CFS 428 Rev. 4/2001

State of Illinois Milistore essela aprivolicit edi to vins earl blido edi ti Department of Children and Family Services

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child	Birthdate	Physical handicaps Sex
Address		
Date Child Received		cobtac - yolg tot enadeldsed
PARENT OR OTHER PERSONS(S) PLACING TH	E CHILD	
Name	Name	
Relation to child		
Home address		Sexili Duo
Phone Number		
Place of employment		
Address	Address	Oces the child take a nep?
Phone Number(.o.e. e.ir	Phone Number	s the child tollet trained?
Working hours	Working hours	Joes the cama nave special r
	medication? If so, wha	Does the child regularly take
Name		
Phone Number	Relationship	Time
Ointment	70b	Alaper Changes. Pow
PHYSICIAN TO CALL IF CHILD BECOMES ILL OF	RINJURED	Other information that will he
lame		
Phone Number	Hospital or Clinic	
PROGRAM		
ays per week	Hours of care	
ate of pay (optional)		
Signature of parent or other person placing child		

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 f				
Medical problems	nily Services	nent of Children and Fan	Departm	Rev. 4/2001
	ACTIVATION OF	<u>was so decosaw</u>	OTAN 1998	
Physical handicaps				
Sex	SISDNING _			
Restrictions for play—outd	oors			_ DEMOCRATION TO SERVER
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Restrictions for play—indo	ors			GH INFI
Allergies				
Fand likes	25000			extraction of the second of th
Food likes				
Food dislikes	radou	A omneSI		Phone Number
Fears	лиринуждага	N 3008 1		
Does the child take a nap?		Time	Leng	gthasarbbA
Is the child toilet trained? _				Various Number
Does the child have specia	al names for objects? (pot	tty, cookies, drinks, etc.)		Profile Books
Does the child regularly tal	51000	Figure 17 A .	AND DESCRIPTION OF A SECURITY	
	(e medication:			
If the child is an infant, wha				
	Amount			
Diaper changes: Po	owder	SEE	Dintment	
Other information that will I	nelp in caring for the child			LIAN OF LASISTER
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		and the second s		ays per week
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CONSENTS TO DAY CARE PROVIDERS

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 a	Il of the following consents:
PMPDCENC	Y MEDICAL CARE
ENTERGENC	Y MEDICAL CARE
This authorizes	
to secure EMERGENCY medical care for my/our child when I	I/we cannot be immediately reached at the time of emergency. I/we w
be responsible for the emergency medical charges upon receipt is the preferred doctor/clinic/hospital.	t of the statement.
postate decentaring nespitat.	
Date	
Relationship to civild	Signature of parent/guardian
	Relationship to child
Date	
bessel or house election of the segment of the solid or blide out to	Signature of parent/guardian
er the super vision or the above-business provides the	Relationship to child
ADMINISTER PRE	SCRIPTION MEDICINE
I/we authorize	to administer prescribed medicine to my/our child a
specified in the prescription's directions for administration.	and the second second to my out office a
Date blisto or girlanomates?	
	Signature of parent/guardian
Signisms of penns/grandism	
	Relationship to child
Date Alado of guidanculario A	•
SWING.	Signature of parent/guardian
	CET ALC
	Relationship to child
Neme of Provider	
	PATENT MEDICINE the appropriate standards for licensure)
. (Administra Only in accord with	the appropriate standards for iteensure)
/we authorize	to administer patent medicine to my/our child as
pecified in written instructions.	Date
Date	
Relationship to child	Signature of parent/guardian
want of dimensional a	
Signature of parent/guardian	Relationship to child
Date	
Relationship to child	Signature of parent/guardian
	Relationship to child

I/we authorize ONLY	Project Paging Survives	al Component and	Phone
	Name	Address	1 110110
	EST OF THE TENED YE	COMBINIE TO D	
and/or ·	N. A. C.		
	Name	Address	Phone
CARE SERVICES	MID MAY ONLY BE USED FOR DAY	SARIE FOR MON-DOES WARDS ONLY	TEESES CONSIENT
to pick up my/our child v	when I am/we are unavailable.		
	of the following consents:	stiling placing the child may sign any or all	RB reduction (chapters
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Date	A.J. C.B. J.P. GOVE.	Signature of parent/guardian	
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time of emergency. I've		Relationship to child	CHO STRAET STROOM OF
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Date		Signature of parent/guardian	
			. Parti
	Signature of percutymardian	Relationship to child	
		•	
	TRIPS EXCITESIONS, AND	PUBLIC PARK FACILITIES	
	IRII b, EZICCIAI		
I/we authorize		to take my/our child on wal	king trips, special
	y public park facilities. I/we also authori	ze the child to ride as a passenger in the veh	HCIC OWNER OF reason by
the above married marries	(c) Thus understand all such trips are un	del me suberalizion of me spoac manage be-	onie) and machemen and
safety precautions are ta	ken in compliance with DCFS standards	for licensure.	
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		Relationship to child	
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	Relationship to child	Relationship to child	
		•	Date
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I/we consent to my/our	child using the swimming pool of	Name of Provider	
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at	Address		
	dhen mase paleining of		
Date	Market Committee of the		and the same and the fill of the
		Signature of parent/guardian	
			Dana
	Signature of parent/spaction	Relationship to child	
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	Signalure of parent/guardian	Relationship to child	
		Transfer and	



STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

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Printed by Authority of the State of Illinoi (Complete Both Sides)

