Nature's Scholars Enrichment Center, Inc. 4400 Beck Lane, Ringwood, IL 60072
Phone 815-653-0240 or Fax 815-653-0390

Admittance Form – (please complete both sides)

***For my child's safety, I agree to inform Nature's Scholars Enrichment Center, Inc. in writing of any changes to the following information. Nature's Scholars Enrichment Center, Inc. assumes no liability if not advised in writing. (initial please)_____

Name of Child_____
(last) (first) (middle)

Child's nickname if preferred_____
(name to be taught/used for everyday interactions)

Child's date of birth (month/date/year)_____Sex: ( ) Male ( ) Female

Mother/Guardian Name_____
(last) (first) (middle)

Requested PIN# # X X X X _____ _____ _____ _____ First four digits are auto assigned.

Home address_____
(street) (City) (state) (zip)

Home phone _____( ) Cell phone _____( )
Please number top 3 contact #'s in order of accessibility, 1 being easiest to reach

Email_____

Employer _____
(company name) (city) (state)

Employer's main phone _____( )Direct work line _____Ext._____( )

Father/Guardian name _____
(last) (first) (middle)

Requested PIN# X X X X _____ _____ _____ _____ First four digits are auto assigned.

Home address _____

Home phone _____( )Cell phone _____( )
Please number top 3 contact #'s in order of accessibility, 1 being easiest to reach

Email_____

Employer _____
(company name) (city) (state)

Employer's main phone _____( )Direct work line _____Ext____( )

Marital Status of Parent(s): Married Single Divorced Separated Deceased
(circle one)

Child lives with: Both parents Mother Father Guardian Other (specify) _____
(circle one)

Special Dietary Release Signature _____
(additional Special Diet Authorization form to be filled out)

Unless stated otherwise it will be presumed that both mother/guardian and father/guardian (listed on front side of form) can pick up the child and/or be contacted in case of an emergency. We also need a minimum of 3 other people authorized to handle these duties if the parents/guardian cannot be reached. Please review and update any information every 6 months or as needed.

Please list at least 3 people **authorized to pick up** child from center (do not list yourself, within 30 minute drive)

1)_____
(name) (address) (daytime phone) (relationship to child)

2) _____
(name) (address) (daytime phone) (relationship to child)

3) _____
(name) (address) (daytime phone) (relationship to child)

Please list at least 3 people to call in case of an emergency if parents/guardian cannot be reached.

1)_____
(name) (address) (daytime phone) (relationship to child)

2) _____
(name) (address) (daytime phone) (relationship to child)

3) _____
(name) (address) (daytime phone) (relationship to child)

Name(s) of person(s) who may **NOT** take child from center:_____

Is the custody/guardianship of your child affected by a court order? YES NO (circle one)

If yes, please refer to the ***Court Orders* section in the handbook on page 19.**

Siblings' names and ages _____

Has your child attended any other preschool, day care, home care? YES NO (circle one)

Name of Provider _____How Long?_____

Does your child have any special needs? (allergies, naps, handicaps, special diet, toileting etc.)

_____

_____

Is there any additional information that would be helpful in getting acquainted with you or your child/children?

_____

_____

****Note: Signature of legal parent(s)/guardian(s) required for admission. ****

Print Name: _____ Print Name: _____

Relationship to child: _____ Relationship to child: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

***Office use only ***

Days Enrolled: AW M T W R F Start Date: _____ Before After School Care

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Checklist for Enrollment

In order for your child to attend Nature's Scholars Enrichment Center, Inc., the following items must be at the center at least one (1) day prior to the child's first day of attendance. However, returning these items does not ensure your child's enrollment. Availability and start date needs to be confirmation with the director or administrator.

_____$75 registration fee

_____Payment to cover one (1) week of childcare

_____completed *Admittance Form*

_____ *Checklist for Enrollment,* with signed *Parent Handbook Agreement* statement below

_____completed *Consent Forms (if needed Pet Release, Transportation Form, Medical Permission Form and Special Diet Authorization)*

_____Illinois Department of Public Health *Child Health Examination* form-both sides completed, signed by a physician and dated within last six (6) months- (*original form-not copied or faxed)*

_____Illinois Department of Public Health *Childhood Lead Risk Assessment Questionnaire*-Complete with a signature by a physician.

