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 ______________________

Email Address ______________________ 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 7/2007

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 ____
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.

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize ______________________________ 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 OVER-THE-COUNTER MEDICINE

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

I/we authorize ______________________________ to administer over-the-counter 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

(Use additional sheet of paper if more than 3 people are authorized to pick up child)

I/we authorize ____

Name Address Phone

and/or

____

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 ______________________________ 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 ______________________________

Name of Provider

at ____.

Address

Date ____________________

____
Signature of parent/guardian

____
Relationship to child

Date ____________________

____
Signature of parent/guardian

____
Relationship to child

State of Illinois
Department of Children and Family Service

I, We,____

Parents of _________________________________, hereby certifiy
That I / we have received of licensing standards and other materials published by the Illinois Department of Children and Family Services. This material is in the Malones Early Learning Center Inc. handbook.

_________________________________ ___________________
(Signature of Parent) (Date)

_________________________________ ___________________
(Signature of Parent) (Date)

I,_________________________give my permission to the staff of Malone's Early Learning Center to transport my Child _________________________
(Name of Child)

_________________________________ ___________________
(Signature of Parent) (Date)

Malones Early Learning Center has permission to photograph my child, ____________________. I understand that the photographs may be used for assessment, documentation or used on Malones Early Learning Centers, facebook page.

_________________________________ ___________________
(Signature of Parent) (Date)

WRITTEN PROCEDURES FOR TERMINATION OF A CHILD'S ENROLLMENT IN THE CENTERS

If a child's enrollment must be terminated because of behavior problems, the following procedure will be followed:

1) The parent will be notified in writing of the problem and parent teacher conference will be scheduled. At that time, a behavior modification plan shall be implemented that is agreeable to both parent and staff.
2) Should the behavior continue the child would be suspended from the center for 3 days.
3) Future incidents will result in termination of the child's enrollment. The center will make every possible effort to assist the parent in finding care That will meet the child's needs in a positive manner.

I HAVE READ MALONES EARLY LEARNING CENTERS INC'S PHILOSOPHY OF DISCIPLINE AND AM IN AGREEMENT WITH THE CONCEPTS PRESENTED.

____________________________________ __________________

Signature Date

__________staff ____________parent

By signing below I have agreed to read the handbook and abide by all center policies covered in Malones Early Learning Center, Inc. Handbook. Malones ELC, Inc. reserves the right to modify or rescind any part(s) of the handbook at any time without prior notice.

I have read Malone's Parent Handbook. While my children are enrolled in Malone's Center, I will comply with the various policies and procedures. By signing this I am verifying that I received the initial parent orientation as described in the family handbook.

Signature________________________ Date______________

I give Malones Early Learning Center Inc permission to release screening information to the appropriate sources in the event that my child is in need of further testing.

Signature_______________________ Date_____________________
Please Print your children's name below.

____

____

____

____

SURVEY

How did you hear about our center?

Word of mouth____________

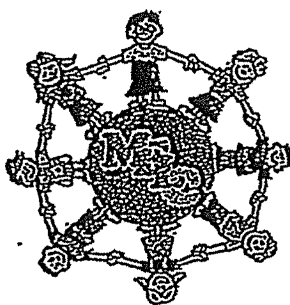
Radio Station _______________

Face book___________

Web Site______________

Other______________________(Please tell us how you heard about us.)

Email Address ____
Revised: February 13th 2020



Dear Parent/Guardian:

You are your child's first and most important teacher! We appreciate the opportunity to be partners with you in his/her development. Because your child's first 5 years of life are so important, we want to work together with you to provide the best start possible.

To help us learn more about your child, we would like you to fill out a brief online questionnaire. You will be asked to answer questions about some things your child can and cannot do. This is a great way to check in on your child's development. Your answers will also help his/her teacher to get to know your child better and how best to support him/her in the classroom. ***This information will remain confidential and we will not share it with anyone without your consent.***

Completing the questionnaire is easy and should take about 8-10 minutes. To access the questionnaire online you can Copy and paste the link below:

https://www.asqonline.com/family/282264

First Page: Make sure you complete all the information on the first page.
Section 1: Each section has six questions in five developmental areas that go from easier to more difficult skills. Your child may be able to do some but not all of the items. Read each question and mark: .

YES if your child is performing the skill
SOMETIMES if your child is performing the skill but doesn't yet do it consistently
NOT YET if your child does not perform the skill yet.

