



Noble Day Care, L3C
1333 W. Chicago Ave.
Chicago, IL 60642
312-929-3575 phone
312-929-2910 fax

Application for Enrollment

Are parents/guardians Noble Network Staff? No____ Yes____ Which Campus?_____

Child's Name: _____ Age: _____ Birth date: ____/____/____
(Last, First, Middle)

Home Address: _____ Home Telephone: _____
_____ Email: _____

Name of parent/guardian: _____ Relationship _____
Cell phone: _____
Name of Employer: _____
Address: _____
Phone: _____

Name of parent/guardian: _____ Relationship _____
Cell phone: _____
Name of Employer: _____
Address: _____
Phone: _____

Transferring from another child care center? No____ Yes____ Which one? _____

Please fill in the days and times you are requesting enrollment, including a drop off and pick up time:
M—F _____ M _____ T _____ W _____ Th _____ F _____

*An enrollment fee of \$100 must accompany this application.

Parent/Guardian Signatures: _____ Date: _____
Director Signature: _____ Fee paid: _____ Date: _____

-----Please do not write below this line at the time of enrollment-----

Date of Enrollment: _____
Discharge Reason: _____
Date of Discharge: _____
Parent/Guardian Signatures: _____ Date: _____
Director Signature: _____ Date: _____



Noble Day Care Child Introduction Form

Child's Name: _____

Please check all that apply			
Is your child...		Does your child...	
	shy?		suck his/her thumb? use a pacifier?
	energetic?		have fears we should know about?
	toilet trained?		play well with other children?
	used to a daily nap? Times? From _____ Until _____ From _____ Until _____		have siblings? Please list names, ages _____ _____
	accustomed to day care setting?		dress him/herself?
	allergic to anything? Please list _____ _____		have any special needs? Please list _____ _____

Please list any other information we should be aware of in order to care for your child as an individual.

Some items to consider:

Events in your home atmosphere often influence your child's attitude and behavior. Please keep us informed of any major changes (divorce, separation, death of a relative or friend) so that we may help your child by giving any special attention, understanding and care. Any such information will remain confidential.

Parent/Guardian Signature _____ Date _____



MUTUAL PERFORMANCE EXPECTATIONS STATEMENT

As the Provider, I/we will...	As the Parent/Guardian, I will...
Ensure a safe environment	Read all forms given to me
Keep families informed about our program	Sign and return forms as necessary
Provide proper developmental explorations for your child(ren)	Pay all fees by expected dates
Recognize the individuality of your child	Drop off and pick my child up on time Arrival_____ Pick-up_____ Late Fee _____
Recognize your child's accomplishments	Let you know if my child will be late or will not attend
Communicate with you about your child's activities and growth	Let you know if someone else will be picking up my child
Provide nutritious meals and snacks	Help my child get enough rest to develop properly
Receive and consider feedback about our program	Bring an extra set of clothing for my child
Work with you in planning for your child's future education	Dress my child appropriately for indoor and outdoor activities
Provide at least 2 weeks notice if we will be unable to continue providing care for your child	Keep my child home if he/she is sick
	Provide constructive criticism for program improvements in a respectful way

Together, we will...
Treat each other and your child with mutual respect
Communicate regularly with each other about your child's social, emotional, developmental and educational growth, accomplishments, struggles, nutrition, and health
Show your child that we are a team to serve his/her best interests
Talk through any differences to decide what is best for all concerned.

Child's Name: _____

Signatures:

Director: _____ **Date:** _____

Parent/Guardian(s): _____ **Date:** _____

_____ **Date:** _____



Child's Name: _____

Emergency Contact and Permission to Drop Off and Pick Up

In case of an emergency, we will first try to contact parents/guardians. When parents/guardians cannot be reached, we will call emergency contacts beginning with the first person on this list. If anyone other than the parent/guardian is picking up a child, they MUST show picture identification and be on this list.

Please list at least two emergency contacts.

Please list all names and phone numbers in the order in which we should call them.

