ROBIN'S NEST
LEARNING CENTER

Enrollment Packet

Please fill out all required documents within this packet.

Robin's Nest Learning Center of Carterville

Phone: (618) 922-8445 | Email: rnest1007@gmail.com

1007 California St, Carterville, IL 62918

LAST UPDATED: AUGUST 2026

ROBIN'S NEST LEARNING CENTER

Robin's Nest Parent Check List

Child(rens): _____

Below are the following things we need the day you start at Robin's Nest:
Please take the time to go over this checklist & check off the items you turned in to Robin's Nest at the time of enrollment.

___ *$75 Registration Fee to hold slot. Without this fee the slot is not guaranteed*
___ *Contract agreement: Fill in time & days! We schedule based on this form.*
___ *Signed rate sheet.*
___ *Deposit for 1 week's tuition: Can divide over 5 weeks. Check here for that option* ____
___ *Read over & sign contract. Email:* _____
___ *Tuition Express* ____ *Not using automatic billing $5.00 weekly fee*
___ *Orientation check list*
___ *Enrollment record Cell Phone Carrier:* _____
___ *Drop off Policy*
___ *DCFS verification form*
___ *Parent consents form (DCFS)*
___ *Authorization to pick up form.*
___ *Sick policy* ____ *Covid Policy*
___ *Family Photo to be displayed in classroom*
___ *Emergency Medical consent form*
___ *Health form: on state form.* ___ *Shot records: a copy will be fine*
___ *Birth Certificate within 30 days* _____ *Reminder* _____ *State Notified* _____
___ *Food paperwork* ___ *Infant feeding agreement*
___ *CCAP paperwork with pay stubs & school schedule to drop off on first day*

I understand by signing this form that I will provide the above needed paperwork within 30 days of the date of this form to avoid the $35.00 per month administration fee.
These are forms required by the state for compliance.

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

INTERNAL OFFICE USE:

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CCAP: Y / N

COMPLETED FILE DATE: _____ / _____ / _____

MEDICAL EXPIRES: _____ / _____ / _____

REMINDER DATE #1: _____ / _____ / _____	REMINDER DATE #2: _____ / _____ / _____	REMINDER DATE #3: _____ / _____ / _____
Items Missing:	Items Missing:	Items Missing:

ROBIN'S NEST LEARNING CENTER

Robin's Nest Contract Agreement

Date Filled Out: _____ /_____ /_____

Date Contract Becomes Effective: _____ /_____ /_____ *(Starts the Monday after receipt)*

I agree that my child/children _____
will be enrolled at Robin's Nest Learning Center for _____ days per week.
The days I have reserved are _____. (Varied or Drop-in) circle if applicable.
Any other days not noted here will be billed at drop-in rate of $_____.

CCAP parents: these are the rates you will be charged for days not covered by CCAP. CCAP allows for 4 (80%) absences per month and then you will be billed private pay rates.

The hours of care I need are _____-_____.
I understand anything outside these hours will add an additional fee as outlined in our drop-in rates.

My weekly tuition is _____ and is due the first day my child attends Robin's Nest to avoid the $20.00 perweek late fee.
Tuition per day is _____.
My transportation fee is _____.
The total weekly amount due on Monday is _____.
In the event there is no school and your child is school aged, you would add _____ to the weekly amount on the Monday of the week the full day is used.

Any variance of the scheduled times and days needed as outlined in this contract need to be submitted two-weeks in advance in writing in the tuition box to avoid drop-in fees. This would include switching days, vacation requests, termination of contracts, change of days or times & transportation needs outside of agreed school runs. Please note these requests are based on staff availability and current ratios. Robin's Nest is very full, and we do our best to accommodate schedule requests with proper planning.

A two-week notice is required to change and or terminate care. If no notice is given, the deposit of _____ will be forfeited and any outstanding balance is subject to the weekly late fee until balance is paid or a written payment plan is signed. In the event this account goes to collections, there is a $150.00 collection fee that will be added, and the account will go to collections and court for resolution. The deposit left here will be your last week of tuition with a two-week written notice.

All notices or changes take effect the Monday they are received. Please email all changes to:

Robin's Nest of Carterville - *rnest1007@gmail.com* | ***Robin's Nest of Marion -*** *jena.parson1988@hotmail.com*

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

Director Signature: _____ *Date:* _____ /_____ /_____

INTERNAL OFFICE USE: *CONTINUE TO THE NEXT PAGE ⟶*

Change of Classroom _____ *Change of Days* _____ *Change of Times* _____

Classroom Name _____ *Lead Teacher's Name* _____

ROBIN'S NEST LEARNING CENTER

Robin's Nest Rate Sheet

PLEASE NOTE:

Full Time is anything over 4 hours per day at Robin's Nest.
All payments are due by Monday at closing using ACH Tuition Express. Credit card payments can be accepted as a method of payments with a $6 service charge. No cash or check payments can be accepted.
Monthly room fee of $5.00 per child is assessed for supplies, crafts, gifts, cooking, treasure box, pictures, and so much more!

Summer Camp School Age Contract Reservation fee due by 3/31: **$75**
Transportation fees to local schools **$2.00** *per day*

Infants & Toddler

Contracted Daily Rate 3 or More Days: **$75** *1-2 Day Rate:* **$80** *Contracted Weekly Rate:* **$295**
*Drop-in Rate:***$85** *per day (No contract)*
Discount for Toddler Full Week Rate: **$275**

2 Year Olds & NOT Potty Trained Classroom *(any age NOT potty trained)*

Contracted Daily Rate 3 or More Days: **$65** *1-2 Day Rate:* **$75** *Contracted Weekly:* **$240**
Drop-in Rate: **$80** *(No contract)* *Fully Potty Trained (Can pull up & down pants):* **$220**

Pre-K & Pre-school class (1-10) Fully Potty Trained

Contracted Daily Rate 3 or More Days: **$60** *1-2 Day Rate:* **$70** *Contracted Weekly:* **$200**
Drop-in Rate (No contract): **$65** *NOT Fully Potty Trained (Can pull up & down pants):* **$220**

School Age Before/After & Full Day Program

Before or After - Contracted: **$17 per day**
Before & After - Contracted: **$20 per day** *or Before &/or After - (No Contract):* **$25 per day**

M-F Before AND After School: $100 *M-F Before OR After School: $87*

Full day out of school (w/ reservation) $40 or Full day no reservation (no contract) $50

*** CCAP School Age (no reservation) $10 per day.***

Summer & Full Weeks during the school year with Pre-Reservation (contract): $180

Contracts received after 3/31 are $190 a week

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

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Robin's Nest Learning Center
Parent Contract & Policy Agreement

ROBIN'S NEST LEARNING CENTER CARTERVILLE CONTRACT

Phone: (618) 922-8445 | Email: rnest1007@gmail.com

1007 California St, Carterville, IL 62918

Please initial on the lines and sign the back page. A copy of the Parent Handbook is attached to this enrollment packet, please keep for your records.