_____Copy of child's *Certified Birth Certificate*

_____Back page of "*Summary of Licensing Standards*" published by DCFS

_____ *Tuffo Rental Agreement Form* & $25.00 rental fee (sizes 12 Mo. – 5T available only)

_____*Customer Acknowledgement & Release Form Coronavirus Notice*

_____ *Sick Child Policy Amendment: COVID-19*

Parent Handbook Agreement

I/we _____, the parents(s)/legal guardian(s) of

_____, acknowledge that I/we have received a copy of Nature's Scholars Enrichment Center, Inc. Parent Handbook and have been given the opportunity to read the manual and ask questions about and understand the policies contained therein. Furthermore, I/we agree to abide by the policies set forth in the manual.

I/we understand that the policies described in the Parent Handbook are not conditions of enrollment, and the language does not create a contract between Nature's Scholars Enrichment Center, Inc. and the parents. Nature's Scholars Enrichment Center, Inc. reserves the right to alter, amend, or otherwise modify these guidelines, in its sole discretion, without prior notice.

Print Name: _____ Print Name: _____

Relationship to child: _____ Relationship to child_____

Signature: _____ Signature: _____

Date: _____ Date: _____

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Consent Forms

Medical

I, _____as parent/legal guardian, give my permission for Nature's Scholars Enrichment Center, Inc. to secure medical care for my child_____. This may include, but is not limited to, first aid, care by a paramedic, Physician, or hospital. I agree to be responsible for any and all costs of such treatment and/or medication.

Signature of parent/guardian_____Date_____

First Aid

I, _____as parent/legal guardian, give my permission for Nature's Scholars Enrichment Center, Inc. staff to administer first aid to my child_____ in the event of a minor injury while in our care.

Signature of parent/guardian_____Date_____

Sunscreen, Insect Repellant, Diaper Cream Application

I, _____as parent/legal guardian, give my permission for Nature's Scholars Enrichment Center, Inc. to apply sunscreen, insect repellant, and/or diaper cream to my child_____when supplied.

Signature of parent/guardian_____Date_____

Photographs

I, _____as parent/legal guardian, give my permission for Nature's Scholars Enrichment Center, Inc. to take photographs of my child_____. Other than display of my child's photographs inside the center or on the centers website www.NaturesScholars.com, I will be notified if such photographs will be used for publicity or used outside the center.

Signature of parent/guardian_____Date_____

Leaving Nature's Scholars Enrichment Center, Inc. Property

I, _____as parent/legal guardian, give my permission for the staff of Nature's Scholars Enrichment Center, Inc. to take my child _____ on walks and/or special excursions.

Signature of parent/guardian_____Date_____

State of Illinois

Certificate of Child Health Examination

Student's Name (Last, First, Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address, City, ZIP Code	Parent/Guardian, Telephone (home/work)

HEALTH HISTORY: MUST 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?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ Yes ☐ No		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Diabetes?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Seizures? What are they like?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Ear/Hearing problems?	☐ Yes ☐ No	
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No	

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Additional Information:

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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 _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

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

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ 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 aged 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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

