



## **Welcome to Kensington School!**

You will find attached forms that will complete your child's file, per DCFS requirements.

Please complete these forms and return to the school at least one month prior to your child's starting date. We will review the forms and contact you if any further information is required.

Forms should be carefully completed by parents or guardians. The medical form must be completed by your child's physician. Please note the child's health history section on the medical form, which must be completed by a parent or guardian.

Thank you!

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**LaGrange · LaGrange Highlands · Western Springs**

**Geneva · St. Charles · Naperville · Wheaton**

**South Naperville · Elmhurst**



# Getting to Know Your Child

(for 2 to 5 year-olds)

Please complete this form so that we may get to know your child better.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Nickname/What would you like us to call your child? \_\_\_\_\_

## Health

Any allergies? \_\_\_\_\_

Any medical conditions? \_\_\_\_\_

## History

Age began talking \_\_\_\_\_ Is your child right handed? \_\_\_\_\_ Left handed? \_\_\_\_\_

Any speech or hearing difficulties? \_\_\_\_\_

Is your child potty trained? \_\_\_\_\_ when? \_\_\_\_\_

## Social Relationships

Previous group experience \_\_\_\_\_

Favorite toys and activities at home \_\_\_\_\_

Knows the following children in our school \_\_\_\_\_

Is your child generally friendly \_\_\_\_\_ shy \_\_\_\_\_ active \_\_\_\_\_ sensitive \_\_\_\_\_ other \_\_\_\_\_

How does he or she get along with siblings? \_\_\_\_\_

How does the child express feelings? \_\_\_\_\_

How do you discipline? \_\_\_\_\_

Has had experience with: Play-Doh \_\_\_\_\_ scissors \_\_\_\_\_ easel painting \_\_\_\_\_ climbers \_\_\_\_\_

finger painting \_\_\_\_\_ climbers \_\_\_\_\_ water play \_\_\_\_\_ tricycles \_\_\_\_\_

## Eating

Favorite foods \_\_\_\_\_

Food dislikes \_\_\_\_\_

Food allergies/restrictions \_\_\_\_\_

Is child hungry at meal times? \_\_\_\_\_ Between meals? \_\_\_\_\_

## Sleeping

Time child goes to bed at night \_\_\_\_\_ awakens \_\_\_\_\_

Does child need help going to sleep? Is there a special blanket or stuffed animal? \_\_\_\_\_

Mood when awakened \_\_\_\_\_

Does child nap at home? \_\_\_\_\_ When to when? \_\_\_\_\_

In what particular ways can we help your child this year? What do you hope your child will gain from this experience? Please add this and any additional comments or information on the back of this form.

Thank you!



# Getting to Know Your Child

(Infant/Toddler)

Please complete this form so that we may get to know your child better.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Nickname/What would you like us to call your child? \_\_\_\_\_

## Health

Any allergies? \_\_\_\_\_

Any medical conditions? \_\_\_\_\_

Is your child teething? Special instructions when teething \_\_\_\_\_

## Large Motor Skills

Age learned to roll over \_\_\_\_\_ to sit up \_\_\_\_\_ to crawl \_\_\_\_\_ to stand \_\_\_\_\_ to walk \_\_\_\_\_

## Small Motor Skills

Age learned to hold objects \_\_\_\_\_ to transfer objects hand to hand \_\_\_\_\_ to hold a cup \_\_\_\_\_

Age began self feeding \_\_\_\_\_

## Social Relationships

Previous group/babysitting experience \_\_\_\_\_

Favorite toys and activities at home \_\_\_\_\_

Is your child generally happy \_\_\_\_\_ shy \_\_\_\_\_ trusting of others \_\_\_\_\_ other \_\_\_\_\_

Does he or she have siblings? \_\_\_\_\_ What age? \_\_\_\_\_

## Eating

Favorite foods \_\_\_\_\_

Food dislikes \_\_\_\_\_

Food allergies/restrictions \_\_\_\_\_

Has your child started eating: Solid Food \_\_\_\_\_ Cereal \_\_\_\_\_ Fruits \_\_\_\_\_ Vegetables \_\_\_\_\_ Meat \_\_\_\_\_

Table Food \_\_\_\_\_ 2% Milk \_\_\_\_\_

## Sleeping

Naps: How many naps a day does your child take? \_\_\_\_\_ Approximately what times? \_\_\_\_\_

How does your child like to fall asleep? \_\_\_\_\_

What is the preferred sleeping position? \_\_\_\_\_

More information regarding your child's eating and sleeping schedule/Additional Comments:

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Thank you!