Child/Children's Name: _____

Financial Contract

I am leaving a non-refundable $75 Registration fee upon receiving the enrollment packet.

_____

If the registration fees have not been paid, the slot is not guaranteed just by having a packet.

_____

There is a $6.00 supply fee due the first of the month for each enrolled child. This money is spent on activities, supplies, holiday gifts for parents, party supplies, and anything extra the teacher in that class needs for the month. Receipts are provided monthly and posted on the parent board. If this additional fee creates a financial hardship for your family, please submit a written request to have this fee waived. _____

I am enclosing my contract agreement which specifies the days and times my child will be attending Robin's Nest. Please note some classrooms do not open at 6:00 AM. Accurate times provided are essential for proper staffing. _____

Robin's Nest holds a non-refundable deposit that will be applied to your last week of a two-week notice. Failure to provide proper notice will forfeit the security deposit. _____

The contract agreement outlines times, days, and fees associated with the childcare contract. Any variance to the contract needs to be submitted 2 weeks in advance to avoid additional fees and is based on availability. _____

CONTINUE TO THE NEXT PAGE ⟶

Robin's Nest cannot "swap days." Any days used outside the contract will be billed at drop-in rates.

I understand that drop-in care must be paid for when reserved. If my child does not attend, I understand I will still pay for the reserved time. Payment for drop-in care is due the day care is used to avoid nonpayment fees. If you use Tuition Express (TE), the amount billed will be deducted the following Monday. _____

All payments are due by Monday at closing. All payments will be processed on Mondays to maintain Monday-to-Monday bookkeeping through Procare. Cash and checks are not accepted as forms of payment. _____

Robin's Nest works with outside subsidies by applying credits after payment has been received. This does not include CCR payments. _____

Tuition Express will automatically pay for my tuition, activity fees, transportation fees, etc., through ACH with no additional fees. Weekly deductions are determined by what is outlined on the contract agreement and any other reserved activities or out-of-school days I sign up for.

_____

Myprocare.com is an online platform where you can pay your bill anytime and view a live ledger of what is being paid or owed. You can collect tax forms and sign up for weekly emails here. _____

There is a credit card option for Tuition Express. I agree to pay a $5.00 credit card fee if I choose this method to cover bank charges assessed to the school for weekly credit card use. I agree to pay the 1.8% credit card fee on large payments. _____

I understand that billing is based on the Robin's Nest time clock, and I will set my clock to reflect that time to avoid misunderstandings. _____

There is a $40.00 return fee assessed on all payments rejected by Procare. A new form of payment must be made within 48 hours to continue care. _____

Robin's Nest will email a copy of this contract. To end this contract, please email a notice to rnest1007@gmail.com. Failure to give a two-week notice will forfeit your deposit and make you liable for 2 weeks of tuition, plus collection costs starting at $150.00, along with attorney and court costs.

_____

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I understand that Robin's Nest cannot refund tuition paid in advance, security deposits, summer camp deposits, or flex spending payments. These payments will only be credited to your account for upcoming services. _____

Holidays, Vacations & Other Closure Information

I understand all holidays noted in the contract are paid in lieu of my free week of vacation or two half-weeks of vacation credit. _____

I understand vacation time must be submitted in writing two weeks in advance and emailed to rnest1007@gmail.com to receive credit. Vacation time cannot be used as part of a two-week notice and applies only to time my child will not attend. Vacation credit is given if the family ledger has a zero balance. Vacation time is valid 3 months after my child starts and renews annually based on the enrollment date. _____

Vacation credit is applied to private pay rates only. There is no vacation co-pay credit. Robin's Nest does not bill for your child's vacation time on the monthly billing form. _____

Robin's Nest closes at 2:00 PM on Christmas Eve & New Year's Eve. We are closed Christmas Day, New Year's Day, Thanksgiving & the day after, Memorial Day, Labor Day, Juneteenth, & the 4th of July.

We close at 4:30 PM on Pre-K Graduation night, and 3:00 PM on Halloween & the night of our Christmas show. Pickups after this time will incur a $1.00 per minute late fee. _____

Long Term closures:

In the event of a governmental shutdown due to COVID, pandemic, or natural disaster, half the tuition rate must be paid during the closure to maintain your spot. Please email rnest1007@gmail.com for this credit. If you do not wish to hold the spot, a 2-week notice is required, and your deposit will be applied to one of those weeks. _____

Parent Orientation

I have been invited to come to the class with my child and interact with the other children and the teacher. _____

I was given a parent orientation to procedures, policies, and daily program operations. I have signed the parent orientation checklist and I have no questions. If you have questions or special contractual needs, please note those here: _____

CONTINUE TO THE NEXT PAGE ⟶

I have been walked through the sign-in/out procedures, file location, manual sign-in board, tuition box, and parent information board, and was given a guided tour of the center and my child's teachers. _____

On your first day: A director will be available to assist you after 7:15 AM. If your drop-off time is before 7:15 AM, we encourage you to come in the day before so we can walk you through everything. _____

A welcome letter with your sign-in/out computer codes will be in your child's file folder. The front door code is your password. Please check your file folder daily. _____

Robin's Nest provides "Ages and Stages" screenings for all enrolled children from birth to age five. Initial if you DO NOT want your child screened: _____

If an outside therapist is needed, I understand RN insurance does not cover them. I give permission for my child to work one-on-one with the therapist where there is no direct supervision provided by RN. _____

I have been shown the location of the Parent Resource Book that holds informational sheets on community services, illnesses, and other items. _____

The safest location for paperwork is the tuition box. Please do not leave items on the desk.

_____

Licensing Requirements

I understand the importance of signing in & out at Robin's Nest. Accurate attendance is required for DCFS & CCR. If the computer is down, please sign in/out manually. There is a $15.00 fee for not signing in/out after being reminded. _____

I understand medical forms must be updated every 2 years to be compliant with DCFS requirements. I agree to provide a new medical form within 30 days of the expiration date, or a $35.00 admin fee will apply monthly until turned in. Children's files are checked monthly for compliance. _____

I understand that I must provide a copy of my child's birth certificate to comply with the Missing and Exploited Children's Act of 2010. Failure to do so could result in action from the state, and Robin's Nest will charge $35.00 per month until the file is complete. Please check the file folder daily for any missing items. _____

CONTINUE TO THE NEXT PAGE ⟶

I understand RN closes at 6:00 PM and earlier on select days. There is a $1.00 per minute per child fee for late pickups. If I am running late, I will call the center. After 6:30 PM with no call, RN will contact emergency contacts. _____

Per state regulations, only an adult 16 years or older can sign a child out and accept responsibility. Staff cannot sign children in/out. Please do not let children sign in/out or retrieve file paperwork.