You will be able to answer many of the questions based on your day to day experiences. That's great! However, there may be some questions involving specific activities that are not part of your normal routine. **If activities are involved in the questionnaire, make it a game that's fun for you and your child. If doing activities, make sure he or she is rested, fed and ready to play before you try them**

Section 2: The Overall section asks important questions about your child's development and any concerns you may have. Answer questions by marking YES or NO, and if indicated, *please explain your response*.

Don't overthink the answers. Have fun completing the questionnaire with your child!. Please be sure to complete the online questionnaire in a timely manner.

Once received, the teacher can review your responses and make arrangements with you to share and discuss the results. If you have any questions or concerns, please contact your child's teacher.

Sincerely,

Lee Eklund

Malone's Early Learning Center

Southern Illinois Screening Collaborative

Permission to Screen and Enter Results into Database

Today's Date: ______________________ Location: ______________

Child's Name: ______________________ Male ☐ Female ☐

Birth Date: __________ If your child was premature, how many weeks? ______________

Parent's/Guardian's Name: ____________________________________

Address: ____________________________________
Street City Zip

Phone Home __________ Cell __________ School District: ______________

Email address: ____________________________________

Primary Home Language: __________ Secondary Home Language: ______________

Do you have any concerns about your child? (Please explain) ______________________

____

Has your child ever been screened before? No ____ Don't know ____ Yes ____ If so, where and when? ________

____

Has your child attended any program or received any services? No____ Yes ____

If yes, what program/services? ____________________________________

The Purpose of the Collaborative is to develop and implement a system, that includes policies, procedures and protocols that ensure all children ages birth to 5 are screened for developmental delays and receive the necessary services and supports that promote positive growth and development.

- I give my permission to the participating agencies* of the *Southern Illinois Screening Collaborative* to assess my child's speech, vision, hearing, and overall development and to enter the information into their secure regional database.
- I understand that the tools used are nationally known and valid in assessing the developmental status of children. The screening is implemented in a "game-like" format of activities and results may be reviewed by participating agencies*. I understand that the results will be reviewed with the parents or guardian.
- Your child's results are confidential and will not be shared outside of the Southern Illinois Screening Collaborative. Demographic information will be used for reporting purposes but all identifying information will be removed.
- I am willing for this information to be shared for potential enrollment into high quality early childhood programs and determining if additional educational services are needed and available.
- I understand that referrals will be made for children as required by law if results indicate a potential delay. Information will be shared between referral agencies.
- I understand that I can revoke this *Permission to Screen* in writing at any time. Until then, this permission is valid.

______________________________ ______________

Parent/Guardian Signature *Date*

*Participating agencies may include: CCR&R at JALC, Child and Family Connections, Early Head Start and Head Start Programs, Early Intervention Programs and Prevention Initiatives, Preschool Programs, Local Education Agencies, Licensed Child Care Centers and Family Child Care Homes, Health Departments and Physicians

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ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT AND CREDIT CARD

I (we) hereby authorize (business name) ______________________ to initiate credit card charges to the below-referenced credit card account (Section A) OR, initiate debit entries to my (our) checking or savings account, indicated below (Section B). To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name ______________________ Phone # ______________

Cardholder Address ______________________ City ________ State ______ Zip ______

Account Number ______________________ Expiration Date ______________

Cardholder Signature ______________________ Date ______________

SECTION B (Bank Account)

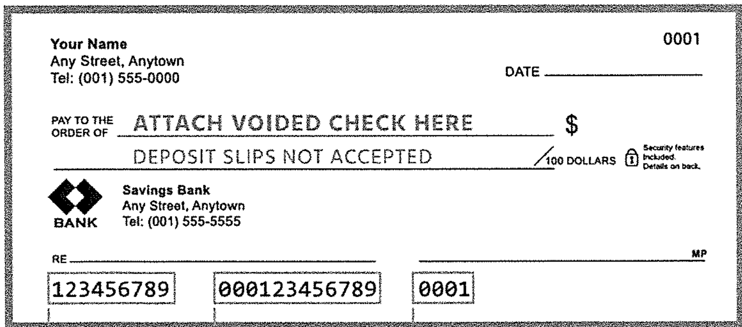
Your Name ______________________ Phone # ______________

Address ______________________ City ________ State ______ Zip ______

Bank or Credit Union Name ____________ Bank or Credit Union Address ____________ City ________ State ______ Zip ______

Routing Transit Number (see sample below) ____________ Account Number (see sample below) ____________ ☐ Checking ☐ Savings

Authorized Signature ______________________ Date ______________



ROUTING NUMBER

ACCOUNT NUMBER

CHECK NUMBER

FOR OFFICIAL USE ONLY

Date Received ______________

Employee Signature ______________

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