Parent/Guardian to call First: _____

Phone : (home/cell/work) _____

Phone : (home/cell/work) _____

Phone : (home/cell/work) _____

Parent/Guardian to call Second: _____

Phone : (home/cell/work) _____

Phone : (home/cell/work) _____

Phone : (home/cell/work) _____

Please check which these contacts are approved for:

Emergency Pick Up Both

Name: _____ Relationship: _____

Address: _____ Phone: _____

_____ Alt. Phone: _____

Name: _____ Relationship: _____ Emergency Pick Up Both

Address: _____ Phone: _____

_____ Alt. Phone: _____

Name: _____ Relationship: _____ Emergency Pick Up Both

Address: _____ Phone: _____

_____ Alt. Phone: _____

Parent Signature(s):

Date: _____

Classroom Sign In/Out:

Noble Day Care Infant Sign-In/Sign-Out Sheet

Date: _____

Name	Monday		Tuesday		Wednesday		Thursday		Friday	
	Time In	Sign	Time In	Sign	Time In	Sign	Time In	Sign	Time In	Sign
Caleb A.										
Wesley A.										
Henry B.										
Patrick C.										
Ariel D.										
Eleanor G.										
Margot G.										
Matthew M.										
Christopher P.										
Anya S.										
Grey W.										
Max A.										

Name	Monday		Tuesday		Wednesday		Thursday		Friday	
	Time Out	Sign	Time Out	Sign	Time Out	Sign	Time Out	Sign	Time Out	Sign
Caleb A.										
Wesley A.										
Henry B.										
Patrick C.										
Ariel D.										
Eleanor G.										
Margot G.										
Matthew M.										
Christopher P.										
Anya S.										
Grey W.										
Max A.										

SAMPLE



Noble Day Care Photo Release

I hereby give to Noble Day Care, my consent to use, publish, republish, disclose or re-disclose any photographs and/or recordings of myself and my child for brochures, videotapes, or any publicity purposes.

I further waive, release, discharge, and disclaim any right or claim to any payment or compensation for this release of my likeness and my child's likeness.

Child's Name: _____

Address: _____

Phone number: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____



STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name Last			First	Middle	Birth Date			Sex	Grade Level			ID#									
Address Street		City			ZIP code			Parent/ Guardian		Telephone # Home		Work									
IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given <i>after</i> the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.																					
VACCINE/DOSE	1			2			3			4			5			6					
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR			
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																					
Diphtheria and Tetanus (Pediatric DT or Td)																					
Inactivated Polio (IPV)																					
Oral Polio (OPV)																					
Haemophilus influenzae type b (Hib)																					
Hepatitis B (HB)																					
Varicella (Chickenpox)																Comments					
Combined Measles, Mumps and Rubella (MMR)																					
Measles (Rubeola)																					
Rubella (3-day measles)																					
Mumps																					
Pneumococcal (not required for school entry)																					
Check specific type (PCV7, PPV23)	Date																				
Other (Specify hepatitis A, meningococcal, etc.)																					

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

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

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

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

Date of Disease Signature Title Date

3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella

Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

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

Printed by Authority of the State of Illinois
(Complete Both Sides)

Student's Name Last First Middle			Birth Date Month/Day/ Year		Sex	School	Grade Level/ ID #
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER							
ALLERGIES (Food, drug, insect, other)				MEDICATION (List all prescribed or taken on a regular basis)			
Diagnosis of asthma? Child wakes during the night coughing?	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes Yes	No No	
Birth complications/prematurity?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes	No	
Diabetes?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Head injury/Concussion/Passed out?	Yes	No		TB disease (past or present)?	Yes*	No	
Seizures? What are they like?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart problem/Shortness of breath?	Yes	No		Alcohol/Drug use?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Dental 9 Braces 9 Bridge 9 Plate Other			
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Other concerns?			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?				Parent/Guardian Signature		Date	
Entire section below to be completed by MD/DO/APN/PA							
PHYSICAL EXAMINATION REQUIREMENTS		HEAD CIRCUMFERENCE		HEIGHT		WEIGHT	
DIABETES SCREENING (Not required for daycare.) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/>							
Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>							
LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (If child resides in Chicago, blood test is required.)							
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. <input type="checkbox"/> No Test Needed <input type="checkbox"/> Test performed Date Read / / Result mm							
LAB TESTS (Recommended)		Date		Results		Date	
Hemoglobin or Hematocrit				Sickle Cell (when indicated)			
Urinalysis				Developmental Screening			
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs		
Skin				Endocrine			
Ears				Gastrointestinal			
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optometrst Yes <input type="checkbox"/> No <input type="checkbox"/>				Genito-Urinary	LMP		
Nose				Neurological			
Throat				Musculoskeletal			
Mouth/Dental				Spinal examination			
Cardiovascular/HTN				Nutritional status			
Respiratory				Mental Health			
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>		Physician/Advanced Practice Nurse/Physician Assistant performing examination			
Print Name		Signature		Date			
Address				Phone			

(Complete both sides)



Authorization for Medical Treatment

Medical Authorization for _____

I hereby grant permission for the director or acting director to take whatever steps may be necessary to obtain emergency medical care. These steps may include, but are not limited to, the following:

Non-serious injuries shall be handled at the center with administration of first-aid. I authorize staff to provide any first aid deemed necessary for my child.