_____

I relieve Robin's Nest of any responsibility, supervision, or liability after signing my child out. If children come back to play at the park, staff supervision is on a commitment level only. Children signed out are no longer part of our ratio or liability insurance. _____

I will walk my child to and from their class/playground to ensure safety and supervision in the center.

_____

Parent Contributions

I agree to fill out an annual evaluation of RN in October by dropping the completed form into the tuition box. This provides administration with input to support learning and improve operations.

_____

I understand the importance of evaluations and parent conferences and will participate as my schedule allows. RN offers after-hours, phone, and Zoom conferences as requested. _____

Robin's Nest uses text messaging for quick notices, not to replace conversations. Please leave a text and we will call you back. _____

I have been invited to contribute to my child's educational experience by volunteering in the classroom, being a guest speaker, or attending events. _____

I understand Robin's Nest has an open-door policy to discuss goals, behavior concerns, or needs.

Field Trips, Transportation & Other Special Activities

I give Robin's Nest permission to take my child on any field trip I sign them up for. If I do not pay the fee, my child may be removed from the list. _____

CONTINUE TO THE NEXT PAGE ⟶

I understand there are no refunds on excursions unless canceled by RN. _____

I give Robin's Nest permission to take my child to assisted living homes to perform or play games. A notice will be posted in advance. If I opt out, I will note it on the communication board. _____

I give Robin's Nest permission to take my child to practice locations for shows (Dates and times will be posted in advance on FB and the whiteboard). _____

I give Robin's Nest permission to transport my child to school in vans/buses insured by the center.
_____

I understand there is a $10.00 fee if the van arrives at a school to pick up my child, but the child was not called in absent to Robin's Nest by 10:00 AM (morning) or 2:00 PM (afternoon).

Robin's Nest will ALWAYS pick up your child unless that call is made. _____

I understand that school-aged children require a non-refundable $75.00 summer deposit ($100.00 for late registration) to ensure a spot. These fees are applied to science projects, parties, art, cooking, and more. _____

I agree to allow my child to attend all pre-planned field trips I sign up for. I agree to pay the fees by the due date to avoid additional charges. _____

I give Robin's Nest permission to take my child outside the gate, on walks in buggies/wagons, and to local parks within walking distance. _____

I agree to send my child in proper footwear and NEVER flip-flops. I will bring replacement shoes within an hour if forgotten. Robin's Nest suggests tennis shoes and socks for safety. _____

I agree to let my child participate in supervised cooking activities (knives & heat), summer water play, and monthly bounce house activities. _____

Attendance is Important! Call our Attendance line!

If my child is ill or absent, I will call/text RN (please do not email, as emails are only checked in the morning). _____

I understand that I cannot drop off my child after 10:30 AM without prior approval, as curriculum is complete and lunch preparation begins. You may pick up anytime. _____

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If you are absent for 2 weeks with no payment or arrangements, we will close your file and open your slot to another family. The two-week notice will be billed. _____

CCR families must attend 80% of the time (no more than 4 missed days per month for a full-time schedule) for the state to pay for services. RN allows 1 week of vacation per year with a 2-week notice. The co-pay is not discounted. CCR families exceeding 20% absenteeism must pay for missed days the state does not cover. _____

Potty Training & Soiled Clothing Policy

I understand the diapering policy. Infants are changed every other hour; toddlers every two hours. A staff member will check your child before you leave to ensure a clean diaper. If you prefer changes strictly "AS NEEDED", please sign here: _____.

To start potty training, I will sign the agreement, pay a $5/week potty fee, and provide 5 labeled outfits in washable/Ziploc bags. RN does not use pull-ups. I agree to pay $1 per Ziploc bag if RN provides one. _____

I agree to be assessed a $5.00 weekly potty fee if my child has frequent accidents. Potty trained rates are based on a larger ratio, and teacher interaction is compromised when changing accidents.

_____

I will provide 1 change of clothing in a Ziploc bag labeled with my child's name (including school-aged kids). _____

I understand there is a $3.00 rental fee if the school provides clothing. I have 1 week to return the clothing, or the fee becomes non-refundable. _____

I agree to provide a box of diapers and wipes weekly. If I run out, I agree to pay RN $7.00 per box of wipes and/or $3.00 per diaper. _____

Medications & Illness

RN has provided a separate sick policy & COVID policy in my enrollment packet. _____

RN requires temperature checks. A fever over 100.4°F requires 24 hours at home. Children may return after being fever-free for 24 hours without medication.

I understand RN may require a doctor's note to return to school if a contagious illness is suspected or medical attention is required. _____

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I will pick up my sick child within an hour. After 1 hour, Robin's Nest charges $20.00 per hour for staff to stay one-on-one with your child. Failure to pick up sick children may result in contract termination.

_____

I understand that Robin's Nest cannot administer medication without it being signed in daily, in its original bottle/label, accompanied by a doctor's note. _____

I understand that Robin's Nest cannot administer the first dose of any medication due to potential allergic reactions. _____

I give permission for RN staff to apply center-provided sunscreen as needed. I will apply sunscreen before arrival, and provide my own if my child has allergies. _____

Other Important Things to Know

I give Robin's Nest permission to take pictures of my child for the website, Facebook, center displays, and local media. My signature is permission to use my child's picture in various media forms. _____

Please join the Robin's Nest Facebook page for real-time updates, events, recalls, and field trip info.

_____

I understand RN is not responsible for lost money, electronics, toys, or clothing. I will label all personal items and place my child's coat in their cubbie when dropping off. _____

Media/TV activities are extremely limited and previewed by staff. An alternative activity is provided if interest is lost. Please do not sign your child up for movie activities if sitting still is challenging.

_____

Cell phones, tablets, and smartwatches are not allowed in classrooms. If seen, they will be kept in the office for safe keeping. _____

Due to severe allergies, outside food is only allowed if packaged for parties and checked by the office first. All allergies are posted in classrooms and the lunchroom. _____

I understand my child will go outside 3 times a day (between 25–100 degrees), always based on child comfort. RN provides hats and gloves in winter; please keep your personal ones in cubbies.