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

State of Illinois
Illinois Department of Public Health

Guidelines for Lead Risk Evaluation and Blood Lead Testing

- Lead risk evaluation is the use of the Childhood Lead Risk Questionnaire to determine the risk of potential for lead exposures.
- Blood lead testing is defined as obtaining a blood lead test either by capillary or venous methodology. Only a venous test can serve as a confirmatory blood test.
- A child is considered to have an elevated blood lead level once a venous test is conducted, confirming the blood lead level is ≥3.5 µg/dL. Capillary (finger/heel stick) test results of ≥3.5 µg/dL must be confirmed by venous draw. Point-of-care instruments such as the LeadCare® II cannot be used to confirm an elevated blood lead level, even if the sample is collected by venipuncture.
- It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or a potential exposure to lead has been identified, regardless of the child's age.
- Federal mandates and the Illinois Department of Healthcare and Family Services' (HFS) policy require that all children enrolled in HFS medical programs be considered at risk for lead poisoning and receive a blood lead test at ages 12 months and 24 months. Children older than the age of 24 months, up to 72 months of age, for whom no record of a previous blood lead test exists, also must receive a blood lead test. Children enrolled in HFS medical programs (such as Medicaid, All Kids, Head Start, and WIC) are expected to receive a blood lead test regardless of where they live. (Consult Handbook for Providers of Healthy Kids Services, Chapter HK-203.3.1, for more blood lead testing and reporting information.)
- Illlinois has defined ZIP code areas at high risk for lead exposure based on a variety of considerations, including housing age and poverty rates. Review the list and determine the status of the ZIP codes in your area.

Childhood Lead Risk Questionnaire

- ✓ Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children 12 and 24 months of age (at minimum) and once a year at annual well-child visits at ages 3, 4, 5, and 6 years.
- ✓ If responses to all the questions are "NO," re-evaluate at the next age referenced above or more often if deemed necessary.
- ✓ If any response is "YES" or "DON'T KNOW," obtain a blood lead test.
  - If there are any "YES" or "DON'T KNOW" answers and
    - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 3.4 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 3.4 µg/dL or less and
    - ✓ there has been no change in the address of the child's home/residential building, child care facility, school, or other frequently visited facilities and
    - ✓ risks of exposure to lead have not changed; further blood lead tests are not necessary.

Illinois Lead Program
Email: dph.lead@illinois.gov
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

IOCI 25-2196 IOCI GRAPHICS
Printed by Authority of the State of Illinois 6/25

State of Illinois
Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

The ** indicates that any ZIP code **within a county** with the preceding numbers is considered high risk

Adams
62301
62305
62320
62324
62325
62338
62339
62346
62347
62348
62349
62351
62359
62360
62365
62376

Alexander
62914
62957
62969
62988
62990

Bond
62086
62246
62262
62273
62275
62284

Boone
61008
61011
61012
61038
61065

Brown
623**

Bureau
613**

Calhoun
62006
62013
62036
62047
62045
62053
62065
62070

Carroll
61014
61046
61051
61053
61074
61078
61285

Cass
626**

Champaign
60949
61801
61802
61815
61816
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Christian
62083
625**

Clark
62420
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Clay
62434
628**

Clinton
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Coles

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Cook

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Crawford
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Cumberland
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62447
62468

DeKalb
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DeWitt
617**
618**

Douglas
61910
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61953
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DuPage
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Edgar
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Edwards
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Effingham
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Fayette
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Ford
609**
61773

Franklin
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629**

Fulton
614**
615**

Gallatin
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62984

Greene
620**

Grundy
60407
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Hamilton
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Hancock
61450
623**

Hardin
62919
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62982

Henderson
614**

Henry
61234
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614**

Iroquois
609**

Jackson
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Jasper
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Jefferson
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Jersey
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62037
62052
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Jo Daviess
61001
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61085
61087

Johnson
62908
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62995

Kane
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Kankakee
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Kendall
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Knox
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Lake
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LaSalle
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Lawrence
624**

Lee
605**
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Livingston
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Logan
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Macon
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62573

Macoupin
62009
62012
62014
62023
62033
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Madison
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Marion
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Marshall
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615**

Mason
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State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

STATE LAW REQUIRES:

Children 6 years of age or younger must be evaluated for lead exposure.

Children must be assessed for risk of lead exposure and tested if necessary for enrollment into day care, preschool, and kindergarten.

Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children 12 and 24 months of age (at minimum) and once a year at annual well-child visits at ages 3, 4, 5, and 6 years.

- If responses to all the questions are "NO," re-evaluate at next the age referenced above or more often if deemed necessary.
- If any response is "YES" or "DON'T KNOW," a blood lead test must be obtained.
- If there are any "YES" or "DON'T KNOW" answers ***and***
  - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 3.4 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 3.4 µg/dL or less, and
  - ✓ there has been no change in the address of the child's home/residential building, child care facility, school, or other frequently visited facilities and
  - ✓ risks of exposure to lead have not changed; further blood lead tests are not necessary.

