ENROLLMENT DOCUMENTATION

CHILDS NAME ***DOB:***

DOE:

DOT:

DATE RECEIVED	***FORMS NEEDED***
_____	**APPLICATION/REGISTRATION FORM**
_____	**ENROLLMENT CONTRACT**
_____	**ORIGINAL BIRTH CERTIFICATE**
_____	**MEDICAL/INSURANCE CARD**
_____	**PHYSICAL FORM**
_____	**DENTAL FORM**
_____	**CONSENT FORM**
_____	**TUITION CONTRACT**
_____	**PICK-UP/DROPOFF**
_____	**PICK-UP LIST**
_____	**STANDARDS VERIFICATION OF RECEIPT**
_____	**PARENT HANDBOOK VERIFICATION OF RECEIPT**
_____	**AFC: NEW APP COP REDT CINFO**
_____	**ISBE ANNUAL ENROLLEMENT FORM**
_____	**ISBE HOUSEHOLD ELIGIBILITY FORM**
_____	**GUAIDANCE POLICY**
_____	**COVID-19 WAIVER OF UNDERSTANDING**

CLASSROOM*(Circle One)*

CATERPILLARS	BUTTERFLIES	BEFORE/AFTERCARE	TRANSPORTATION

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 _____

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/Guardian **Director Signature** **Date**

.

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

Enrollment Contract

This contract is made between the parent(s)/guardians: _____(name of parent(s)

and ***Steps To The Future Daycare*** for the care of the following children:

_____

_____

_____

_____

_____

_____

The payment for care shall be $_____ per WEEK/MONTH and reflects a schedule as follows:

arrival time _____am and pick up time _____pm on the following days: _____

The above times and days {*are or are not*} flexible. _____

If parent is going to be late picking up the child, every effort must be made to contact the provider. A late pick up fee of $____/minute after _____PM will be charged. _____

Payment is due to the provider in advance of care and paid on the following: _____. Accepted methods of payment include cash, personal check, Debit/credit card(3% fee), or money order. If a personal check is returned due to a lack of funds, the parent/guardian must pay a $ 35 returned check fee. If a check is returned more than one time, only cash or money orders will be accepted as payment. _____

If a payment is not made on time, the following fee will apply: $15. _____

Illinois Action For Children Child Care Assistance Program - CCAP

If you are utilizing the CCAP, the payment policy is as follows:

Approved days _____
Monthly Copay $_____
Redetermination _____

- *Families using the Child Care Assistance Program are responsible for paying any and all amounts not covered by CCAP._____*

Extended Care:

For the purpose of this contract, extended care is considered any amount of time that care occurs for 10 or more hours a day. There is a $25 fee for any child who exceeds care for 10 hours a day. _____

Payments during Holidays, Vacations, and Other absences:

The provider will not be open for business on the following Holidays: See attatched closed days

Parents {*are or are not}* expected to pay for care on those Holidays.

The provider will take one weeks vacation during the calendar year (winter break) and will give parents 2 week's notice of such upcoming vacations.

If a parent plans on taking a vacation and the child will not be in care, the provider must be given 1 weeks notice. _ _ _ _

Termination Procedures:

This contract may be terminated by the parent(s) or the provider.A 2 week notice prior to the last date of care is required._____

*STTF may immediately terminate this contract without any notice if payment is not made on time.*_____

Other:

- *If the provider chooses not to enforce any portion of the contract, it does not give up the provider's right to enforce any other portion of the contract.*
- *The contract can be revised at any time by the provider if necessary.*

_____ _____

Parent Signature Date

_____ _____

Center Director Date

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. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO	DA	YR	DOSE 2 MO	DA	YR	DOSE 3 MO	DA	YR	DOSE 4 MO	DA	YR	DOSE 5 MO	DA	YR	DOSE 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																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										**Comments:**								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

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 (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies 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**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

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)	Yes No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**

Diagnosis of asthma? Child wakes during night coughing?	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.			
Bone/Joint problem/injury/scoliosis?	Yes	No	**Parent/Guardian Signature**		**Date**	

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **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. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

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		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**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 Agonist) ☐ 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** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