# Getting to Know Your Child

(Kindergarten)

Please complete this form so that we may get to know your child better.

Child's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Nickname/What would you like us to call your child? \_\_\_\_\_

## Health

Any allergies? \_\_\_\_\_

Any medical conditions? \_\_\_\_\_

Any speech or hearing difficulties? \_\_\_\_\_

## Social Relationships

Previous school experience \_\_\_\_\_

Knows the following children in our school \_\_\_\_\_

Is your child generally friendly \_\_\_\_\_ shy \_\_\_\_\_ active \_\_\_\_\_ sensitive \_\_\_\_\_ other \_\_\_\_\_

How does he or she get along with siblings? \_\_\_\_\_

How does the child express feelings? \_\_\_\_\_

Favorite pastime activities or hobbies? \_\_\_\_\_

## Eating

Food allergies/restrictions \_\_\_\_\_

Is child hungry at meal times? \_\_\_\_\_ Between meals? \_\_\_\_\_

Favorite foods \_\_\_\_\_

Food dislikes \_\_\_\_\_

## Preferences

Does your child enjoy active play? \_\_\_\_\_

Has he/she participated in group activities? \_\_\_\_\_

Does your child enjoy team sports? Which ones? \_\_\_\_\_

## Sleeping

Time child goes to bed at night \_\_\_\_\_ awakens \_\_\_\_\_

Does your child nap? \_\_\_\_\_

In what particular ways can we help your child this year? What do you hope your child will gain from this experience? Please add this and any additional comments or information on the back of this form.

Thank you!



# Authorization for Emergency Medical Care

I authorize the staff and Director to administer first aid to my child. I give consent for any necessary medical care for my child \_\_\_\_\_ while said child is in said individual's custody and the parent cannot be reached.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Permission is given if my child becomes seriously ill or injured for the school's staff to proceed as follows: the emergency ambulance service (911) will be immediately called to the school and the emergency paramedics will make the decision as to whether or not the child will be transported to the hospital. A member of the staff will accompany the child until the parent arrives. Parents will be notified immediately.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

In the event of an emergency, we must have the name, address and phone number of someone we can reach if we cannot contact you.

Father's Work Phone \_\_\_\_\_ Father's Cell Phone \_\_\_\_\_

Mother's Work Phone \_\_\_\_\_ Mother's Cell Phone \_\_\_\_\_

Home Phone \_\_\_\_\_

1. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

2. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

3. Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Does your child have any allergies, food restrictions or medical conditions? \_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_



## Consent Form

- I understand the policies and the tuition procedures of the school as stated in the parent handbook and enrollment forms and assume responsibility for such.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

- I understand that the center is not responsible for my child(ren) until he/she has been placed in the personal care of a teacher or after the child has been personally placed into the hands of the person picking up the child(ren) from the school. At those times, responsibility is that of the parent.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

- Permission is given for \_\_\_\_\_ to go on walking field trips in the surrounding neighborhood and/or to be transported and to go on field trips planned by the school on a chartered bus. Specific dates and details would follow. A separate authorization will be given at that time.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

- Permission is given to release my telephone number to other parents throughout the year.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

- My child \_\_\_\_\_, has my permission to participate in water activities and other school related activities planned by the school. I understand that he/she will be supervised by adults and safety rules will be enforced. This is not intended as a waiver or release of any legal responsibility.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

- I understand the school's policy concerning parents soliciting our teaching staff for babysitting and nannying services.

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_



# Contingency Pick-Up Form

Please complete either #1 or #2:

1. The following people have my permission to pick up my child on an occasional basis:

Name: \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address: \_\_\_\_\_ Evening Phone \_\_\_\_\_

\_\_\_\_\_  
Driver's License # \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address: \_\_\_\_\_ Evening Phone \_\_\_\_\_

\_\_\_\_\_  
Driver's License # \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Name: \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address: \_\_\_\_\_ Evening Phone \_\_\_\_\_

\_\_\_\_\_  
Driver's License # \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

—OR—

2. \_\_\_\_\_ may only be released to a parent or guardian.  
(Child's Name)

Signature of Parent or Guardian: \_\_\_\_\_

Child's Birth Date: \_\_\_\_\_



## Guidance and Discipline Policy Statement

Kensington School's philosophy of guidance is to provide a nurturing classroom environment in which children are encouraged to model their teacher's positive behavior. Kensington School's philosophy encourages communication and cooperation through positive reinforcement.