Child's name: _____ Today's date: _____

Age: _____ Birthdate: _____ ZIP code: _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**
1. Does this child reside in or regularly visit a home/residential building, child care setting, school, or other facility built before 1978 or in a high-risk ZIP code area? (See reverse side of page for high-risk ZIP code area list.)	❑ Yes ❑ No ❑ Don't Know
2. Is this child eligible for or enrolled in Medicaid, All Kids, Head Start, WIC, or any HFS medical program? ***Medicaid-eligible children and children enrolled in HFS medical programs shall have a blood lead test at 12 and 24 months of age. If a Medicaid-eligible child or an Illinois Department of Healthcare and Family Services (HFS) medical program-enrolled child between 36 months and 72 months of age has not been previously tested, a blood lead test shall be performed.	❑ Yes ❑ No ❑ Don't Know
3. Does this child have a sibling with a confirmed blood lead level of 3.5 µg/dL or higher?	❑ Yes ❑ No ❑ Don't Know
4. In the past year, has this child been exposed to repairs, repainting, or renovation of a building/ home built before 1978?	❑ Yes ❑ No ❑ Don't Know
5. Is this child a refugee, adoptee, or recent visitor of any foreign country?	❑ Yes ❑ No ❑ Don't Know
6. Is this child frequently exposed to imported items (such as ayurvedic medicine, folk medicines, cosmetics, toys, glazed pottery, spices or other food items, sindoor, or kumkum)?	❑ Yes ❑ No ❑ Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (e.g., jewelry making, building renovation, bridge construction, plumbing, furniture refinishing, work with automobile batteries or radiators, lead solder, leaded glass, bullets, lead fishing sinkers, or recycling facility work)?	❑ Yes ❑ No ❑ Don't Know
8. If the child is younger than 12 months of age, did the child's mother have a past confirmed blood lead level of 3.5 µg/dL or higher?	❑ Yes ❑ No ❑ Don't Know
9. Has the water in your home/residential building, child care setting, school, or other regularly visited facility been tested and had a confirmed level of lead (5 ppb or higher)?	❑ Yes ❑ No ❑ Don't Know
10. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead?	❑ Yes ❑ No ❑ Don't Know

*****Blood lead test results MUST be submitted to the Illinois Lead Program.**
Fax: 217-557-1188 Phone: 866-909-3572

_____ _____
Signature of Doctor/Nurse *Date*

Illinois Lead Program 866-909-3572 or 217-782-3517 Email: dph.lead@illinois.gov
TTY (hearing impaired use only) 800-547-0466

IOCI 25-2196 IOCI GRAPHICS
Printed by Authority of the State of Illinois 6/25

Submit

Nature's Scholars Enrichment Center, Inc. 4400 Beck Lane, Ringwood IL 60072

Phone 815-653-0240 or Fax 815-653-0390

Medical Permission Form

This original form,(not a copy), needs to be on file at Nature's Scholars Enrichment Center, Inc. before staff may dispense any medication to your child; this applies to prescription medication. Over the counter medication needs a handwritten note from the parent, stating that we are allowed to administer the medication to their child.

Physician's Certification and Authorization

I hereby certify that it is **absolutely necessary** that our patient, _____, receive the following medication while in attendance at Nature's Scholars Enrichment Center, Inc.

Medication_____Dosage_____

Specify day/dates to be dispensed_____
(i.e. M-01/01/14, T-01/02/14, W-01/03/14)

Specific times to be dispensed_____
(i.e. 8:00am, 12:00 noon, 4:00pm)

Prescribed for (diagnosis) _____

Observe for these side effects_____

Physicians Signature_____Date_____

Print Physicians Name_____ Phone (____)_____

Parent/Guardian Authorization

My signature on this form authorizes staff of Nature's Scholars Enrichment Center, Inc., to dispense the above medication to my child and releases Nature's Scholars Enrichment Center, Inc. and its employees of liability associated with it. I understand that the medication must be in the original container and labeled with my child's name, the name of the medication, dosage and frequency of administration: the dosage on the medication must be the same as the Physician's authorization above. I also understand it is my responsibility to remove any unused medication from the center. If not picked up within 10 days of last date listed above, the medication will be disposed of.