CFS 601
Rev. 4/2007

Illinois Department of Public Health
PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle		Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code		Telephone:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date _____

Address _____ Telephone _____
Street City ZIP Code

PARENT CONSENT FORM

NAME OF CHILD _____

EMERGENCY MEDICAL CARE

This authorizes **STEPS TO THE FUTURE DAYCARE INC.** 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 **STEPS TO THE FUTURE DAYCARE INC.** 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 **STEPS TO THE FUTURE DAYCARE INC.** 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

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 **STEPS TO THE FUTURE DAYCARE INC.** 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

PHOTOGRAPHS AND VIDEO

I/we authorize **STEPS TO THE FUTURE DAYCARE INC.** to take PHOTOGRAPHS AND VIDEOS of my/our child. I/we understand all photos and videos are under the supervision of the above-named person(s) and 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

Tuition Contract

Steps To The Future Daycare offers a variety of payment options based on various payment methods. Paying secures the spot your child will hold in our center. **Payment is expected based on the written arrangement signed off on below.**
WEEKLY TUITION IS DUE BY FRIDAY MORNINGS REGARDLESS OF THE CHILDS ATTENDANCE. _____

Steps To The Future Daycare, is authorized to receive payments from Department of Children and Family Services (DCFS), Illinois Action for Children, and other Federal/State childcare assistance programs. A parent who wishes to apply must make these arrangements on their own and list our Center as their child care provider. A payment of **$100 COPAY FOR THE MONTH** is required until an approval letter from the childcare assistance program is received. Parents are required to pay the full tuition from the 1st day the child started._____

Steps To The Future also requires that all DCFS or Illinois Action for Children clients pay for any absence above 2 days per month. Tuition is due regardless of the child's attendance habits. _____

Clients of DCFS and/or Action for Children are responsible for additional cost when subsidy payments and co-payments do not equal Steps To The Future's weekly tuition. This amount must be paid in full by the end of each given month. It is the responsibility of the parent to ensure that no outstanding balance is brought forward._____

Steps To The Future does not issue refunds. In the event you have over paid, your credit will be applied to your next month's tuition. In the event you have a balance after your child's last day, all applicable fees required will be subtracted from any balance prior to a final refund being issued. **A two week notice is required prior to your child's last day.** If no two week notice is given, full two week tuition is required. Refunds will be issued in the form of a check and will be cut and mailed according to our monthly bill payment schedule._____

I, Parent or Guardian, agree to pay the sum of $_____per week for the care of my child/children. Payment is to be made every _____. By signing below, I understand and agree and will adhere to the above contract rules.

_____
Child's Name

_____ _____
Parent/Guardian Signature Date

_____ _____
Center Director Date

CHILD PICK-UP LIST

Child(s) Name _____

Parent/Guardian Name _____ _____

Phone Number

Email Address _____

Parent/Guardian Name _____ _____

Phone Number

Email address _____

	NAME	EMAIL ADDRESS	*PHONE NUMBER*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Introduction

The Department of Children and Family Services (DCFS) is responsible for licensing day care centers. When a day care center is licensed, it means that a DCFS licensing representative has inspected the facility and the facility was found to meet the minimum licensing requirements. A license is valid for three years. The day care center's license must be posted. It will indicate the maximum number of children allowed in the facility and the areas where children may receive care.

Licensed day care facilities are inspected annually by DCFS licensing staff. If a complaint has been received regarding a violation of the licensing standards of a day care center, a licensing representative will conduct a licensing complaint investigation to determine if the alleged violation should be substantiated or unsubstantiated. Individuals may contact the Day Care Information Line to learn of substantiated violations.

Day Care Information Line 1-877-746-0829

This statewide toll-free information line provides information to the public on the past history and record, including substantiated violations, of licensed day care homes, day care centers, and group day care homes. This number operates Monday through Friday from 8:30 a.m. to 5:00 p.m.

