evaluators, using a set of nationally recognized standards,observed in classrooms. They evaluated how the teachers work with the children, how rooms are set up and what learning materials are available. Director and teacher education and overall administrative practices of the center were also reviewed.

What does this Star Award mean to you and your child? By earning this distinction, your child care program has met specific standards of quality care and is helping to give your child a good start in learning and in life. If you would like more information on the QRS process, ask the center director or visit www.inccrra.org.

Congratulations on selecting a Star Award Program for your child and please make sure to congratulate Hillsboro Community Child Development Center on earning a QRS Star Award.

Sincerely,

Linda Saterfield

Linda Saterfield, Chief
Bureau of Child Care & Development

Child and Adult Care Food Program

INFANT FORMULA/FOOD WAIVER NOTIFICATION

Hillsboro Community Child Development Center
(Name of Child Care Center/Home)

_____ (Infant's Name)

_____ (Birth Date)

For Parent/Guardian of Infants Age Birth Through 11 Months

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

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

This center/home will provide:

Iron-fortified infant formula (list brand) Similac W/Iron;

Iron-fortified infant cereal (list type such as baby rice cereal) Gerber Rice; and

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

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

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

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

Section 1—Infant Formula or Breast Milk

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

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

Section 2—Infant Cereal

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

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

Section 3—Baby Food

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

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

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

_____ (Parent's Signature)

_____ (Date)

Hillsboro Community Child Development Center, 1220 Tremont St., Hillsboro, IL 62049 · Phone 217.532.4327 · Fax 217.532.3137

Parent Reflection of Orientation

Child's Name:

Child's Start Date:

Please check all the ways that you connected with HCCDC when you first started.

_____ spoke to HCCDC staff on the phone or walked in and spoke to someone.

_____ spoke to Sheri or Nancy on the phone or in person to get the particulars of the program.

_____ tour of the facility by the Director or center staff.

_____ introduced to my child's teacher and spoke to her about the room.

_____ spent some time in the room with children and teachers.

_____ talked with the teachers about personal care of my child. Such as; things to bring, what they eat, class schedule, and napping.

_____ Nancy went through all the paper work with me and assisted me if I needed it.

_____ sat in on a formal orientation with Ms. Adkins and Ms. Annette for Pre - school.

Please feel free to give us any suggestions for orientation in the future.

Parents name:

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

CFS 593
Rev 12/00

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD _____

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

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

EMERGENCY MEDICAL CARE

This authorizes Hillsboro Community Child Development Center to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement. _____ is the preferred doctor/clinic/hospital. Please fill this in. →

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

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

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

ADMINISTER PATENT MEDICINE

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

I/we authorize Hillsboro Comm. Child Dev. Center to administer patent medicine to my/our child as specified in written instructions.

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

Date _____

_____
Signature of parent/guardian

_____
Relationship to child

- over -

CHILD PICKUP

I/we authorize ONLY _____
Name Address Phone

and/or

_____
Name Address Phone

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

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES

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

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

SWIMMING

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

at 1210 E. Tremont St. Hillsboro, IL.
Address

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child