

# APPLICATION FOR ENROLLMENT

Tots Land Day Care/ Learning Center

7460 W Addison St

Chicago IL 60634

Date of Birth: _____		Sex: _____	
Date of Enrollment: _____		Date of discharge: _____	
Full Name: _____			
Last		First	Middle Nickname
Home Address: _____			
No		Street	City State Zip
Language spoken at home: _____			
Primary Days of Care: M T W TH F		Total number of Days: _____	
Primary Hours of Care From _____ To _____			
Before School Only: _____		After School Only: _____	Both: _____
Child Lives With: _____			
Custody: Mother Father Both Other (specify) _____			
Mother's Name: _____		Father's Name: _____	
Address: _____		Address: _____	
Home Phone: _____ Mobile: _____		Home Phone: _____ Mobile: _____	
Occupation: _____		Occupation: _____	
Work address: _____		Work address: _____	
Work Phone: _____		Work Phone: _____	
Email: _____		Email: _____	
Child's siblings and their ages: _____			
I hereby grant permission for the staff of Tots Land Day Care to contact the following medical personnel to obtain emergency medical care if warranted. I will reimburse any expenses incurred by the child's service.			
Doctor/Dentist/Hospital	Phone	Address	
Please list allergies, special medical or dietary needs, or other areas of concern. _____			

**EMERGENCY CONTACTS**

The following people will be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent or legal guardian cannot be reached.

Name	Home Phone	Work Phone	Address

Your child(ren) will be released only to the custodial parent or legal guardian and the persons listed below.

**CONTACTS**

		Home/ Work Phone:	Address .
Names of persons authorized to pick up the child regularly.	1.		
	2.		
	3.		
Names of persons authorized to pick up the child occasionally:	1.		
	2.		
	3.		

1. A parent manual with additional policies, procedures, and helpful information will be given to all of our clients.
2. All day care enrollees must have a current physical and immunizations prior to admittance.
3. No child will be admitted to Tots Land if he/she appears ill, is not feeling well or has a fever.
4. Upon acceptance of your child at Tots Land a deposit equivalent to one week's tuition must be paid, plus the first week's tuition in advance. Tuition is due and payable each Friday for the following week in advance.  
There will be a late charge of \$10 for past due tuition.
5. You are obligated to give Tots Land two weeks notice, in writing, that you wish to disenroll your child  
At that time you will pay for one week, and your deposit will be applied to the last week's tuition.  
Deposits are not refundable.
6. All checks should be made out to Tots Land, INC.
7. Registrations are considered to be incomplete if any of the above conditions are not met.

The foregoing regulations and standards are established to provide the best care for your child.

Signature of Parent/Guardian

Date

**Tots Land Day Care-Learning Center**  
**7460 W Addison Ave**  
**Chicago, IL 60634**  
**773 574 9290**

**CHILD DEVELOPMENTAL HISTORY INFORMATION**

**Child's Name** \_\_\_\_\_ **Age** \_\_\_\_\_ **Birth date** \_\_\_\_\_ **Sex: M** ☐ **F** ☐  
**Child's Address** \_\_\_\_\_ **Telephone** \_\_\_\_\_  
**Language(s) child speaks** \_\_\_\_\_

**Health History**

Does your child have any health issues? \_\_\_\_\_  
Does your child take any medication? (Give name/dose/frequency) \_\_\_\_\_  
Has your child ever had a ☐ Serious accident/illness? ☐ Hospitalization? \_\_\_\_\_  
Did/does your child have ☐ Recurrent ear infections? Have tubes in his/her ears? ☐ Yes ☐ No  
☐ Allergies? Describe: \_\_\_\_\_  
☐ Asthma? Treatment? \_\_\_\_\_  
Has your child had a ☐ Hearing Screening ☐ Vision Screening ☐ Speech/Language Screening?  
When? \_\_\_\_\_

**Developmental Milestones**

As accurately as you can remember, how old was your child when s/he: Sat up \_\_\_\_\_ Crawled \_\_\_\_\_ Walked \_\_\_\_\_  
Talked (2 words) \_\_\_\_\_ Fed self (spoon) \_\_\_\_\_ Toilet trained: Started \_\_\_\_\_ Completed \_\_\_\_\_  
Do you have concerns about your child's development in *any* of these areas?  
☐ Speech or Language ☐ Motor Skills ☐ Social Skills ☐ Cognitive (Intellectual) ☐ Sensory ☐ Behavioral ☐ Emotional  
Describe: \_\_\_\_\_  
Does your child have any developmental delays or special needs? \_\_\_\_\_  
Has your child had a developmental or diagnostic assessment? \_\_\_\_\_  
Does your child receive any special services (*i.e.: Speech, O.T., Behavior Therapy, etc.*)? \_\_\_\_\_  
\_\_\_\_\_