Summary of Licensing Standards for Day Care Centers

The following is a summary of the licensing standards for day care centers. It has been prepared for you so that you may monitor the care provided to your child. This is a summary and does not include all of the licensing standards for a day care center. State licensing standards are *minimum* standards. If you observe a violation of any of these standards, you are encouraged to discuss your concerns with the day care center operator. In most cases, parents and day care operators are able to resolve the parents' concerns and issues. If you believe the day care operator is not responding to your concerns and may not be meeting state licensing standards, you may make a complaint to the local DCFS Licensing Office or by calling the Child Abuse Hotline at 1-800-252-2873 and stating that you want to make a licensing complaint. A DCFS licensing representative will investigate your complaint and report the results back to you. The day care center is required to provide a copy of its own written policies regarding the operation of the facility to each staff person and to parents of enrolled children.

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.

_____ Date
Signature of Parent

_____ Date
Signature of Parent

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

Parent Handbook 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 the Parent Handbook printed by Steps To The Future Daycare Inc.

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

ILLINOIS STATE BOARD OF EDUCATION

Annual Enrollment Form

Child and Adult Care Food Program

This form is required for Child Care Centers, Pre-K, Head Start, Even Start, and Licensed Outside School Hours Programs.

This form is NOT required for At-Risk After-School, License-exempt Outside School Hours, or Emergency Shelters.

Parents/Centers: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. If parent does not complete Section 5, center staff should complete to the best of their ability (by observation) and initial the section. The center will review completed enrollment form.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age) | **2** DAYS OF WEEK IN ATTENDANCE | **3** TIMES CHILD NORMALLY ATTENDS DURING WEEK | **4** MEALS RECEIVED

First Child

Name

Birth Date

Age

☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday
☐ Saturday
☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack
☐ Breakfast
☐ A.M. Snack
☐ Lunch
☐ P.M. Snack
☐ Supper
☐ Evening Snack

Second Child

☐ Same Days as Above | ☐ Same Times as Child Above | ☐ Same Meals as Above

Name

Birth Date

Age

☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday
☐ Saturday
☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack
☐ Breakfast
☐ A.M. Snack
☐ Lunch
☐ P.M. Snack
☐ Supper
☐ Evening Snack

Third Child

☐ Same Days as Above | ☐ Same Times as Child Above | ☐ Same Meals as Above

Name

Birth Date

Age

☐ Monday
☐ Tuesday
☐ Wednesday
☐ Thursday
☐ Friday
☐ Saturday
☐ Sunday

TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL	
AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center

☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours

☐ Early Morning Snack
☐ Breakfast
☐ A.M. Snack
☐ Lunch
☐ P.M. Snack
☐ Supper
☐ Evening Snack

Please answer both questions. This information is voluntary.

5 **ETHNIC/RACIAL CATEGORIES—**

A. Ethnic data of child(ren) — Mark only one. ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren) — Mark one or more that apply. ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

6 **SIGNATURE**

I certify the information above is correct. _____ *Signature of Parent or Guardian* _____ *Date* _____ *Telephone Number of Parent or Guardian*

CHILD CARE REPRESENTATIVE USE ONLY

Effective Date of this enrollment form: _____

The effective date may be made retroactive back to the first day the child participates in the CACFP as long as it occurs in the same month in which this form is received.

The U.S Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at http://www.ascr.usda.gov/complaint_filing_cust.html, or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at program.intake@usda.gov. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339; or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer

HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS
CHILD AND ADULT CARE FOOD PROGRAM

1. All Household Members

NAMES OF ALL HOUSEHOLD MEMBERS First, Middle Initial, Last	Ages of Children at Center	FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6	SNAP OR TANF CASE NUMBER Skip to Part 6 if you list a SNAP or TANF case number. At least one SNAP/TANF must be provided below.
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

4. Homeless, Migrant, or Runaway

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

Signature of Homeless Liason, Migrant Coordinator, or Head Start Director _____ Date _____

5. Total Household Gross Income (before deductions) You must tell us how much and how often.

NAMES (LIST ALL HOUSEHOLD MEMBERS WITH INCOME)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	Earnings From Work (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		Worker's Comp., Unemployment, SSI, etc. (All other income)	
	Amount	How often?	Amount	How often?	Amount	How often?	Amount	How often?
i.	$		$		$		$	
ii.	$		$		$		$	
iii.	$		$		$		$	
iv.	$		$		$		$	
v.	$		$		$		$	

6. Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Section 5 is completed or if zero income is listed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "*I do not have a Social Security Number*" box.