Student's Name	First	Middle		rth Date Month/Day/ Year	Sex	School	Grade Level/ ID #	
HEALTH HISTORY	TO BE	COMPLETED AND S	SIGNED BY PARENT/G	UARDIAN AND VERI	FIED BY HE	EALTH CARE PR	OVIDER	
ALLERGIES (Food, drug	, insect, other)	\$979. E 9	Sex Grad	MEDICATION (List a	all prescribed or	taken on a regular basis.	int end in the control of the contro	
Diagnosis of asthma? Child wakes during the	night coughing?	Yes No Indica	ate Severity	Loss of function of on organs? (eye/ear/kidne		Yes No		
Birth complications/pre		odT bereizininthe exch	Hospitalizations? When? What for?	ovider. Not	Yes No	TO SEE STATE		
Developmental delay?	CHARLES DO BODIES	Yes No	etralodicated, à supare	epecine is modifically so	shipes in	To see for stall	effective and readly assume yourse and	
Blood disorders? Hemo Sickle Cell, Other? Exp		Yes No	The law is in	Surgery? (List all.) When? What for?		Yes No	affinity axes out hel antess leaffe	
Diabetes?	ŧ · ·	Yes No		Serious injury or illnes		Yes No		
Head injury/Concussion	/Passed out?	Yes No		TB skin test positive (Yes* No	*If yes, refer to local health department.	
Seizures? What are the	y like?	Yes No		TB disease (past or pro	esent)?	Yes* No	department	
Heart problem/Shortnes	s of breath?	Yes No.	The second secon	Tobacco use (type, fre	quency)?	Yes No	A STATE OF THE STA	
Heart murmur/High blo	od pressure?	Yes No		Alcohol/Drug use?		Yes No	atc.1.2010 (16%)	
Dizziness or chest pain exercise?	with	Yes No		Family history of sudd before age 50? (Cause		Yes No	(V90) silo	
Eye/Vision problems? Other concerns? (crosse		☐ Contacts ☐ Last ex s, squinting, difficulty rea		Other concerns?	es 🗆 Brid	ge 🗆 Plate Otl	her (mil) it soot oss martin autino	
Ear/Hearing problems?		Yes No	100		d with appropri	iate personnel for heal	th and educational purposes.	
Bone/Joint problem/inju	ry/scoliosis?	Yes No		Parent/Guardian Signature			Date (Rontowkyd 3) all.	
Entire section belo	ow to be com	pleted by MD/D	O/APN/PA				Middle States assessed and account in the	
PHYSICAL EXAMIN				HEIGHT		WEIGHT	BMI B/P	
	mmended only for se exposed to adults	children in high-risk gro	ups including children who a See CDC guidelines.				ns, recent immigrants from high // Result mn Results	
Hemoglobin or Hemato	crit		A	Sickle Cell (wh	en indicated)	Sente	
Urinalysis	otesti.		_	Developmental	Screening T	ool	not not o	
SYSTEM REVIEW	Vormal	Comments/Foll	ow-up/Needs	e 10 grant to seminar yare	Normal	Comn	nents/Follow-up/Needs	
Skin	and a			Endocrine			Andrew Control	
Ears			125 (207 5), (3 200 200	Gastrointestinal	199 0012	itation history se	Catteria create of the steel only	
Eyes Normal Yes□	No□ Objectiv	ve screening Yes□ No	□ Result	Genito-Urinary			LMP	
Amblyopia Yes□		d to Opthalmologist/Opto		Neurological		YTIMUME	PERNATIVE PROOF OF B	
Nose	1 :		,	Musculoskeletal		Algerance R	Crintical desgrossis to acceptants	
Throat		TO SEA CONTROL OF BUILDING	28 E7 60 GH 2	Spinal examination	AG DAX	STREET, and	and the following the company of	
Mouth/Dental	datasy at document	l dome, objektor at bru er	And the to see that	Nutritional status	of Holds q	coon at seasoth (a	A VI de reconstante de la constante de la cons	
Cardiovascular/HTN	stell						the second and an advantage case of	
Respiratory	2 Variation	1 Removed	D alled or D	Mental Health				
NEEDS/MODIFICATI	IONS required in t		(Delta)	DIETARY Needs/R	estrictions		Entertaine Confirmation (1996)	
SPECIAL INSTRUCT	IONS/DEVICE:	S e.g. safety glasses, gla	ass eye, chest protector for a	Thythmia, pacemaker, pros	thetic device,	dental bridge, false to	eeth, athletic support/cup	
MENTAL HEALTH/O	THER Is ther	re anything else the school	ol should know about this stu	ndent?	unnigod yth	cwarra – Inados-si	19	
f you would like to discuss	this student's healt	h with school or school h	nealth personnel, check title:	□ Nurse □ Teache	r 🗆 Couns	elor 🏻 Principal	The same of the sa	
EMERGENCY ACTIO	ON needed while	at school due to child's h	ealth condition (e.g., seizure	es, asthma, insect sting, foo	d, peanut aller	gy, bleeding problem	n, diabetes, heart problem)?	
Yes No I If yes,	nlease describe							
Blomban'S		I approve this child's n	articipation in	A A A (IEN	o or Modifie	d.nlease attach avol	anation.)	
	ation on this day,	I approve this child's p				d,please attach expl	250	
HYSICAL EDUCATI Physician/Advanced Practic	ation on this day,	□ No □ Modif	ied INTE	RSCHOLASTIC SPO		+		
	ation on this day,	□ No □ Modif	ied INTE			+		