Student File Checklist

Child's name : ____ Enrollment date: _________

This checklist has been prepared to help you complete the documents for your child's file in accordance with Department of Children and Family Services licensing regulations. All forms must be completed and turned in to NFCNS two weeks prior to the first day of school.

Please fill out every form completely, using N/A (not applicable) when appropriate

If your child was a Cub, Bear, 3-Day or 4-Day student last year, only those forms marked with an asterisk are required.

____ Photocopy of birth certificate
____ *Certificate of Child Health Exam (remember to complete the parent portion and sign it) This form is due every 2 years. If you are claiming exemption from immunization for your child based on religion, also complete and return the Illinois Certificate of Religious Exemption
____ Lead Risk Questionnaire
____ *Emergency Contact form
____ *Release and Notification form
____ Student Information form
____ *Consent form
____ Guidance and Discipline Policy
____ Illness Policy
____ Late Pick-Up Policy
____ *Allergy Alert form – if your child has an allergy to be managed at school, please complete the Allergy Action Plan and Permission to Dispense Medication for **each medication** indicated by the Action Plan
____ *Handbook Acknowledgement
____ DCFS Licensing Regulations Summary, Verification of Receipt
____ *Volunteer Sign-Up

Other forms that may be indicated:
____ Illinois Certificate of Religious Exemption
____ Allergy Action Plan
____ Permission to Dispense Medication

State of Illinois
Certificate of Child Health Examination

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

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

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

Student's Name			Birth Date	Sex	School	Grade Level/ ID #
Last	First	Middle	Month/Day/ Year			

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)

EMERGENCY CONTACT FORM

This form will be used by Northfield Community Nursery School in the event of a medical emergency which requires the school and/or medical personnel to contact a child's parent/guardian. It contains important information about your child that may be needed in an emergency situation, and provides the fastest way to reach parents and/or other individual in the event that neither parent can be reached.

Child's name: ___________________________________ Birthdate: ______________________
(first) (last)
Any known allergies or medical conditions: ____

Address: ____Home Phone: __________________

Physician's name: _______________________________ Phone_____________________________
Address: ____

Dentist's name: _________________________________Phone _____________________________
Address: ____

1st person to contact in the event of emergency: mother / father / guardian (circle one)
Name: ____________________________________
Cell phone:__________________________________
Work phone: ______________________________
Home phone: _______________________________
Name and place of business if applicable: ____

2nd person to contact in the event of emergency: mother / father / guardian (circle one)
Name: ________________________________
Cell phone:________________________________
Work phone: ______________________________
Home phone: _______________________________
Name and place of business if applicable: ____

Authorized person to contact if neither parent is reachable:
Name: ________________________________ Relationship to child: _________________________
Cell phone:________________________________
Work phone: ______________________________
Home phone: _______________________________
Name and place of business if applicable: ____

I hereby authorize school officials to seek immediate medical attention with Northfield Paramedic Emergency Service in an emergency situation involving my above named child. I agree to accept all financial responsibility incurred by such action which may include transportation to and/or treatment at Glenbrook Hospital, Glenview, IL.

___________________________________	______________________________	_______________
(parent / guardian name)	(signature)	(date)

Child Release & Notification Form

Child's Name____

(first) (last)

Northfield Community Nursery School will not release a child to anyone other than a parent/guardian, unless they are listed and authorized below. It is a DCFS licensing regulation that NFCNS is prohibited from releasing a child without **written parental/guardian authorization**. This authorization must include the name, address and phone number of the alternate pick-up people. These same people will be notified if neither parent is able to be contacted for other child-related needs such as illness, diaper changing, or non-arrival of parent/guardian 10 minutes after the school session has ended.

I hereby authorize Northfield Community Nursery School to release my child to the following individuals. I will notify these individuals that they must provide photo identification in order for my child to be released to them.

Name: ________________________________ Relationship to child: _____________

Address:____

Daytime phone: _________________________ Cell: _________________________

Name: ________________________________ Relationship to child: _____________

Address:____

Daytime phone: _________________________ Cell: _________________________

Name: ________________________________ Relationship to child: _____________

Address:____

Daytime phone: _________________________ Cell: _________________________

Parent/Guardian signature: ____

Parent/Guardian name: ____________________________________ Date:___________________

NFCNS Consent Form

Photographic Release

Northfield Community Nursery School periodically takes photographs of children for use in educational portfolios, school newsletters, promotional materials, on the school website and in local publications. Names of children are not used.

____ I authorize the photographing and use of my child's picture as described above

____ I **do not** authorize the photographing and use of my child's picture

________________________________	______________________________	____________
(parent/guardian name)	(signature)	(date)

~~~~~~~~~~~~~
~~~~~~~~~~~~~

northfield community nursery school

Allergy Alert

Child's Name: _____________________________Child's Classroom: ______________

Please check and sign **one** of the following statements:

☐ My child has an allergy or sensitivity to the following:

____

____

The above indicated allergens/sensitivities need to be managed in my child's environment. I agree to complete and submit the *Allergy Action Plan* for my child, provided to me by NFCNS. I further agree to provide the medications necessary to manage my child's allergy/sensitivity at school, and to complete the forms authorizing NFCNS staff to administer such medications should they be indicated.