_____

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I give my child permission to use the monthly bounce house. _____

During summer, my child has permission to use the Splash Pad. RN provides swimsuits, towels, and sunscreen. _____

I understand RN offers birthday party rentals for the lunchroom, gym, and splash pad. _____

I understand RN is NOT responsible for clothing and shoes worn to school. We recommend clothing that can get dirty, messy, and wet. _____

I understand my child naps on cots (or cribs if under 15 months) and RN provides all essentials. If providing your own blanket, it must be in a labeled backpack and washed weekly.

_____

RN sprays for pests inside/outside on weekends when children are absent. _____

RN enforces a strict anti-idling policy. Please do not leave your car running in the parking lot.

_____

I understand a current contract is posted online. A one-month notice of changes will be provided electronically, and no signature is required if rates are unaffected. _____

Tax forms are sent electronically. You can also access year-end statements at myprocare.com.

_____

Behavior & Professionalism

I understand the behavior code must be followed. If behavior escalates, a behavior modification agreement must be signed to continue care. Profanity, vandalism, physical/verbal threats, or running away from teachers may result in immediate termination without refunds. I agree to work with staff to help my child succeed.

I understand the biting policy: After 3 bites, a child goes home. A shadowing plan and parent meeting will follow. Parents agree to supply teethers. _____

I agree to observe my child in class for an hour if requested and partner with administrators. Failure to attend these meetings results in dis-enrollment. _____

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Behavior issues will be discussed in private via the office to protect privacy. _____

I agree to communicate professionally. Profanity, threats, or abuse toward staff will end our business relationship. _____

I will not approach RN staff for romantic relationships or outside employment. _____

Childcare Assistance Program (CCR/CCAP) Requirements

I will provide a complete application, 2 recent pay stubs, school schedule, and wage verification BEFORE obtaining CCR approval. _____

If participating in CCAP, I will pay my parent fee by the 1st of every month (or split into 4 weekly Monday payments). If I leave mid-month, the full co-pay is due. Late payments incur a $20.00 weekly fee. Care not covered by CCR is billed at private rates. _____

I will submit all required documents promptly to get approval within 14 business days.

_____

After 14 days, I agree to pay private rates until CCR approval is received. _____

I agree to pay a $25 co-pay until approval is received (max 3 weeks), which will be adjusted on the ledger once approved. _____

I will respond promptly to redetermination notices sent by text to prevent termination. _____

RN will NOT backdate childcare past 30 days. Approval must be obtained within 30 days to avoid private rates. _____

Family, job, marital, or financial changes must be submitted to CCR within 10 days, with a CC moore42601@gmail.com. Failure to do so may result in termination and back-payment. _____

I will submit renewal paperwork 2 weeks prior to my certificate's termination date. _____

I must give a 2-week written notice via email to rnest1007@gmail.com. My child must attend those weeks, or CCAP will not pay and I will be billed at private rates. _____

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Parent e-mail for monthly calendars, invoices & other pertinent center information:

_____ ***Please do not e-mail Robin's Nest anything. Robin's Nest can only use hard copy documents for legal purposes.***

Phone Carrier: _____ *(Verizon, AT&T, Sprint etc.)*

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

Director Signature:_____ ***Date:*** _____ / _____ / _____

Parent Questionnaire *Questions, comments, additions to contract needed for family:*

Where did you hear about Robin's Nest? *Choose from the following:*

SOCIAL MEDIA **GOOGLE/ONLINE SEARCH** **MAIL/POSTCARD** **ADVERTISMENT** **WALK-IN**

REFERAL/REFERRED BY:_____

Allergies, special diets, modifications needed at school:

_____

Are there family values, beliefs, cultural or childrearing practices you can share to make adjustment easier?

_____

Our goal is to be an extension of your family. What steps could the staff take to meet this goal?

_____

Would you like information about family programming and supports? **YES | NO**

Do you need information provided in a language other than English? **YES | NO**

Does your child have special needs? Are there physical therapists visiting our school?
(Please provide contact info/permission to speak with them).
*Name:*_____ *Phone:*_____ **YES | NO**

Are there any questions we can answer?

_____

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ROBIN'S NEST LEARNING CENTER

Parent Orientation Checklist

Welcome to Robin's Nest Learning Center!

Please look over the following checklist & ask questions as we go through the following procedures.

Child(rens): _____

1. RN director has walked me through the center and introduced me to my child's teachers. My child will be in _____ and the lead teacher is _____

2. RN offers the extra time needed for you and your child to spend in the classroom and get to know the classroom, teachers and new friends. We have an open door policy for you and your family to visit anytime!

3. RN director has gone over all needed paperwork and provided a check list of needed items to complete by child's file. An overview of the contract was provided and signed off on at the time of enrollment.

4. RN director has asked what my expectations are of RN and the needs of my child.

6. RN director has showed me where my child's classroom lesson plans are posted, the class schedule & the "Coty Bug sign" on each classroom door.

7. RN director has provided me a file folder for my child to collect art work, file information needed and monthly updates. These folders are filed by classroom and child's first name. I understand it is important to check file folder daily in the event there might be an accident form.

8. RN director has showed me where to sign in medications that needed to be given and I understand that I need a doctor's note for RN to give medications. I agree to give first dose of any medication at home.

9. RN director showed me where the parent resource binder is and location of monthly informational sheets located by the front office door.

10. RN director has offered interpreter services as needed in home language or ASL.

11. RN director has showed me where to put important paperwork

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12. RN director has provided me with a list of items I need for my child's file and I agree to get these items to the school within 30 days to avoid the incomplete file fee of 35.00. Upon turning in paperwork there is a 35.00 registration/technology fee required to accept paperwork.

13. RN director has explained there is no refunds on deposit.

14. RN director has explained tuition express, the card reader and I agree to pay child care on Mondays to avoid late fees.

15. RN is not responsible for any cash dropped in tuition box or given to a child for an activity.

16. RN has a quiet time from 10:30 AM - 2 PM. I agree not to drop off my child during these hours.

17. RN director explained the importance of NOT bringing any outside food into the center. We have children with death allergies. Please do not allow children to carry in left over breakfast or uneaten snacks.

18. RN has meal times and menus posted and has showed me the lunch room for all pre-school age children.

19. RN director has explained our cloth potty training policy and the $5.00 per week potty fee associated with changing potty accidents. If your child is potty trained and they start having multiple accidents, the potty fee many be reinstated/charged.

20. RN director explained that I need 1 set of clothing labeled in a Ziplock bag with my child's name on it if my child is potty trained. If my child is potty training we need 5 sets of pants and underwear.

21. RN director showed me where to pick up soiled clothing, lost and found toys and coats. Both are located by the front door.

