NEWPORT CHILDREN'S ACADEMY

Child's Name: _____ Sex: M____ F_____ Birthdate: _____

Home Address:_____City:_____State:___Zip:_____

Birthplace:_____

Does your child have any medical concerns or allergies? Please list:

Parent Information Marital Status:_____ *If Divorced, Decree must be on file at school.*

Mother _____ Stepmother _____ Guardian _____

Name:_____ Home Phone: _____

Home Address: _____City: _____ Zip: _____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Hours: _____ Cell Phone: _____ Email: _____

Father _____Stepfather _____Guardian_____

Name:_____ Home Phone: _____

Home Address: _____City: _____ Zip: _____

Employer: _____ Occupation: _____

Work Address: _____ Work Phone: _____

Hours: _____Cell Phone: _____Email: _____

Enrollment: The hours and days your child will be attending:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY

How did you hear about our program? _____

Parent/Guardian Signature: _____

ADMISSION DATE: _____ **Discharge Date:** _____

NEWPORT CHILDREN'S ACADEMY

Pick-Up Information

Children enrolled at Newport Children's Academy will be released to their parents/guardians, and those persons authorized on this form. Please list, in the appropriate sections below, persons authorized to pick up your child on a regular and on a contingency basis.

Persons authorized to pick up your child on a regular basis: Persons listed will be required to show a photo I.D. in order for your child to be released.

1. Name:_____ Phone Number: _____
   Address: _____City:_____ Relationship:_____

2. Name:_____ Phone Number: _____
   Address: _____City:_____ Relationship:_____

3. Name:_____ Phone Number: _____
   Address: _____City:_____ Relationship:_____

4. Name:_____ Phone Number: _____
   Address: _____City:_____ Relationship:_____

Contingency list of persons authorized to pick up your child *occasionally*: Parents/Guardians will need to inform the director if your child is to be picked up by the following persons. Persons listed below will be required to show a photo I.D. in order for your child to be released.

1. Name:_____ Phone Number: _____
   Address: _____City:_____ Relationship:_____

2. Name:_____ Phone Number: _____
   Address: _____City:_____ Relationship:_____

3. Name:_____ Phone Number: _____
   Address: _____City:_____ Relationship:_____

4. Name:_____ Phone Number: _____
   Address: _____City:_____ Relationship:_____

Parent/Guardian Signature: _____ **Date:** _____

NEWPORT CHILDREN'S ACADEMY

Emergency Contact Information

Child's Name: _____

In case of an emergency, which parent should we call first? _____

Please number the following phone numbers in the order in which they should be called:

_____ Home: _____

_____ Work Phone: _____

_____ Cell Phone: _____

Name, address, and telephone numbers of persons to be contacted in an emergency if parents cannot be reached. Examples: additional family members, co-workers, neighbors, etc. Please list these persons in the order in which they should be called. Please note that these persons are not authorized to pick up your child unless they are listed on the Pick-Up information form.

1. Name: _____ Relationship: _____
   Address: _____ City: _____
   Daytime Phone: _____Evening Phone: _____
   Cell Phone: _____

2. Name: _____ Relationship: _____
   Address: _____ City: _____
   Daytime Phone: _____Evening Phone: _____
   Cell Phone: _____

3. 3. Name: _____ Relationship: _____
   Address: _____ City: _____
   Daytime Phone: _____Evening Phone: _____
   Cell Phone: _____

4. 4. Name: _____ Relationship: _____
   Address: _____ City: _____
   Daytime Phone: _____Evening Phone: _____
   Cell Phone: _____

Child's Physician Information

Doctor's Name: _____Phone: _____

Address: _____ City : _____

NEWPORT CHILDREN'S ACADEMY

Medical Release Forms

Emergency Medical Care

In case of an accident or serious illness with my child, I request that the school contact me immediately. If the school is unable to reach me, I hereby authorize the school to call my child's physician listed on the Emergency Contact form, and follow his/her instructions. If it is impossible to contact this physician, the school is hereby authorized to call any physician of it's choosing or arrange ambulance services to a nearby hospital, if the school deems necessary. I request further that you contact me regarding the accident as soon as possible thereafter.

Signature of Parent/Guardian: _____ Date: _____

Administer Prescription Medication

I authorize Newport Children's Academy, it's staff or designated agents to administer prescribed medication to my child as specified in written instructions. All medications must be in original packaging, with dosage and instructions clearly labeled. A separate authorization form will be completed for each prescription.