In case of an emergency, every reasonable attempt shall be made to first contact the parent/guardian of a child. If the parent/guardian cannot be contacted, the attending physician listed on the emergency form shall be notified of the status of the child's health and his/her advice shall be followed.

If neither the parent/guardian nor the child's physician can be reached, we will do one or both of the following:

1. Call another physician or paramedics.
2. Have the child taken to an emergency hospital in the company of a staff member.

Any expenses incurred are the responsibility of the parent/guardian.

I also authorize the transfer of my child's health records to the local hospital.

Physician Name: _____ Phone: _____

Address: _____

Health Insurance: _____

Parent/Guardian Signature: _____ Date _____



Topical Ointment Consent Form

I give my permission to staff of Noble Day Care to apply the below topical ointment on my child as directed by the manufacturer's label.

Child's Name: _____

Topical Ointment:

Diaper Cream: _____

Frequency of administration: _____

Consent to begin _____ (date) until _____ (date).

Sun Screen: _____

Frequency of administration: _____

Consent to begin _____ (date) until _____ (date).

Other: _____

Frequency of administration: _____

Consent to begin _____ (date) until _____ (date).

Other remarks:

Date: _____

Parent/Guardian's Signature(s):

Print name

Print Name



Travel and Activity Authorization

I give my permission for my child _____, to use all equipment, to participate in all center activities and to leave the center premises under the supervision of a staff member for neighborhood walks or field trips in an authorized vehicle.

Restrictions for my child include:

Parent/Guardian Signature: _____ Date: _____



Incident/Illness Report

Name of Child: _____ Date: _____ Time: _____

Caregiver in charge at the time: _____

Location incident Occurred: _____

Please describe the details of the incident:

Was First Aid provided? Yes _____ No _____ Details: _____

Was medical attention required? Yes _____ No _____

Was EMS called? Yes _____ No _____ Time: _____ Time Responded: _____

Details of On-set of Illness While in Care

Type of Illness: _____

Does the illness require exclusion from care? Yes _____ No _____

If communicable: other parents notified? Yes _____ No _____

Notification method used: _____

Health Dept. notified? Yes _____ No _____ Date _____

Temperature of Child _____

Medication given _____

I verify that the above information is a true and accurate account of the incident/injury that occurred concerning this child.

Signature of Director/Person in Charge: _____ Date: _____

I verify that the director/person in charge appropriately relayed the information concerning the incident/injury concerning my child. I have received a copy of this report.

Parent/Guardian Signature: _____ Date: _____



Late Pick-Up Policies

It is extremely important that you pick your child up on time each day. Please keep in mind that your child relies on you both physically and emotionally to be there to pick them up each day. Please also keep in mind that our staff may have other responsibilities outside of their scheduled work time that may be affected by any lateness.

Fees:

We will assess a late fee of \$5 for the first ten minutes after 6:00 pm and \$1 for each minute thereafter to encourage on-time pick-up. This fee must be paid before your child can return to care the next day.

Procedures:

1. If you have not arrived to pick up your child by 6:00 pm, we will attempt to call you at any and all phone numbers listed.
2. If we have not reached you and you have not arrived by 6:10, we will begin calling those listed on the approved pick-up list to come and pick up your child until we reach someone or until we have exhausted the list.
3. If you have not arrived and we have been unable to reach anyone by 6:30 pm, we reserve the right to call the police for assistance in locating someone or guidance on next steps for safety of the child.

Important Notes:

It is extremely important that you keep an updated list of emergency contact information, including names and phone numbers.

We will maintain responsibility of your child's protection and well-being until you, an emergency contact, or outside authorities arrive.

We will not hold your child responsible for the situation, and we will not discuss the situation with your child.