_________________________________	____________________________	_______________
(parent/guardian name)	(signature)	(date)

OR

☐ To my knowledge, my child has no allergies or medical conditions that need to be managed at NFCNS.

_________________________________	____________________________	_______________
(parent/guardian name)	(signature)	(date)

Food Allergy Action Plan

Emergency Care Plan

Place Student's Picture Here

Name: ________________________________ **D.O.B.:** ___/___/___

Allergy to: ________________________________

Weight: ________ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

Extremely reactive to the following foods: ________________________________
THEREFORE:
☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

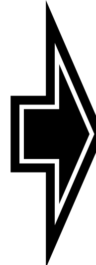
Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

LUNG:	Short of breath, wheeze, repetitive cough
HEART:	Pale, blue, faint, weak pulse, dizzy, confused
THROAT:	Tight, hoarse, trouble breathing/swallowing
MOUTH:	Obstructive swelling (tongue and/or lips)
SKIN:	Many hives over body

Or **combination** of symptoms from different body areas:

SKIN:	Hives, itchy rashes, swelling (e.g., eyes, lips)
GUT:	Vomiting, diarrhea, crampy pain



1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   - -Antihistamine
   - -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

MOUTH:	Itchy mouth
SKIN:	A few hives around mouth/face, mild itch
GUT:	Mild nausea/discomfort

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): ________________________________
Antihistamine (brand and dose): ________________________________
Other (e.g., inhaler-bronchodilator if asthmatic): ________________________________

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

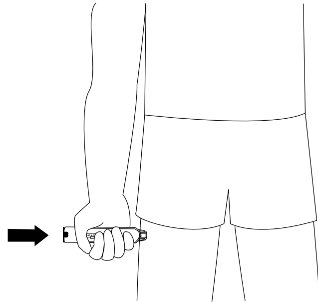
________________ ________ ________________ ________
Parent/Guardian Signature **Date** **Physician/Healthcare Provider Signature** **Date**

TURN FORM OVER **Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011**

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap

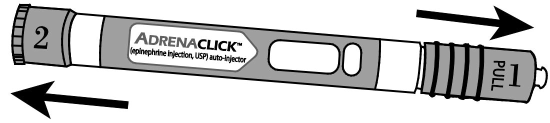
- Hold orange tip near outer thigh (always apply to thigh)

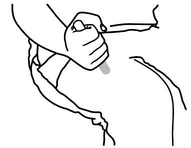


- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds

DEY® and the Dey logo, EpiPen®, EpiPen 2-Pak®, and EpiPen Jr 2-Pak® are registered trademarks of Dey Pharma, L.P.

Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions





Remove GREY caps labeled "1" and "2."

Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: (___) _____-_________) Doctor: _________________ Phone: (___) _____-_________

Parent/Guardian: ____ Phone: (___) _____-_________

Other Emergency Contacts

Name/Relationship: ____ Phone: (___) _____-_________

Name/Relationship: ____ Phone: (___) _____-_________

Northfield Community Nursery School

2017-18 Family Handbook Acknowledgements

I have read and understand the **2017-18 Family Handbook** of Northfield Community Nursery School.

Parent/guardian name: __________________________________ Date: ____________________

Parent/guardian signature: ____

Your child(ren)'s name(s):

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Volunteer Sign-Up

Here at NFCNS we rely on family participation. Please take a moment to let us know how you would like to help!

Toy Cleaning (August and/or January) - clean items at school or take items home to clean and keep our school healthy

Room Parent (2-3 needed per class) - help teachers with logistics of classroom events and coordinate teacher gifts

Pre-K Sharing Celebration (November) - help coordinate, prepare and serve a special Thanksgiving snack (Pre-K families only)

Cookie Walk (December 6th- 7th) - coordinate, bake, set up, or clean up - this is our traditional bake sale fundraiser

Saturday Splat (morning of January 13th) - set up, greet, supervise, or clean up for this “friendraiser” open to the public

Pre-K baking for soup kitchen (week of February 1st) - (Pre-K families only)

Alliance ScreenBreak Event (one afternoon, early March) - set up, greet, supervise or clean up for this fun family event

Bird Feeder Monitor – purchase bird seed and fill the school bird feeders once during the school year

Join the NFCNS Parent Board! Did you know that in addition to a wonderful staff, NFCNS has a parent-run board executing many functions for the school? NFCNS’s board of parent volunteers dedicates their time to work on a wide range of activities, including:

- Programs – welcome coffees and fundraisers
- Administration – budgeting, tuition planning and teacher contracts
- Facilities – overseeing playground and classroom materials maintenance

There are lots of different ways you can be part of the learning and excitement that happen at NFCNS every day. If you are interested in getting involved at any level, please check here and contact our Board President, Steph Stefanik, at SH65@ntrs.com.

Did we miss something? Is there another way you’d like to help? Please let us know:

____

____

Your name (please print): ____

Phone Number:________________________________ Email address:____

Child’s name: ____________________________ Child’s class and teacher:___________________________________

Child’s name: ____________________________ Child’s class and teacher: __________________________________

Thank you for volunteering! Our Volunteer Coordinator will be in touch. You may contact her with questions at nfcnsparents@gmail.com.