Signature of Parent/Guardian: _____ Date: _____

Administer Non-Prescription Medication

I authorize Newport Children's Academy, it's staff or designated agents to administer non-prescribed medication (ex. sunscreen and ointments) to my child as specified in written instructions. All non-prescription medications must be in original packaging, with dosage and instructions clearly labeled. A separate authorization form will be completed for each prescription.

Signature of Parent/Guardian: _____ Date: _____

Administer Fever Reducing Medication

In the event that my child develops a fever and I cannot be reached, I authorize Newport Children's Academy, it's staff or designated agents to administer fever reducing medication (i.e. Tylenol or Ibuprofen) to my child as specified in written instructions. All medications must be in original packaging, with dosage and instructions clearly labeled. A separate authorization form will be completed for each prescription.

Signature of Parent/Guardian: _____ Date: _____

NEWPORT CHILDREN'S ACADEMY

Additional Release Forms

Trips, Excursions and Field Trips

I hereby give my consent that Newport Children's Academy staff or designated agents take my child on neighborhood nature walks, excursions, and field trips. Any time my child leaves the premises, accompanying staff will follow protocol, and be in possession of a cell phone for communication purposes, a first aid kit, and the attendance book. I also authorize my child to ride as a passenger in any vehicle contracted by Newport Children's Academy. If I arrive late to the school and my child's class has already left the premises, I will first check-in with the director or designee at **Newport Children's Academy** before releasing my child to staff at the park or field trip location.

Signature of Parent/Guardian: _____ Date: _____

Photography

I hereby authorize Newport Children's Academy, it's staff or designated agents to photograph my child (without compensation) for possible use in school bulletin boards, newsletters, classroom projects, brochures, social media, or other publicity materials.

Signature of Parent/Guardian: _____ Date: _____

Giving Thanks

I have been notified that Newport Children's Academy students give thanks before every meal.

Signature of Parent/Guardian: _____ Date: _____

Proof of Identity Notification

Any child enrolled at Newport Children's Academy must provide a certified copy of the child's birth certificate or other reliable proof of identity and age of the child. The center shall make a duplicate and return the original certified copy to the parent or guardian. If a certified copy of the birth certificate is not available, the parent or guardian must submit a passport, visa or other governmental documentation as proof of the child's identity and age, and an affidavit or notarized letter explaining the inability to produce a certified copy of the birth certificate. By law, Newport Children's Academy is required to notify the Illinois State Police or local law enforcement agency if the parent or guardian fails to submit proof of the child's identity within thirty days of enrollment.

Agreement

I have received and read Newport Children's Academy policies and procedures. I will comply with all Newport Children's Academy policies and I realize if I do not follow the school policies, it will end in dismissal.

Signature of Parent/Guardian: _____ Date: _____

NEWPORT CHILDREN'S ACADEMY

Late Departure Policy

Our departure policy states that your child is to be picked up at your designated time, agreed upon at enrollment.

Newport Children's Academy closes at 6:30 pm. There is a late fee of $5.00 per every 5 minutes that you are late, per child. For example, if you arrive at 6:35 pm, you will be charged a $5.00 late fee. At 6:36 pm another fee of $5.00 is charged for the next five minutes, for a total of $10.00 due upon arrival.

At 6:35 pm Newport Children's Academy will make three attempts to contact the parent/guardian by telephone. If contact is not made, we will begin contacting individuals on the contingency list. We will make three attempts to contact those listed on the contingency list. If that fails, we move to the emergency contact list. If contact is not made after attempting to contact those listed on the emergency list, we will contact the police. If the police cannot assist, we will keep the child until 7:00 pm. After that, we will contact the child abuse hotline to assist us in this matter.

Parents/guardians are required to maintain up-to-date emergency contact information in their child's files.

Newport Children's Academy acknowledges the fact that we are responsible for the protection and well-being of the child until the parent or outside authorities arrive.

The staff at Newport Children's Academy have been trained in handling a situation in which a parent or guardian is late in picking up their child. Newport Children's Academy staff will not hold the child responsible for late pick-up, will only discuss the issue with parents/guardians, and never discuss the issue with the child.

Any child who is picked up fifteen minutes late, more than five times in a calendar year, may be dis-enrolled from the program at the discretion of the center director.

I have read and understand Newport Children's Academy late departure policy, and understand that it is my responsibility to provide accurate and up-to-date contact information for parents and other adults listed as emergency contact and authorized pick-up people.