X X X - X X - _ _ _ _
Social Security Number

☐ I **do not** have a Social Security Number.

I certify all information on this application is true and all income is reported. I understand the center will get federal funds based on the information I give. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date _____ *Printed Name of Adult Household Member* _____ *Signature of Adult Household Member* _____

7. Contact Information (Optional)

Work Telephone Number (Include Area Code) _____ *Home Telephone Number (Include Area Code)* _____ *Home Address (Number, Street, City, State, ZIP Code)* _____

8. Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity:
☐ Hispanic/Latino
☐ Not Hispanic/Latino

Mark one or more racial identities:
☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander
☐ White ☐ American Indian or Alaska Native

9. Optional – Sharing Information With All Kids Insurance Program

May we share your information on this application with the *All Kids Insurance Program*, the complete health insurance program for every child in Illinois? If ***yes***, do not sign below.
☐ No, I do not want my information from this application shared with the *All Kids Insurance Program.*

Date: _____ Sign here: _____

CHILD CARE REPRESENTATIVE USE ONLY
Eligibility Determination - Complete Sections A and B Below

SECTION A Annual Income Conversion Weekly X 52 Every 2 Weeks X 26 Twice a Month X 24 Once a Month X 12 *Convert income only if different frequencies of pay are reported.*

TOTAL INCOME $ _____ **Per:** ☐ Week ☐ Every 2 Weeks ☐ Twice a Month ☐ Month ☐ Year **NUMBER IN HOUSEHOLD:** _____

☐ **Free based on:**
☐ foster child
☐ SNAP or TANF
☐ homeless

SECTION B Signature of Determining Official: _____ Date: _____

INSTRUCTIONS FOR APPLYING - COMPLETE ONE APPLICATION PER HOUSEHOLD

Follow These Instructions and Return the Completed form to your Center. Once approved for meal benefits, a child's Household Eligibility Application is effective for 12 months.

FOSTER CHILD(REN)

A foster child remains the legal responsibility of the state through a foster care agency or the court. If you submit documentation from the state or local agency that the child is in foster care, that documentation replaces completing a Household Eligibility Application.

1) If all children in your household (who attend this center) are foster children that are the legal responsibility of a foster care agency or court, provide the following:
   - Part 1 — List the name(s) and age(s) of your foster child(ren) attending this center.
   - Part 2 — Check the box(es) indicating a foster child(ren).
   - Part 3 — 5 Skip
   - Part 6 — Provide a signature of an adult household member and date the application.
   - Parts 7-9 — (OPTIONAL)

2) If you have some foster children that are the legal responsibility of a foster care agency or court along with other children attending this center, please provide the following:
   - Part 1 — List ALL household members, including the foster child(ren), and the age(s) of the child(ren) attending the center.
   - Part 2 — Check the box(es) identifying the foster child(ren).
   - Part 3 — Record a valid SNAP/TANF case number if applicable
   - Part 4 — Skip
   - Complete Parts 5 and 6 if applicable. See the instructions for **INCOME–HOUSEHOLDS REPORTING** section.
   - Parts 7-9 — (OPTIONAL)

SNAP OR TANF BENEFITS - HOUSEHOLDS RECEIVING

If any member (child or adult) of your household receives SNAP or TANF benefits, provide the following:
- Part 1 — List ALL people in your household (including grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the center.
- Part 2 — Skip
- Part 3 — Record a valid SNAP or TANF case number for any member (child or adult) of this household. You will find your SNAP or TANF case number on your letter of eligibility for benefits.
- Part 4 — 5 Skip
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (OPTIONAL)