22. RN director explained we are fully trained on emergency procedures and in the event we ever needed to relocate, the address and phone number are on the front door of the school.

23. RN director has invited me to participate in parent/teacher conferences in May, Nov or anytime that I feel I need to meet.

24. RN director has explained there is an annual review of the school and I agree to provide information that is important to me, my family and the raising of our child in your program.

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25. RN has given me a copy of their discipline policy. I agree if my child ever hits or hurts a child or teacher before a field trip, the director can take my child off that activity.

26. RN takes ANY concern very seriously and we will follow up in writing or with a call. Please check file folder for that document. If you feel your concern was not handled properly, please call Brittany any time: 618-922-8445 for Carterville and Jena for Marion 618-997-7734.

27. RN was explained that a two week notice is required to change days, change contract, request vacation or end contract. RN does everything Monday to Monday. Email is the preferred way to communicate these contract changes. A written notice can be put in the tuition. box. The tuition box is opened on Monday nights only.

28. RN director has explained the 5.00 per month per child supply fee. The receipts are posted on the bulletin board in the follow for parental view.

29. RN director has explained CCAP procedures with me. I will pay my co-pay the first of the month, or divide into 4 weeks due on Monday nights. If I leave mid-month, the whole copay is due.

30. If I am applying for CCAP, I understand that I will pay $25.00 per week for the first 2 weeks until approval is obtained. After the 3rd week of no approval, I agree to pay private pay rates as outlined on rate sheet.

31. I understand all CCAP paperwork needs to be turned in to RN to be logged and accounted for. If CCAP paperwork is late, childcare can be terminated by the state resulting in private pay rates.

32. I understand that I am required to notify CCAP of any changes: change of job, marital status, pregnancy, pay raise, loss of job, school schedule etc... within 48 hours of the change. If this is not done, CCAP will terminate payment and I will be required to pay private pay rates.

33. School age building is open in the afternoon when school is in session or after 9:00 AM during summer/out of school days. I will drop off and sign in & out in the main building.

34. There is a large sign in the parking lot telling parent where to pick up school age children. When the sign is covered, I know to go to school age building.

35. RN director has explained school age procedures, drop off, meals etc.. to me.

CONTINUE TO THE NEXT PAGE ⟶

36. RN director has explained the summer camp calendars, field trips fees, out of school days (how to sign up for them).

37. RN director has given me information on the RN FB page to stay on top of activities, deadlines. and what we are doing on a daily basis.

38. RN has been given an email to send me updates, reminders, invoices and monthly calendar. I agree to read brightly colored signs that are posted on doors to provided additional information.

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

Director Signature: _____ *Date:* _____ / _____ / _____

Director who went over these procedures

CONTINUE TO THE NEXT PAGE ⟶

CFS 428
Rev. 4/2001

State of Illinois
Department of Children and Family Services

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 or other person placing child | Signature of caregiver | Date

A completely filled in form must be kept by the licensee for each child not related to the licensee. Please have this form available at all times to licensing representatives of the Department of Children and Family Services. Contact the Area Office for supplies of this form.

If the child has any of the 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

Automated Payment Processing
Safe – Convenient – Easy

We are excited to offer the safety, convenience and ease of Tuition Express®—a payment processing system that allows secure, on-time tuition and fee payments to be made from either your bank account or credit card.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FOR BANK ACCOUNT and CREDIT CARD

I (we) hereby authorize (business name) _____ to initiate credit card charges to the below-referenced credit card account **(Section A)** OR, initiate debit entries to my (our) checking or savings account, indicated below **(Section B).** To properly affect the cancellation of this agreement, I (we) are required to give 10 days written notice. Credit union members: please contact your credit union to verify account and routing numbers for automatic payments. Check with the center for accepted credit card types.

COMPLETE ONE SECTION ONLY

SECTION A (Credit Card)

Cardholder Name _____ Phone # _____

Cardholder Address _____ City _____ State _____ Zip _____

Account Number _____ Expiration Date _____

Cardholder Signature _____ Date _____

SECTION B (Bank Account)

Your Name _____ Phone # _____

Address _____ City _____ State _____ Zip _____

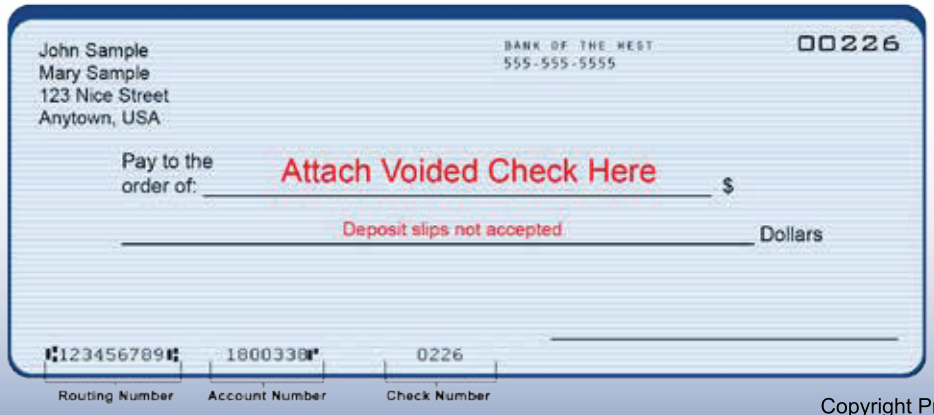
Bank or Credit Union Name _____ Bank or Credit Union Address _____ City _____ State _____ Zip _____

Routing Transit Number (see sample below) _____ Account Number (see sample below) _____ ☐ Checking ☐ Savings

Authorized Signature _____ Date _____

For Official Use Only

Date Received
Employee Signature



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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

CFS 593
Rev 7/2007

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD _____

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES.

Parent(s) or legal guardian placing the child may sign any or all of the following consents:

EMERGENCY MEDICAL CARE

This authorizes _____
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 _____ 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 _____ 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

- over -

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 _____ 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

SWIMMING

I/we consent to my/our child using the swimming pool of _____
Name of Provider

at _____.
Address

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

Date _____ _____
Signature of parent/guardian

_____
Relationship to child

HOUSEHOLD ELIGIBILITY APPLICATION
PARENT/GUARDIANS LETTER

Dear Parent or Guardian:

Your day care home provider participates in the U.S. Department of Agriculture's (USDA) Child and Adult Care Food Program (CACFP) and receives Federal funds to offer healthy meals and snacks to all of the enrolled children. The amount of reimbursement the day care home provider receives is based on the information you provide on the attached Household Eligibility Application. To receive meal reimbursement payments, your day care home provider must follow menu planning guidelines, keep accurate meal records each day and agree to monitoring visits by our staff while children are in their care.