Parent Name: _____

Parent Signature_____
Date: _____

Nature's Scholars Enrichment Center, Inc. 4400 Beck Lane, Ringwood, IL 60072
Phone 815-653-0240 or Fax 815-653-0390

Special Diet Authorization Form

I, _____as parent of _____ authorize the staff of Nature's Scholars Enrichment Center, Inc. to give my child the food items I have prepared and/or supplied for them. I request that the staff of Nature's Scholar's Enrichment Center, Inc. serve the items in place of what the center is serving for the specified meal(s) and/or times I have listed below. I hereby certify that Nature's Scholars Enrichment Center, Inc. or staff of Nature's Scholars Enrichment Center, Inc. is not held responsible if my child develops a reaction or illness symptoms after consuming what I have prepared or supplied for them. I agree to train the director/administrator and staff member directly involved with my child on any special procedures related to my child's needs.

Print Parent Name: _____

Signature of Parent: _____

Date: _____

.....

Please provide a brief description below.

Type of food provided _____

_____

Time food should be supplied to my child_____

_____

Reason food is substituted _____

_____

_____

Nature's Scholars Enrichment Center, Inc. 4400 Beck Lane, Ringwood, IL 60072
Phone 815-653-0240 or Fax 815-653-0390

Pet Release Form

I, _____as parent/legal guardian, give my permission for the staff of Nature's Scholars Enrichment Center, Inc. to let my child _____ interact with center pets or other animals used at the center for learning purposes. This may include but not be limited to, handling, feeding & cleaning of animals and their habitat.

All safety precautions and hand washing will be strongly practiced.

Animals/Pets that may be at center include; Rabbits, fish, butterflies or other form of, insects, worm and ant farms, hermit crabs or other pets similar.

.....

Transportation Authorization Form

STUDENT INFORMATION:

_____

Student's Last Name **Student's First Name**

_____

Address

_____

City **State** **Zip**

AGREEMENT:

- I understand that District #12 offers busing to and from Johnsburg schools with a pick up and drop off at Nature's Scholars Enrichment Center, Inc.., or nearest location. Our Van transports to/from Richmond Elementary School District 2 & from Harrison School District #36.
- I agree to be responsible for transporting my child to and their school if my child misses the bus/van route at Nature's Scholars Enrichment Center, Inc., or nearest location.
- I understand a qualified staff from Nature's Scholars Enrichment Center, Inc. will be walking my child safely to the bus stop/van and staying with my child until the bus arrives or van drops off at location.
- I understand a qualified staff from Nature's Scholars Enrichment Center, Inc. will be at the bus stop/van to help my child get safely off the bus/van and walk him/her inside the center
- I understand that once my child gets safely on the bus he/she is the responsibility of District #12 until he/she is returned to Nature's Scholars Enrichment Center, Inc.
- I agree to be responsible for picking up my child at their school if for any reason he/she gets ill and/or needs to be picked up before the end of the school day.
- I agree to notify Nature's Scholars Enrichment Center, Inc. if my child's daily transportation schedule should change or is absent and will not be going to or returning from their school.
- I agree to be responsible for transporting my child to and from Nature's Scholars Enrichment Center, Inc. if my child displays harmful or continual inappropriate behavior, as seen by the Director, at any time while being transported to and from schools.

_____

Parent/Guardian Signature **Date**

Nature's Scholars Enrichment Center, Inc. 4400 Beck Lane, Ringwood, IL 60072
Phone 815-653-0240 or Fax 815-653-0390

CUSTOMER ACKNOWLEDGEMENT & RELEASE FORM
CORONAVIRUS NOTICE

I, _____ and parent/guardian of _____ acknowledge that I have voluntarily entered NSEC for childcare services and acknowledge that by doing so waive and release any claims against NSEC, it's employees, fellow parents/guardians and classmates and hold harmless to any claims, suits, charges, or costs relating to any diagnosis or treatment of COVID-19. That I or a member of my household or workforce (and any guests visiting my household or workplace) receive following the date the services started by NSEC.