Signature of Parent/Guardian: _____ Date: _____

NEWPORT CHILDREN'S ACADEMY

Discipline and Guidance Policy

It is very important that a child's development is nurtured through caring, patience and understanding. Firm positive statements about behaviors or redirection of behaviors are the techniques we use with infants and toddlers. Age two or older, we redirect the child to another activity. If a child is out of control, we remove them from the group and allow them to go to a separate area to gain control. When a child is placed in the thinking chair, they will sit there for one minute per year (i.e. a three year old child would be sitting in the thinking chair for three minutes.) The following is prohibited for Newport Children's Academy staff:

- Corporal punishment
- Threatening or withdrawal of food
- Withdrawal of usage of the bathroom
- Abusive/profane language
- Humiliation or Isolation
- Any form of emotional abuse

All discipline is to be positive. Cooperation from the parent is necessary to ensure optimal results. We will work together to reach a successful solution. Children who have repetitive behavior that jeopardizes the health/safety of other children will be discharged from the school. The following are school rules for the children, parents, and staff to adhere to at all times:

- We always show respect to adults, staff, and children. Be polite.
- We always walk inside the school
- We respect school property and equipment. Any child who deliberately destroys school property will be asked to reimburse the school for the damages. This is the parents' responsibility.
- We do not allow pushing, hitting, biting, pinching, foul language, pulling hair, screaming, or running.

The Early Childhood Educator (teacher) is responsible for disciplining your child. The teacher has a daily, ongoing relationship with your child and understands each child's behavior pattern.

I have read the discipline policy and understand continual misbehavior will result in dismissal.

Signature of Parent/Guardian: _____ Date: _____

NEWPORT CHILDREN'S ACADEMY

Child's Social/Emotional Background Information

Child's Name: _____

1. Please list members of your child's household:

Name	Age	Gender	Relationship to Child

2. What language, other than English, is spoken in your home? _____

3. Which holidays does your family celebrate? _____

4. Is there anything we should be aware of regarding your child's current development?
   _____
   _____

5. Do you have any family pets at home?
   _____

6. Has your child attended a play group or previous school? _____
   Name of School: _____ Location: _____

7. How did your child adjust to that situation? _____
   _____
   _____

8. How does your child spend his/her free time? Does he or she have any special play patterns or favorite types of play? _____
   _____

9. Are there specific situations in which he or she tends to become shy, afraid, or angry?
   _____
   _____

10. In general, how do you limit or discipline your child?
    _____
    _____

11. Is there anything in particular you would like us to work on together this year?
    _____
    _____

12. Does your child have special names for objects (potty, cookies, drinks, etc.)?
    _____
    _____

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)

received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

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

																					Code:
Date																					
Age/ Grade																					**P = Pass** **F = Fail**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**U = Unable to test** **R = Referred**
Vision																					**G/C = Glasses/Contacts**
Hearing																					

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)

NEWPORT CHILDREN'S ACADEMY

TB Test and Lead Poison Waiver

Dear Physician,

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

I. The initial medical report shall be dated less than 6 months prior to enrollment of infants, toddlers and preschool children.

II. If the child is in a high-risk group, as determined by the examining physician, a tuberculin skin test by the Mantoux method and the results of that test shall be included in the initial examination for all children who have attained one year of age, or at the age of one year for children who are enrolled before their first birthday. The tuberculin skin test by the Mantoux method shall be repeated when children in the high-risk group begin elementary and secondary school.

III. The initial examination shall show that children from the ages of one to 6 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 (77 Ill. 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 (the physician) feel that a TB test is not necessary at this time, please indicate below.

_____ I do not feel that a TB test is necessary at this time.

If you (the physician) feel that a Lead Poison screen is not necessary at this time, please indicate below.

_____ I do not feel that a Lead Poison screen is necessary at this time.

Physician Comments:

_____

_____

Child's Name: _____

Physician Signature: _____ Date: _____

NEWPORT CHILDREN'S ACADEMY

Recurring Payment Authorization Form

Your payment will be automatically deducted from your bank account, or charged to your credit card. We accept Visa, MasterCard, American Express and Discover. Just complete and sign this form to get started!

Recurring Payments Will Make Your Life Easier:

- It's convenient (saving you time)
- Your payment is always on time, eliminating late charges

Here's How Recurring Payments Work:

You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below, at the beginning of each billing period. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

Please complete the information below:

I _____ authorize Newport Children's Academy to charge my credit card or bank account, indicated below, in the amount of $_____ on the first day of each month for payment of my Preschool/Child Care.

Billing Address: _____City, State, Zip: _____

Phone: _____ Email: _____

Social Security Number: _____

Checking Account

Name on Account: _____

Bank Name: _____

Account Number: _____

Routing Number: _____

Bank City/State: _____

Credit Card: (Circle One)

VISA Amex MasterCard Discover

Cardholder Name: _____

Account Number: _____

Expiration Date: _____

CVV: _____