STATELINE FAMILY YMCA
ROSCOE GROWING TREE
Preschool Enrollment Form

CHILD'S NAME _____
LAST **FIRST** **MI**

CHILD'S DATE OF BIRTH _____ **STATELINE YMCA MEMBER** ◯ **YES** ◯ **NO**

PARENT/GUARDIAN _____
LAST **FIRST** **MI**

PARENT/GUARDIAN DATE OF BIRTH _____

PARENT/GUARDIAN E-MAIL ADDRESS _____

ADDRESS _____
CITY **STATE** **ZIP**

PHONE _____ _____ _____
CELL **HOME** **EMERGENCY**

ENROLLMENT:

◯ **AM CLASS**
M-TH
8:30AM-11:00AM

FEES:

YMCA MEMBER $225/MONTH
NON MEMBER $265/MONTH

BY ENROLLING IN THE STATELINE FAMILY YMCA PRESCHOOL PROGRAM, I AGREE TO THE FOLLOWING:

- **My $50 Registration and the First Months Fee is due at time of registration. These fees are non-refundable.**
- **Preschool Fees will be automatically drafted on the 1st of each month using the banking information you provide. The drafts will occur October-May (Sept. due at time of registration). There are no pro-rates/discounts for missed days, each month will be the same you will be charged the same fee.**
- **There will be a $25 fee for every declined/returned payment.**
- **All enrollment changes must be made by the 15th of the month prior to the change.**

PARENT/GUARDIAN SIGNATURE _____ _____
DATE

OFFICE USE ONLY

___ Registration Fee and First Months Payment Paid **___ Enrolled in AM Preschool**

___ Fees Up-Dated in Spreadsheet **___ Discount Applied if Applicable**

Program Specialist Signature _____ **Date** _____

STATELINE FAMILY YMCA
BANK OR CREDIT CARD DRAFT AUTHORIZATION

Name (please print) _____
Last First Middle Initial

Address _____
City State Zip Code

Program: Child's Name_____

[ ] Afterschool Enrichment Program (Monthly draft occurs the 1st of the Month)

[ ] Preschool (Monthly draft occurs the 1st of the Month)

[ ] Daycare (Weekly draft occurs Monday of the week attending)

Draft Options

[ ] Checking Account Bank Name _____

Account #_____ Bank Routing # _____

[ ] Savings Account Bank Name _____

Account #_____ Bank Routing # _____

[ ] Credit Card Name on Card _____

Account # _____ Card Type _____
(Discover, MasterCard or Visa)

Expiration Date_____CID# _____

- **This authorization continues indefinitely and automatically until cancelled by the person signing this authorization. Draft cancellations require a 15 day notice.**
- Amount of draft will be determined by elected program and the fee and adjustments defined by the program policy. The draft may be adjusted based on increased fee rates or adjustments as defined by the program policy.
- Each program requires separate authorization forms.
- All drafts are non-refundable
- A fee of $25 will be charged for all returned drafts because of non-sufficient funds, account closing or payment stopped. Two charges of this type will result in expulsion from the program.

I authorize the Stateline Family YMCA to draft the above named bank or credit card account for payment of membership or program fees. Any change in fees may constitute a change in the draft amount. I understand that the Stateline Family YMCA may initiate a preauthorization to validate the account number and bank transit number listed. I also understand that I am liable for the entire balance plus the processing fee for returned drafts.

_____ _____
Authorized Signature Date

DHS

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 1/2012

DCFS

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 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 ☐ 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)

STATELINE FAMILY YMCA EMERGENCY CARD

General Information

Child's Name: _____ D.O.B.: _____

Home Address: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Parent/Guardian Name: _____ Phone: _____

Child's Medical Information

Allergies: _____ Current Medication: _____

Preferred Hospital (if needed): _____

Physician & Phone: _____

Parent/Guardian Signature Authorizing Emergency Care:

_____ Date: _____

In addition to the parent(s)/guardian(s) listed on the front of this card, the following people have permission to pick up my child:

1) _____ Phone _____

2) _____ Phone _____

3) _____ Phone _____

4) _____ Phone _____

5) _____ Phone _____

6) _____ Phone _____

Parent/Guardian Signature: _____ Date: _____

Other Information that may be helpful: _____

_____

_____

My child has permission to be photographed by the Y: Yes or No

My child's photo may be used on the Y's social media, website, or other marketing materials: Yes or No

STATELINE FAMILY YMCA
ROSCOE GROWING TREE
CHILD INFORMATION

Please fill out and return this form to help us get know your child.

Child's Name _____ **DOB** _____

What is your child's experience with social interactions and how do they adapt to group settings?

_____

_____

_____

Is there anything your child is afraid of or experiences anxiety from that we should be aware of? (Examples: The dark, bathrooms, characters)

_____

_____

Does your child need a comfort item? If yes, please share a little more about the item.

_____

Does your child have any habits and/or exhibit any frequent behaviors? (Examples: Nail biting, hair twisting, pacing)

_____

_____

What is something you hope your child learns/experiences this school year?

_____

_____

_____

Is there anything else we should know about your child?

_____

_____

_____