Your day care home provider will receive a higher rate of reimbursement if your household income meets or is below the Income Eligibility Guidelines listed in this letter or if a member of your family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF); Women, Infants, and Children (WIC); or other state or federal program benefits for your children. Also, if you care for a foster child that is the legal responsibility of the Department of Children and Family Services (DCFS) or the court, these children are eligible for meal benefits regardless of your household income.

If your income(s) is over the income guidelines on the following page, you are not required to complete this application; however, it would be helpful if you would write your child's name on the application and return it to our day care home provider or mail to the address provided on the enclosed envelope. Please notify us, if you or someone in your household becomes unemployed and the loss of income causes your household income to be within the income eligibility standards.

The information you provide on the application will be used to determine your child's eligibility for meal benefits. The information will be kept confidential and only available to staff directly connected with administering the CACFP.

Please note that by signing Number 4 of the enclosed HEA for the Illinois *All Kids* Health Insurance that you are stating ***you do not want*** your information shared with the Illinois Department of Healthcare and Family Services. If you agree to disclose the application information, it may be used to identify your child(ren) for the health insurance program. If you would like more information on *All Kids*, call toll-free 866/255-5437 or 877/204-1012 (TTY).

Income Eligibility Guidelines
Effective from July 1, 2026 to June 30, 2027

Reduced-Price Meals
185% Federal Poverty Guideline

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	29,526	2,461	1,231	1,136	568
2	40,034	3,337	1,669	1,540	770
3	50,542	4,212	2,106	1,944	972
4	61,050	5,088	2,544	2,349	1,175
5	71,558	5,964	2,982	2,753	1,377
6	82,066	6,839	3,420	3,157	1,579
7	92,574	7,715	3,858	3,561	1,781
8	103,082	8,591	4,296	3,965	1,983
For each additional family member, add	10,508	876	438	405	203

If you have any questions or need help, please contact our day care home provider or sponsoring organization listed below.

Sincerely,

Non-Discrimination Statement

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, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. 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 responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or 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 discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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. USDA is an equal opportunity provider, employer, and lender.

PARENT INSTRUCTIONS FOR COMPLETING THE HOUSEHOLD ELIGIBILITY APPLICATION

Once properly approved for meal benefits, a child's Household Eligibility Application (HEA) will remain in effect for 12 months.

Complete the Household Eligibility Application (HEA) for one of the following areas:

- If anyone (child or adult) in your household receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) follows **Instruction A** below.
- If you or a child receives benefits from the Women, Infants, and Children Program (WIC); Low Income Home Energy Assistance Program; or free or reduced-priced meals from the National School Lunch and Breakfast Programs, please follow **Instruction B** below.
- If you have a foster child who remains the legal responsibility of the Department of Children and Family Services (DCFS) or the court, follow **Instruction C** below.
- If you receive income, follow **Instruction D** below.

Instructions A—Households Receiving SNAP or TANF

If any member (child or adult) of your household receives benefits from SNAP or TANF, provide the following information:

- **Number 1**—List the names of ALL people in your household (such as grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the day care home.
- **Number 3**—Record a valid SNAP or TANF case number for any member (child or adult) of this household. Do not list your Illinois LINK card number. You may find your SNAP or TANF case number on your medical card or letter of eligibility for benefits.
- **Number 4 (OPTIONAL) —***Illinois All Kids Health Insurance Program*.
- **Number 6**—Provide a signature of an adult household member and date the application.
- Your application is complete.

Instructions B—Individuals receiving WIC or Low Income Home Energy Assistance Program

If any member (child or adult) of your household receives benefits from WIC or Low Income Home Energy Assistance Program, provide the following information:

- **Number 1**—List the names of ALL people in your household (such as grandparents, other relatives, or friends who live with you) and the age(s) of the child(ren) attending the day care home.
- **Number 3**—Identify the individual that is receiving WIC and record a valid WIC case number for that member (child or adult) of this household. If an individual or household is receiving assistance from Low Income Home Energy Assistance Program; or free or reduced-priced meals from the National School Lunch and Breakfast Programs identify the individual that is receiving benefits and mark the Other Extended Categorical.
- **Number 4 (OPTIONAL)—***Illinois All Kids Health Insurance Program*.
- **Number 6**—Provide a signature of an adult household member and date the application.
- Your application is complete.

Instructions C—Application for a Foster Child(ren). A **foster child** remains the legal responsibility of DCFS or the court.

1) If you have a legal document from DCFS or the court for your foster child, please provide a copy; you do not need to complete this application. If you don't have a legal document, follow Step 2 or 3 below.
2) If <u>all children in your household (who attend this day care home) are foster children</u> provide the following information:
   - **Number 1**—List the name(s) and age(s) of your foster child(ren) attending this day care home.
   - **Number 2**—Check the box(es) indicating the child is a foster child(ren).
   - **Number 4 (OPTIONAL)—** *Illinois All Kids Health Insurance Program*.
   - **Number 6**—Provide a signature of an adult household member and date the application.
   - Your application is complete.
3) If you have a <u>foster child(ren) along with other children attending this day care home</u>, please provide the following information:
   - **Number 1**— List the names of ALL household members including the foster child(ren) and the age(s) of the child(ren) attending the day care home.
   - **Number 2**—Check the box(es) identifying the foster child(ren).
   - **Number 4 (OPTIONAL)**— *Illinois All Kids Health Insurance Program*.
   - **Next Go to Instruction D—Households Reporting Income** below and complete Numbers 5 and 6.

Instructions D—Households Reporting Income

It is <u>not</u> necessary to complete income information if you provided SNAP or TANF information in Number 3. However, 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:

- **Number 1**— List the names of ALL household members and the age(s) of the child(ren) attending the day care home.
- **Number 4 (OPTIONAL)**—*Illinois All Kids Health Insurance Program*.
- **Number 5**—List total gross income (before deductions), not your 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.
  - For ONLY the self-employed, list monthly income after expenses. This is for your business, farm, or rental property.
  - If you are in the Military Privatized Housing Initiative or get combat pay, do not include these allowances as income.
- **Number 6**—Provide the last four digits of the social security number for the adult household member 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*.
- Your application is complete.