Children will be encouraged toward appropriate behavior through positive tones of voice and praise. Misbehaving will be met with a verbal reminder of accepted behavior and redirection toward more positive actions. Throughout the day, the children will be encouraged to remember the following five rules: Eyes Watching; Ears Listening; Hands Still; Brain Thinking; Heart Caring.

Children whose behavior endangers others will be supervised away from the other children while processing the problem. Time Outs are never used at Kensington School. Children will not be embarrassed for toilet accidents.

Serious inappropriate or disruptive behavior will be discussed with the parents, either in a telephone conversation or a conference, at which time a plan for resolving this behavior will be put in place. Since discipline is the responsibility of the adults who have an ongoing relationship with the child, when there is a specific plan for unacceptable behavior, all staff who affect the child shall be aware of and cooperate with the plan. If problematic behavior management plans are developed to meet the needs of a particular child, all staff working with the child shall receive training on implementing the plan.

The following forms of discipline are prohibited in our schools: any kind of corporal punishment, withholding (or threatening to withhold) food, abusive or profane language, any kind of humiliation, any form of emotional abuse i.e. shaming or isolating a child.

### DISCHARGE POLICY:

A child may be discharged from the school due to any of the following:

1. If it is determined that the child is disruptive, uncooperative, or in any way disturbs the other children or the program.
2. If it is determined that the child's needs are not being met at the school.
3. If the parent does not comply with the policies of the school such as: fees not paid on time, child not picked up on time, etc.

The Director and the staff will work with the child and parents to attempt to arrive at an amicable solution to any problem. If all avenues of intervention have been unsuccessful, the school will offer assistance in locating suitable alternate care. Parents will be given ample time to visit and secure placement for their child. Discharge will occur as a last resort.

I have read and agree to comply with the school's policies regarding discipline and discharge.

Parent/Guardian Signature \_\_\_\_\_ Child's Name \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_





## Late Pick-Up Policy Statement

FOR OUR PART-DAY STUDENTS, children may be picked up 10 minutes before to 10 minutes after the scheduled ending time for the class. Parents will be required to pay a late pick-up fee of \$5.00 if the parent is ten minutes late or less. If the parent is more than ten minutes late, the fee is a dollar per minute thereafter. This late fee is per family, not per child, and is payable to Kensington School. The fee will be added to your account. Please be aware that this policy will be enforced regardless of weather or any unexpected circumstance. If a parent is later than fifteen minutes picking up a child and has not called, the closing director will begin to contact the child's emergency contacts.

FOR OUR FULL-DAY STUDENTS, our school is open at 7:00am and closes promptly at 6:00pm. The parent of any child remaining in the school after 6:00pm will be required to pay a late pick-up fee of \$5.00 if the parent is ten minutes late or less. If the parent is more than ten minutes late, the fee is a dollar per minute thereafter. This late fee is per family, not per child, and is payable to Kensington School. The fee will be added to your account. Please be aware that this policy will be enforced regardless of weather or any unexpected circumstance. If a child's parent has not arrived by 6:10pm, the closing staff will begin attempting to contact the child's parents to determine the estimated time of arrival. At 6:15pm, if these attempts are unsuccessful, the closing staff will begin contacting the emergency contacts provided by the parents to arrange for them to pick up the child. At 7:00pm, if all attempts to reach the parents and emergency contacts are unsuccessful, the closing staff will contact the school director and notify her of the situation. The closing staff will then contact the police for assistance.

It is the responsibility of the parents to ensure that the school has current contact information for their emergency contacts at all times. Emergency contact information must be on the child's enrollment form and contingency form. If a parent is late, our staff will diligently call all phone numbers for parents and emergency contacts. If we are unable to reach any contacts, we will have to notify the police department.

Our teachers will maintain a positive, caring atmosphere for the child during this time and ensure that the child is comfortable, reassured and not in any distress. Our teachers will only discuss the issue with a parent or emergency contact, never with the child.

I have read and agree to comply with the school's Late Pick-Up Policy.

Parent/Guardian Signature \_\_\_\_\_ Child's Name \_\_\_\_\_

Date \_\_\_\_\_



## Photo Release

As the parent/guardian of a child at Kensington School, I agree to the following:

- I understand that my child, whose name is listed below, may be photographed at Kensington School during class time, field trips, special events and celebrations.
- I understand that photographs may be used internally in classroom and hallway displays.
- I understand that photographs may be used externally in school newsletters, promotional print materials, on Kensington School's website, Kensington School's Facebook page and other social media outlets.  
*No names will be used in external publishing.*
- I understand that photographs will be reviewed and authorized by Kensington School administration prior to utilization.