HOMELESS, MIGRANT, RUNAWAY, OR HEAD START

If no one in your household receives SNAP or TANF benefits and if any child is homeless, a migrant, a runaway, or head start, follow these instructions.
- Part 1 — List ALL household members, and the age(s) of the child(ren) attending the center.
- Part 2 — 3 Skip
- Part 4 — If any child you are applying for is homeless, migrant, or a runaway, check the appropriate box and call your local school.
- Part 5 — Complete only if a child in your household isn't eligible under Part 4. See instructions for **INCOME – HOUSEHOLDS REPORTING** section below and complete Parts 5 and 6.
- Part 6 — Provide a signature of an adult household member and date the application.
- Parts 7-9 — (OPTIONAL)

INCOME - HOUSEHOLDS REPORTING

If no one in your household receives SNAP or TANF benefits, please report all household income. The Household Eligibility Application must include the following information:
- Part 1 — List the names of ALL household members and the age(s) of the child(ren) attending the child care center.
- Part 2 — 4 Skip
- Part 5 — List total gross income (before deductions), not take-home pay; and the frequency, how often the money is received, for each household member for last month. If the income last month was not the usual amount you normally receive, you may provide a projected amount that better represents your gross income.
  - o For ONLY the self-employed, list income after expenses. This is for your business, farm, or rental property.
  - o If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
  - o If you have no income, list zero in the earnings from work column.
- Part 6 — Provide a signature of an adult household member and date the application. Also, provide the last four digits of the Social Security Number for the adult signing the application. If you refuse to provide the last four digits of the social security number, the application cannot be approved. If the adult does not have a Social Security Number, mark the box, I do not have a Social Security Number.
- Parts 7-9 — (OPTIONAL)

PRIVACY AND DISCRIMINATION STATEMENT

The **Richard B. Russell National School Lunch Act** requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the last four digits of the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the Child and Adult Care Food Program. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: (1) mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410; (2) fax: (202) 690-7442; or (3) email: program.intake@usda.gov. This institution is an equal opportunity provider.

CHILD GUIDANCE POLICY

The Center's child guidance policy is designed to help children become independent and caring by learning self-control, decision-making skills and responsibility for their own actions. Since children are a precious gift from God, we believe they should be treated with the same respect that we, as adults, wish to be treated. Our goals are to help children develop positive self-esteem, respect for themselves and the rights of others and socially acceptable ways of expressing their needs and feelings. This is accomplished through positive guidance and loving, Christ-centered discipline.

Our staff uses the following guidelines and techniques to help children develop self-discipline:

- A learning environment that promotes consistent routines and well-defined expectations
- Use of praise through kind words and actions (hugs, smiles) to reinforce desirable behaviors.
- Use of problem solving instead of punishment. Teachers and children will talk through the situation.
- Redirection to another activity when a child displays undesirable behaviors.
- If a child causes physical or emotional harm to him/herself or others, the child will be removed from the situation for a short time to calm down and provide time to talk with the teacher about alternate, appropriate behaviors.
- Time-outs may not be used with children under three years of age. When a younger child needs to be removed from a situation, they will remain with the teacher until they have calmed down.

We believe the primary responsibility for raising young children rests with the parents; however, the staff strives to assist parents in the training and guidance of their children. We will provide parents with feedback about their children (both positive and negative, if necessary). If you desire help in dealing with a specific behavior, please discuss it with us. Parent support is expected for any guidance techniques used by staff to solve unwanted behaviors. Staff are not allowed to discipline a child using prohibited methods (according to licensing regulations) even at the request of a parent.

Time-Out

Time-Out is the removal of a child for a short period of time (3 to 5 minutes) from a situation in which the child is misbehaving and has not responded to other discipline or redirection techniques. The Time-Out space, usually a chair, is located away from classroom activity, but within the teacher's sight. During Time-Out, the child has a chance to think about the misbehavior, which led to his/her removal from the group. After a brief interval of age appropriate timeout according to licensed regulations, the teacher discusses the incident and appropriate behavior with the child. Then the child will return to the group.