CHILD AND ADULT CARE FOOD PROGRAM – HOUSEHOLD ELIGIBILITY APPLICATION FOR PARENT/GUARDIANS OF ENROLLED CHILDREN IN A DAY CARE HOME

1 LIST EVERYONE IN HOUSEHOLD (Children and Adults)

NAME (First, Middle and Last)	Check If No Income	Date of Birth	Ages of Children Enrolled in Day Care Home	**2 FOSTER CHILD** Check box for all foster children that are a legal responsibility of DCFS or the court.
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐
	☐	/ /		☐

3 CATEGORICAL ELIGIBILITY FOR FEDERAL OR STATE PROGRAMS

Name of Child: _____

SNAP or TANF Number:

_ _ _ _ _ _ _ _

WIC Number _ ___ ___ ___

OTHER CATEGORICAL ELIGIBILITY –

☐ Low Income Home Energy Assistance Program

☐ Other Extended Categorical

4 OPTIONAL—SHARING INFORMATION WITH *ALL KIDS INSURANCE PROGRAM*

May we share your information on this application with *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 *All Kids Insurance Program*. *Sign here:* _____

5 HOUSEHOLD MEMBERS WITH INCOME—List only the names of individuals living in the household, their gross income, and how often it is received. If a person has a second job, list that income in the last column. After completing, **go to Number 6.**

NAMES (List only individuals with income)	Earnings from Work (Gross before Deductions)		Income from Welfare, Child Support, Alimony		Income from Retirement, Pensions, SSI, Social Security		Income Received From Savings, Investments, Trust Accounts, and Other Resources	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	
	$ /		$ /		$ /		$ /	

6 Signature and Social Security Number (Adult must sign)

An adult household member must sign the application. If Number 5 above is completed the adult signing the form must also list the last four digits of his or her social security number or mark the box *I do not have a social security number.*

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 day care provider 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*	*Address of Adult Household Member*

PRIVACY ACT 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.*

NON-DISCRIMINATION STATEMENT: 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, religion, sex, gender identity (including gender expression), sexual orientation, disability, age, marital status, family/parental status, income derived from a public assistance program, political beliefs, or reprisal or retaliation for prior civil rights activity, in any program or activity conducted or funded by USDA (not all bases apply to all programs). Remedies and complaint filing deadlines vary by program or incident. 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 responsible Agency or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or 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 discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint 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. USDA is an equal opportunity provider, employer, and lender.

SPONSOR REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION—Follow the instructions provided in the Household Income instructions.

Mark one of the boxes below to show how you are going to determine eligibility.

CONVERSION TABLE

To convert all income to annual income use the following conversion calculations:

Weekly Income x 52

Every 2 Weeks x 26

Twice a Month x 24

Monthly x 12

Annual income total the number of household members from Section 5.

Total Household Annual Income $ _____

Total Household Size _____

☐ Approved for Tier I Meal Rate ☐ Denied

Signature of Representative: _____

Date

**Effective Date of Application:* _____

**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 the child's eligibility is certified.*

ILLINOIS STATE BOARD OF EDUCATION

100 North First Street
Springfield, Illinois 62777-0001

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. Section 5: this section is optional. CACFP sponsors must ensure households are made aware that failure to provide racial or ethnic identity information will not impact their eligibility. However USDA strongly encourages CACFP sponsors to explain the importance of this data to parents/guardians to complete this 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. _____ *Digital or Original 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.

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or 2. fax:(833) 256-1665 or (202) 690-7442; or, 3. email: program.intake@usda.gov

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	2. FOSTER CHILD Foster children are a legal responsibility of DCFS or court. If all are foster children, skip to Section 6	3. 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
- ☐ migrant
- ☐ runaway
- ☐ household's income
- ☐ Head Start

☐ **Reduced based on:**
- ☐ household's income

☐ **Denied — Reason:**
- ☐ income too high
- ☐ incomplete application
- ☐ Non-qualifying SNAP/TANF

SECTION B **Signature of Determining Official:** _____ **Date:** _____

Print Reset Form

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, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity.Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the responsible state or local agency that administers the program or USDA's TARGET Center at (202) 720-2600 (voice and TTY) or contact USDA through the Federal Relay Service at (800) 877-8339. To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program Discriminatior Complaint Form which can be obtained online at: https://www.usda.gov/sites/default/files/documents/USDA-OASCR%20P-Complaint Form-0508-0002-508-11-28-17Fax2Mail.pdf, from any USDA office, by calling (866) 632-9992, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted 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; or 2. fax:(833) 256-1665 or (202) 690-7442; or, 3. email: program.intake@usda.gov

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.

ROBIN'S NEST LEARNING CENTER

Robin's Nest Drop-off Policy

Welcome to Robin's Nest Learning Center!

We want to thank you for choosing Robin's Nest to be your child's early learning program!

Robin's Nest starts educational activities as young as the infant room and with each classroom starts a new set of skills we hope to teach your child to master!

Most of our primary learning objects start at 9:00 AM. We ask that you have your child at school in time for circle time and these valuable learning opportunities. Our screenings and assessments happen between 9 AM - 11 AM and it is important that your child attends as much as possible to learn & master these skills in a routine and structured way. Repetition strengthens the newly learned skills and routine helps keep children feel safe and confident in their classroom with their teachers and peers.

Robin's Nest wants your child to come to school and love learning.

Robin's Nest has a drop off policy that limits drop off times at 10:30 AM.

After 10:30 AM the children are settling down with lunch and a nap and a dark napping room is not inviting to a child coming in and leaving mom & dad.

Please understand- this policy is to keep children happy and confident in our program. We do not want children coming in crying at nap time when there is sleeping children who really need that rest. (This policy came from a parent concern)

If you need to drop off after 10:30 AM and there is a way we can work it out without being disruptive to the whole group- we want to work with you. This exception to our policy will require advance-notice so we can properly plan.

If you miss the 10:30 AM drop off time, you are welcome to drop off at 2:00 PM after quiet time has ended!

Child(rens): _____

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

CONTINUE TO THE NEXT PAGE ⟶

ROBIN'S NEST LEARNING CENTER

Robin's Nest Two-Week Notice

We take great pride in offering part-time and drop-in care. Please note the following policies:

Two-Week Notice Requirement

A written two-week notice is required to end care or change your schedule. This includes parents who use Childcare Assistance Programs (CCR).

Submitting Your Notice

The written notice needs to be submitted via email for dating purposes to:

Robin's Nest of Carterville - rnest1007@gmail.com

Robin's Nest of Marion - jena.parson1988hotmail.com

All bookkeeping is done Monday to Monday. If you give notice or submit a vacation request on a Wednesday, the 2-week window will start the Monday after the email is dated.

Important Paperwork

Please place all important paperwork securely in the tuition box. Important paperwork includes contract changes, medical forms, children's paperwork, Childcare Assistance paperwork, and food program paperwork. Please do not leave these items on our desks.