I recognize that a national emergency has been declared related to the Coronavirus (COVID-19) pandemic. In response to this emergency, numerous state, and federal public health agencies, including the Centers for Disease Control and Prevention, have promoted "social distancing" from other individuals.

I recognize, acknowledge, and accept the health risks of allowing my child(ren) in NSEC given the current COVID-19 pandemic, and acknowledge the recommendations of state and federal public health agencies, including the Centers for Disease Control and Prevention.

_____ Date:_____
Printed Name of Parent/Guardian

_____
Signature of Parent/Guardian

Sick Child Policy Amendment: COVID-19

The safety and wellbeing of all staff, children, and the families at NSEC continues to be of utmost importance to us. We always commit to taking all precautions toward keeping children and staff safe and healthy, including the current time of the COVID-19 outbreak. The following is an additional sick child policy that will help NSEC do this.
Children will be monitored for signs or symptoms of COVID-19 daily. **Children will be required to stay home or return home if any of the following applies with no exception:**

- Have a fever of 100.4 or higher
- Have had a fever of 100.4 or higher or other potential symptoms of COVID-19, such as shortness of breath or persistent dry cough, within the last 72 hours.
- Have come in contact with others who have COVID-19.

To prevent the spread of COVID-19:

- Children with signs/symptoms of COVID-19 or who have been exposed to others with COVID-19 will be asked to stay home.
- Children who develop signs/symptoms of COVID-19 while at the program will be immediately separated from others and the program staff will contact the family member and/or emergency contact to pick the child up. (restricted to directors' office on cot)
- We encourage families to practice frequent handwashing at home.
- NSEC will practice handwashing upon arrival to the program, before meals and snacks, after outdoor play, after using the bathroom, prior to going home, after nose blowing or assisting a child with blowing their nose, coughing, or sneezing.
- Cover cough and sneezes with tissues, throw tissues in the trash, and clean hands with soap and water or hand sanitizer (if soap and water is not readily available).
- Clean and disinfect frequently touched surfaces at least four times daily, including tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.
- Require face coverings for persons over age 2 to the extent practicable, staff either masks or face shields. This will be optional while outdoors.
- Require children and staff to change shoes upon arrival or use shoe covers while indoors.

If an enrolled child or employee tests positive for COVID-19:

- The local public health department and the Department of Children and Family Services will be contacted. NSEC will follow their guidance for next steps.
- The program will post and notify families of any confirmed staff or child cases of COVID-19.
- Payment will be required at 50% tuition for duration of required absence or vacation week can be used as well.

Returning to a childcare facility after suspected COVID-19 symptoms:
If a staff member or child has symptoms of COVID-19 or is in close contact of someone with COVID-19, they can return to the childcare facility if the following conditions are met:

- If an individual has a fever, cough or shortness of breath and has not been around anyone who has been diagnosed with COVID-19, they can return to the center no sooner than 72 hours after the fever is gone (without the use of fever-reducing medication) and symptoms get better. If the person's symptoms worsen, they should contact their healthcare provider to determine if they should be tested for COVID-19.
- Any child suspected of having COVID-19, diagnosed with COVID-19, or having been in contact with persons suspected of or diagnosed with COVID-19 shall be excluded from the facility until written documentation is provided by the child's physician that the child is no longer communicable and may return to childcare.

I, (family member name)_____, parent/guardian of,

_____, have read and agree to the above sick child policy amendment.

Family member signature:_____Date:_____

Rental Agreement Form

I/we as parent/guardian _____ would like our
parent/guardian name
child_____ to have use of a Nature's Scholars Enrichment Center Tuffo all-weather suit. I understand that it is property of Nature's Scholars Enrichment Center and that the suit is not to leave the premises. I/we understand that I am responsible for paying a $25.00 rental fee that is good for as long as my child attends at the center and can fit comfortably in the largest size available. I understand that Nature's Scholars will make the best accommodations to supply my child with an appropriate fitting suit while my child is in attendance at the center and when center's staff deem necessary to wear per weather conditions.

_____ _____

parent/guardian signature date

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.