Parent Signature: _____

Days and Hours of Operation Arrival/Late Pick-Up

The Center is opened from 6:00 a.m. to 6:00 p.m.; extended hours through 12a.m., Monday through Friday. Breakfast will be served from 8:30 am thru 9:00am. **The DROP OFF CUT OFF IS 9:30AM**. After 9:30 am no children will be accepted. The children are required to be picked up by 6:00 pm. There is a late fee of $1.00 per minute, per child for every minute you are late (after 6pm or 12am). This will be charged to cover overtime for the staff, NO EXCEPTIONS. Please bring the late fee in cash at pickup. Your child may not return to the center until your late fee is paid. After 6:00 p.m.(or 12am), every attempt will be made to contact parents and emergency parent support. After 7:00 p.m.(or 1am) and no contact, we are required to drop the children off at the local police station.

Parent Signature: _____

Step To The Future COVID -19 Parent Waiver of Understanding

- I UNDERSTAND, I am required to keep children that are exhibiting any signs of illness or COVID-19 related symptoms home. This includes, running nose clear or discolored, fever, cough, diarrhea, sore throat, shortness of breath, chills, muscle aches, headache, vomiting, any symptoms of a virus.
- I UNDERSTAND, that if anyone in my home parent or sibling has exhibited any of the COVID-19 symptoms above in the last 48 hours and have been in contact with students enrolled at S.T.T.F, that I must keep the child home.
- I UNDERSTAND, that if myself or my child are exhibiting any of the COVID-19 symptoms that we are not permitted to enter the building.
- I UNDERSTAND, All persons entering the building and dropping off children are subject to a Health screening which includes temperature check with a non-contact thermometer, visual inspection and questionnaire is required to enter the building.
- I UNDERSTAND, Parents and Children with a temperature of 100.4 or higher will not be permitted.
- I UNDERSTAND, Children that appear flushed and feverish, have a running nose clear or discolored or cough during arrival visual inspection will not be permitted.
- I UNDERSTAND, that if my child presents with any of the above COVID-19 symptoms during the day, that my child will not be able to return to the center until they are symptom free for 72 hours without the use of fever-reducing medication.
- I UNDERSTAND, that if I am called during the day because my child is ill with any of the above COVID-19 related symptoms, that my child will be excluded from their classroom, and that I am required to pick my child up within the hour.
- I UNDERSTAND, I am required to notify STTF immediately if myself, my child, or anyone in my home are notified that we have come in contact with or have been diagnosed with COVID-19.
- I UNDERSTAND, that if I travel out of the country or to a hot spot state, and have come in contact with children enrolled at STTF that we must quarantine for 14 days before returning to the center.
- I UNDERSTAND, that if my child or I are suspected or diagnosed with COVID-19, in order to return to STTF we must meet the following three requirements: 1. Fever free without the use of fever-reducing medication for at least 72 hours. 2. Symptom free including cough. 3. It has been at least 10 days since the onset of the illness.
- I UNDERSTAND, that due to the unknown nature of how the COVID-19 virus spreads and the inability to determine when an individual is exposed, I agree not to hold STTF liable for any illness my child may come in contact with, and I understand enrollment is optional and I am enrolling according to my own cognizant.

Child's Name

I understand by signing below I have read and agree to the conditions above.

Parent Signature **Date**

Tuition and Fee Schedule

Weekly Full-Time Tuition Rates

Full-Time childcare IS CONSIDERED 10 hours per day (see extended care fee for children attending more than 10 hrs)

$260.00 – 15 months thru 23 months
$250.00 - 2 years
$240.00 – 3-5 years
$175.00 – School Age Before/Aftercare (School Age is defined as a child enrolled/attending Kindergarten + up)
$200.00 – Summer Camp

Fees

Toilet Training - $25 weekly for children 3 years and older

Credit Card Transactions – 3% per occurrence

Extended Care (Attending over 10 hours)- $25 per child **(non-negotiable)**

Late Pick-up - $1 per minute per child

Late Tuition - $15 per occurrence

Late Monthly Co-payment - $15 per occurrence

Transportation - $25 weekly

Weekly Tuition payments are due by Friday prior to the weekly schedule.

Monthly Co-payments are due on the 1st and the 5th, there is a $15 late fee after the 5Th

Transportation Fees are due the 1St + 15th of each month.

Fees will automatically be assessed and charged to your account upon occurrence.

Special Events, Field Trips, and in-house programs may require an additional fee. You will be notified in advance.

All rates and fees are subject to change, the center will provide 30 days written notice.