Drop-In Contracts

If you have a drop-in contract, any day reserved will be billed. If you decide not to use the day, a two-week notice is required to cancel the request.

School-Aged Children & In-Service Days

If you have a school-aged child, there is a full-day reservation sheet posted for any day out of school. You will be required to sign up if services are needed for that in-service day. If you do not sign up in advance, you will be billed at the drop-in rate. If you do sign up, you will be billed for that day even if your child ends up not attending.

Part-Time Schedules

If you have a part-time schedule contract, you cannot swap out days without a written two-week notice of the schedule change. Any changes will be based strictly on availability.

Child(rens): _____

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

Copy Given to Parent by: _____ *Date:* _____ / _____ / _____

CONTINUE TO THE NEXT PAGE ⟶

ROBIN'S NEST LEARNING CENTER

Robin'S NesPick Up Authorization Form

Please list any family member, friend, or co-worker who may be picking up your child. If there is a parent or individual who is NOT allowed to pick up the child, be sure to note that clearly at the bottom of this page.

Child(rens): _____

Mother's Name: _____ *Father's Name:* _____

Parent 4-Digit Code (Numbers Only): _____

Authorized Pick-Up 4-Digit Code: _____

(To be used by any of the authorized individuals listed below)

I authorize the following individuals to pick up my child/children:

1. NAME _____ PHONE _____

ADDRESS _____

2. NAME _____ PHONE _____

ADDRESS _____

3. NAME _____ PHONE _____

ADDRESS _____

4. NAME _____ PHONE _____

ADDRESS _____

5. NAME _____ PHONE _____

ADDRESS _____

Court-Ordered Parenting Time/Restrictions

This person can pick up my child ONLY on certain days according to court-ordered parenting time:

Name: _____

Times/Days Allowed: _____

Unauthorized Individual(s)

(Please highlight or note if there is a parent or specific person who is NOT allowed to pick up the child)

Name: _____ **Name:** _____

CONTINUE TO THE NEXT PAGE ⟶

ROBIN'S NEST LEARNING CENTER

Robin's Nest Sick Policy

Robin's Nest understands that children will have stuffy noses & coughs. Some children have allergies and constantly have runny noses. We do ask that if you child has had any of the following symptoms, please keep your child home. This is the best way to keep the staff healthy to care for your child & keep other children from getting sick. If your child comes to daycare & we call you to pick up your child, you have 1 hour to make arrangements. After 1 hour, there is a $2.50 per 15 minutes. Please help us keep sickness down at Robin's Nest.

Please do NOT bring your child to the center with ANY of these symptoms or illnesses listed here:

Fever of 100.4 & Up

Ring Worm

Head Lice

Impetigo

Chicken Pox

Pink Eye

Strep Throat

Discharge from Eyes

Severe Cough *(Sounds croupy or whooping)*

Diarrhea *(Two or more loose stools)*

Bacterial Meningitis

RSV

Hand, Foot & Mouth

Sore Throat

Trouble Swallowing

Rashes/Spots on Body

Severe Headaches

Difficulty in Breathing

Vomiting

If your child was vomiting/throwing up the night before:

Please do NOT bring your child to school!

Here is a good rule of thumb: If your child needs tylenol or cold medication, they should probably be at home with you. ***We can not give your child medications without a signed medical form from your physician.***

Report any medications being taken by your child to the office, in case of an allergic reaction. ***If your child needs a prescription, ask your pharmacist to spilt the medication into two labeled bottles. One for home & one for daycare. This will help in leaving medications at school & your child not getting the medications as prescribed by your doctor.***

Please be sure to sign in your child's medication daily to be given at school. We can not give medication if it has not been signed in by you and permission to be given by both you and your doctor. Please see attached form.

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

CONTINUE TO THE NEXT PAGE ⟶

ROBIN'S NEST LEARNING CENTER

COVID Policy

The following precautions have been put in place to keep everyone safe & healthy in our program:

A. *If you are NOT feeling well or are being tested for COVID because of a close contact: do NOT come into our school. Call us and we will bring your child to you. Your child/children will need to stay home with you until your results come back.*
B. *A " close contact or positive case of COVID" will require a written health department release to come back to RN.*
C. *If RN is mandated to close down the school or a classroom by the health department, no payment is required during that closure. After health department releases our classroom to reopen fees will resume.*
D. *In the event you are quarantined, you may use your vacation time by sending an email. 1 week of vacation credit will be given if available.*
E. *Please come into our school wearing a mask and provide a mask for all children 3 & older.*
F. *Please do **NOT** go into our classrooms for any reason.*
G. *Please use hand sanitizer when signing in & out.*
H. *We will be doing temperature checks at drop off: Please do not leave until that temperature has been confirmed. Anything over 100.4 is not permissible.*
I. *If your child has been showing 2 or more signs of COVID a doctor's note will be required for your child to return school.*
J. *In the event there is a school closure: we may reopen with limited parental access to the front of the school. Please plan drop off/ pick up time accordingly.*
K. *Robin's Nest reserves the right to terminate our contract if a parent willingly violates this COVID policy and endangers the wellbeing of our families and our team. (example: not telling the school about being tested for COVID or being a close contact and not quarantining as required by the health department)*

Long Term closures:

In order to maintain your spot in the event there is any governmental shut down due to COVID or any other virus, pandemic, environmental/natural disaster event is half rate of tuition paid during this closure. If you do not want to pay the fees to hold the spot, a 2-week notice is required and any deposit on file will be applied to one of those weeks.

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

CONTINUE TO THE NEXT PAGE ⟶

ROBIN'S NEST LEARNING CENTER

Emergency Medical Release

I, _____, being the parent or legal guardian of _____, give my consent for emergency medical and surgical treatment of this minor by a licensed physician should his/her condition so require it in my absence. I understand that in such a case, reasonable attempts would first be made to contact me, time and condition permitting.

As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow:

Medical Information

My child is allergic to these medications:

_____

My child takes these medications on a regular basis:

_____

Parent/Guardian Emergency Contact Information

Parent/Guardian:	*Parent/Guardian:*
Mobile Number:	*Mobile Number:*
Home Number:	*Home Number:*
Home Address:	*Home Address:*
Work Number:	*Work Number:*
WorkAddress:	*Work Address:*

☐ *I DO NOT have medical insurance.*

☐ *I HAVE medical insurance*
(Please provide a copy of your card or print out insurance information).

Hospital Coverage Information / Choice: _____
Address: _____ *Phone:* _____
Dentist Coverage Information / Choice: _____
Address: _____ *Phone:* _____
Doctor Coverage Information / Choice: _____
Address: _____ *Phone:* _____

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

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