**Yes, I grant consent** to Kensington School to utilize photographs of my child in classroom and hallway displays, school newsletters, promotional print materials, on Kensington School's website, Kensington School's Facebook page and other social media outlets.

**No, I do not grant consent** to Kensington School to utilize photographs of my child in classroom and hallway displays, school newsletters, promotional print materials, on Kensington School's website, Kensington School's Facebook page and other social media outlets.

*This consent is valid for the entire time my child is enrolled at Kensington School.*

*I may revoke this consent at any time by notifying the school director.*

**\*\*Individual form required for each child\*\***

Child's Name (please print) \_\_\_\_\_

Parent/Guardian Name (please print) \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**PLEASE CIRCLE LOCATION:**

Elmhurst

Geneva

Highlands

LaGrange

Naperville

South Naperville

St. Charles

Western Springs

Wheaton

Dear Parent, Guardian, or Staff Member:

Kensington School practices Integrated Pest Management (IPM), an approach to pest control that reduces pest populations while minimizing pesticide applications. If, after trying non-chemical and least-toxic means to control a current pest problem, and a pesticide has been deemed necessary, applications will be scheduled for Friday afternoons whenever possible.

We will notify and/or post any needed pesticide applications for your review. The term pesticide includes insecticides, herbicides, rodenticides and fungicides. If you have any questions or comments, please contact the school Director.

Thank you for your cooperation.

Kensington School

Parent Signature \_\_\_\_\_

Child Name \_\_\_\_\_

Date \_\_\_\_\_



## Child's Birth Certificate

The Department of Children and Family Services  
requires all licensed programs  
to have a copy of a child's birth certificate on file.

A copy of your child's birth certificate  
must accompany all of the forms  
to complete his or her file.

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Dear Physician,

Section 407.310 (Health Requirements for Children) DCFS licensing standards states:

- ◆ A medical report, on a form presented by the department, shall be on file for each child and shall include a physical that should be administered no earlier than six months prior to the first day of enrollment. This physical shall be repeated every two years. For school-age children, a copy of the most recent regularly scheduled school physical may be submitted (even if more than six months old).
- ◆ A tuberculin test shall be included in the initial only. A TB test is required within six months prior to enrollment unless the physician verifies in writing that the current test is valid and anew TB test is not necessary.
- ◆ The initial examination shall show that children from the ages of one to six years have been screened for lead poisoning (for children residing in an area defined as high risk by the Illinois Department of Public Health in its Lead Poisoning Prevention Code 977III. Adm. Code 845) or that a lead risk assessment has been completed for children residing in an area defined as low risk by the Illinois Department of Public Health.

If you feel that a TB test is not necessary at this time because of low risk factors, please indicate below. If you feel that a lead poison screen is not necessary at this time because of low risk factors, please also indicate below.

\_\_\_\_\_ I do not feel a TB test is necessary at this time.

\_\_\_\_\_ I do not feel that a lead poison screen is necessary at this time. .

Physician comments:

Child's Name \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

**ON THE MEDICAL FORM:**

- ◆ **physician must sign/date under physical examination**
- ◆ **health care provider must sign/date under immunization dates**
- ◆ **parents must complete health history**



## State of Illinois Certificate of Child Health Examination

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



<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>
Last	First	Middle	Month/Day/Year			
<b>Address</b>			<b>Parent/Guardian</b>		<b>Telephone # Home Work</b>	
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		
	<b>DTP or DTaP</b>																	
<b>Tdap; Td or Pediatric DT</b> (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		
<b>Polio</b> (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		
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>								
<b>MMR</b> Combined Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>											
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> 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.)

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**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.

<b>Date of Disease</b>	<b>Signature</b>	<b>Title</b>	<b>Date</b>
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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													
<b>Date</b>													<b>Code:</b> P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
<b>Age/Grade</b>													
	R	L	R	L	R	L	R	L	R	L	R	L	
<b>Vision</b>													
<b>Hearing</b>													

<b>Student's Name</b> Last First Middle	<b>Birth Date</b> Month/Day/ Year	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

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

<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ (Blood test required if resides in Chicago.)				
<b>TB SKIN OR BLOOD TEST</b> 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. <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/>				
<b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____				

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"/> Controller medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> 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 _____
Address _____		Phone _____

(Complete both sides)