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!

LaGrange · LaGrange Highlands · Western Springs

Geneva · St. Charles · Naperville · Wheaton

South Naperville · Elmhurst · Glenview · Arlington Heights

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:

_____

_____

_____

_____

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. This includes:

  Kensington School of Arlington Heights is a full day, year-round early childhood program. If a child disenrolls, re-enrollment is dependent upon availability.

  A child must start within two weeks of his or her anticipated start date listed on the enrollment form. Full tuition must be paid to hold a child's place should there be a delay in a start date beyond two weeks or that child's place is forfeited. There is a one month courtesy hold for a delay in an infant's proposed start date. All enrollment fees and deposits are forfeited should a child not enroll.

  Signature of Parent or Guardian _____ Date _____

- I understand that the school 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 _____

AH

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 _____

2016

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: Arlington Heights Elmhurst Geneva Glenview 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.

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**

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

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	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 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)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ 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**

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																						
Age/ Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L		
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

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? 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				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	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		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

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☐ 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 QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionairre Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **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 ☐** **Test performed ☐**
Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ 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☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

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?

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)