Child's Name: _____

I understand and accept these late pick-up policies:

Signature

Signature

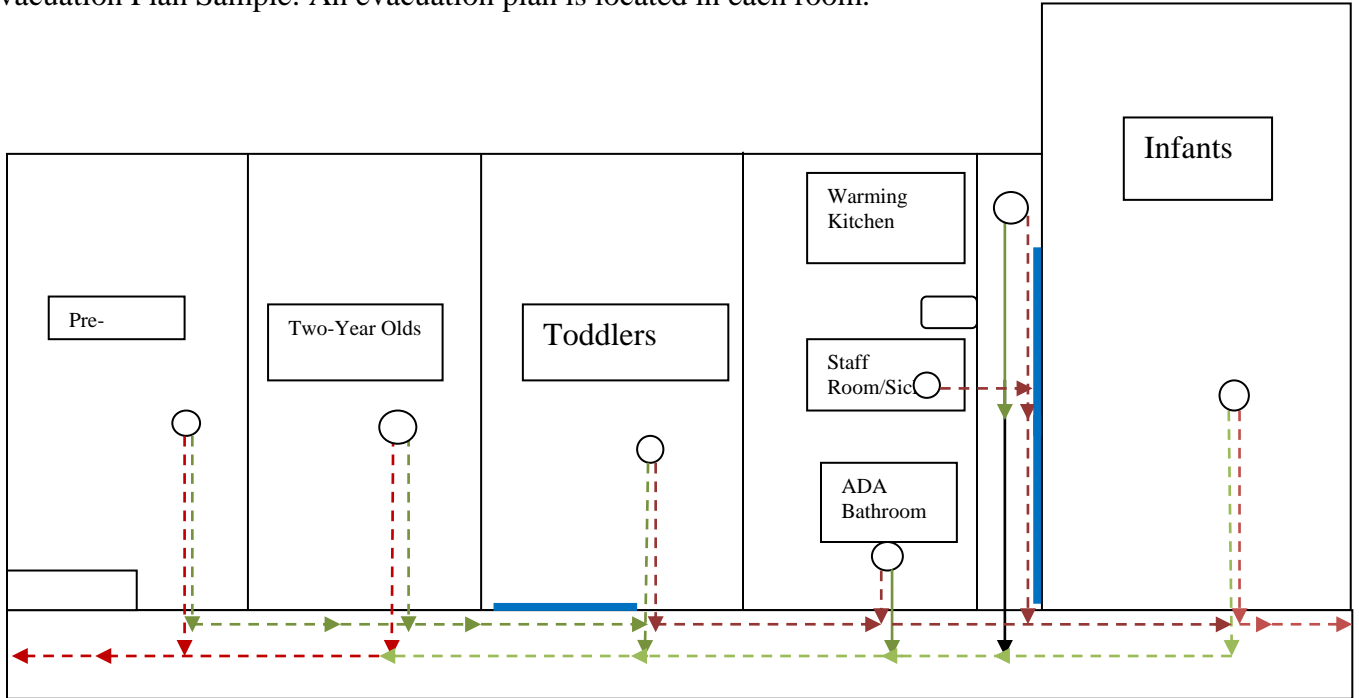
Print Name

Print Name




Date

Date

** Evacuation Plan Sample: An evacuation plan is located in each room.**



Noble Day Care Evacuation Plan

	Tornado
	Primary
	Secondary



Proof of Identity

Please submit a certified copy of a birth certificate or other form of acceptable proof of identity with all other forms in this packet.

As part of the Missing Children Records Act mandate, any child enrolled must provide a certified copy of the child's birth certificate or other reliable proof of identity and age of the child—we will make a copy and return the certified copy to you. If a certified copy of a birth certificate is not available, the parent or guardian must submit a passport, visa or other governmental documentation as proof of the child's identity and age and an affidavit or notarized letter explaining the inability to produce a certified copy of the birth certificate.

Noble Day Care is required by law to notify the Illinois State Police or local law enforcement agency if the parent or guardian fails to submit proof of the child's identity within 30 days.



Acknowledgement and Acceptance of Procedures and Policies

I acknowledge that I have received, read and understand all procedures and policies in Noble Day Care's Parent Handbook. I accept all procedures and policies, including those relating to discipline. I agree to abide by all policies stated in the Parent Handbook. We understand that we will be notified in writing of any changes in these policies.

We also understand that any breach of policies may be grounds to terminate childcare. A two-week notice will be given in such circumstance unless the infraction is severe enough to warrant termination without notice.

Child's Name _____

Parent Signature _____

Parent Signature _____

Today's Date _____