

**Morton Grove Park District
Preschool Health and Parental Authorization Form**

Immunization: <input type="checkbox"/>
Birth Certificate: <input type="checkbox"/>

Preschool Location: Mansfield Oketo Austin National 2 Year 3 Year 4 Year

GENERAL INFORMATION

Child's Name: _____ Phone #: _____ Cell #: _____

Home Address: _____ City: _____ Zip: _____

E-mail Address: _____ Birthdate: ____/____/____ Sex: _____

Nickname: _____ Name to be used in school: _____

Mother's Occupation: _____ Father's Occupation: _____

No. of Brothers: _____ Ages: _____ No. of Sisters: _____ Ages: _____

Include all authorized individuals to be contacted other than parents.

1. Name: _____ Phone #: _____ Relationship: _____

2. Name: _____ Phone #: _____ Relationship: _____

Include all authorized individuals to pick up child from program other than parents or emergency contacts. Children will **ONLY** be released to persons listed below. Notify teacher if there is a change on the list.

1. Name: _____ Phone (work) _____ (home) _____

2. Name: _____ Phone (work) _____ (home) _____

How will your child be picked up from school? By parent Car Pool Other _____

List other schools your child has attended: _____

HEALTH RECORD

Date of Last Examination: _____ General Results: _____

Allergies, diseases, disorders, disabilities or physical defects: _____

Activities child should not participate in: _____

Right or Left Handed: _____

Does your child require special assistance? Yes No _____

Does your child require medication during program hours? Yes No
(if Yes, Medication Dispensing Information Form must be completed)

Doctor's Name: _____ Address: _____

Phone #: _____

SOCIAL RECORD

Other members of your household including yourself: _____

Primary language spoken at home: _____ Secondary language: _____

PERMISSION SLIPS

Fieldtrips: In our Preschool program, we take fieldtrips and feel this a great way for children to gain new experiences. In the Fall and Spring, the preschool staff likes to take a trip with some of the 3 year olds and 4 year olds. When the weather does not cooperate, the Park District requires permission to change the destination of a trip. If a trip destination is to be changed, it will be posted on the door of the designated drop-off area.

Parent Helper: A parent will be asked to assist in our preschool program several times during the school year. The exact number of times you are asked to help depends on which program your child is enrolled and the number of children enrolled. Sign-up sheets will be available at the Parent’s Meeting. You are responsible for the days you are signed up for and if you can’t help you must find someone to take your place. Parent Helpers can be other family members, friends or caregivers. If you do not fulfill your obligation to help, you will be asked to withdraw your child from the program. In addition, you may also be asked to accompany your child on any or all fieldtrips if the staff feels uncomfortable taking your child along for any reason.

In the event that younger siblings must attend the program with the assisting parent, the parent must fully understand that that they are responsible for their children.

Parent/Guardian Signature: _____

Walk Around Permission: We will be going for walks around our school neighborhood during the school year. We will go looking for signs of Fall, Spring, etc. Some classes might walk to the fire station, post office or the mail box on the corner. A note will be posted on the school door in case of an emergency.

My child has permission to accompany the teacher and class on walk around trips.

Parent/Guardian Signature: _____

EMERGENCY TREATMENT RELEASE: As a parent and/or guardian, I authorize that in a medical emergency regarding my minor child, that the local emergency medical service be contacted. If, as determined by the local emergency medical service, my child needs emergency medical treatment and needs to be transported to an emergency care center, I authorize treatment and transportation. If in the opinion of the attending physician at the emergency care center that further treatment is necessary, I authorize the treatment of my child, However, a reasonable effort should be made to contact myself and/or if needed, the alternate emergency contacts listed. I declare that I exercised my own judgement in deciding whether to sign this agreement and I further declare that my decision to sign was not based on or influenced by any declarations or representations of the Morton Grove Park District or its employees, agents or instructors. In addition, I agree that I will be responsible for payment for any and all medical services provided.

Signature of Parent/Guardian: _____ Date: _____



State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011



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

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA YR		
	DTP or DTaP																	
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										COMMENTS:								
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps											
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

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

Date of Disease	Signature	Title	Date
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3. Laboratory confirmation (check one) ** Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN													
Date													Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade													
	R	L	R	L	R	L	R	L	R	L	R	L	
Vision													
Hearing													

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

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night	Yes	No	Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____					
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?	Yes	No	Parent/Guardian Signature		
Bone/Joint problem/injury/scoliosis?	Yes	No	Date		

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

HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date (Blood test required if resides in Chicago.)				
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____				
Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____				

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist) <input type="checkbox"/> Contoller medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting	DIETARY Needs/Restrictions
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SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes No If yes, please describe.
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified,please attach explanation.)

PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited

Print Name	(MD,DO, APN, PA) Signature	Date
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Address	Phone
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(Complete both sides)