**Your Child's Daily Routine**

What is the best time of day for you with your child? \_\_\_\_\_

**Eating**

Does your child ☐ use a pacifier ☐ suck thumb ☐ use a bottle? When? \_\_\_\_\_  
Does your child ☐ feed him/herself? ☐ parent feeds child? \_\_\_\_\_  
Food issues? \_\_\_\_\_  
Food allergies? \_\_\_\_\_

**Diapering/Toileting**

Is your child toilet trained? ☐ Yes ☐ No ☐ "In progress" Concerns? \_\_\_\_\_

**Sleeping**

Does your child go to sleep ☐ easily ☐ with difficulty ☐ with a bottle ☐ with a parent ☐ use a "lovely" ☐ have a bedtime ritual?  
Describe: \_\_\_\_\_  
Does your child have a regular bedtime? ☐ Yes ☐ No Wakes at: \_\_\_\_\_ Naps at: \_\_\_\_\_ Goes to bed at: \_\_\_\_\_

**Activities and Play**

Describe the type of activities your child enjoys: \_\_\_\_\_  
Does your child *avoid* any physical activities? \_\_\_\_\_

Does your child attend any other regular groups or classes? ☐ Yes ☐ No

Describe: \_\_\_\_\_

Does your child demand a lot of adult attention? ☐ Yes ☐ No Describe: \_\_\_\_\_

### Social Relationships

Has your child been recently enrolled in childcare? When/Where? \_\_\_\_\_

Describe any previous experiences the child has had: \_\_\_\_\_

Does your child usually play ☐ alone ☐ w/ siblings ☐ w/parents ☐ w/ younger children ☐ w/older children ☐ w/adults?

What are your child's positive personality traits? \_\_\_\_\_

What are your child's negative personality traits? \_\_\_\_\_

How does your child handle separation? \_\_\_\_\_

What works best? \_\_\_\_\_

Does your child have any fears? \_\_\_\_\_

How does your child express these fears? \_\_\_\_\_

What helps? \_\_\_\_\_

When does your child get angry? \_\_\_\_\_

How does she/he express this? \_\_\_\_\_

How do you respond? \_\_\_\_\_

### What describes your child's "natural" temperament?

(please circle)

**Energy** Quiet ☐ ----- ☐ ----- ☐ Very active

**First Reaction** (to new people, activities, ideas) Outgoing, jumps right in ☐ ----- ☐ ----- ☐ Shy, holds back

**Mood** (general emotional tone) Usually positive, happy ☐ ----- ☐ ----- ☐ More serious, analytical

**Intensity** (strength of emotional reactions) Has mild reactions ☐ ----- ☐ ----- ☐ Has strong reactions

**Persistence** (ease of stopping when involved in an activity) Easily redirected ☐ ----- ☐ ----- ☐ "Locks in"

**Sensitivity** (to noises, emotions, tastes, textures, stress) Usually not sensitive ☐ ----- ☐ ----- ☐ Very sensitive

**Perceptiveness** (notices people, noises, objects) Hardly ever notices ☐ ----- ☐ ----- ☐ Very perceptive

**Adaptability** (copes with transitions, changes in routine) Flexible, adapts quickly ☐ ----- ☐ ----- ☐ Adapts slowly

**Regularity** (regular about eating/sleeping times, etc.) Regular, follows routine ☐ ----- ☐ ----- ☐ Irregular

**Attention Span/Distractibility** (ability to follow through with task) Stays focused ☐ ----- ☐ ----- ☐ Easily distracted

### Parent Comments

would like us to know about your child? \_\_\_\_\_ Is there anything else you

Do you have any concerns about your child (*i.e.: eating, sleeping, toileting, behavior, etc.*)? \_\_\_\_\_

What behaviors do you find "hard to handle" in your child? \_\_\_\_\_

What kind of discipline works best with your child? \_\_\_\_\_

What are your goals for your child in preschool at Tots Land? \_\_\_\_\_

☐ Thank you for taking the time to complete this form. It will help us to be sensitive to your child's needs.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_



# State of Illinois Certificate of Child Health Examination

<b>Student's Name</b>				<b>Birth Date</b>		<b>Sex</b>		<b>Race/Ethnicity</b>		<b>School /Grade Level/ID#</b>																	
Last		First		Middle		Month/Day/Year																					
Address				Street		City		Zip Code		Parent/Guardian Telephone # Home Work																	
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> 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.</b>																											
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>			<b>DOSE 2</b>			<b>DOSE 3</b>			<b>DOSE 4</b>			<b>DOSE 5</b>			<b>DOSE 6</b>											
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR									
<b>DTP or DTaP</b>																											
<b>Tdap; Td or Pediatric DT (Check specific type)</b>	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT											
<b>Polio (Check specific type)</b>	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV											
<b>Hib Haemophilus influenza type b</b>																											
<b>Pneumococcal Conjugate</b>																											
<b>Hepatitis B</b>																											
<b>MMR Measles Mumps. Rubella</b>										<b>Comments:</b>																	
<b>Varicella (Chickenpox)</b>																											
<b>Meningococcal conjugate (MCV4)</b>																											
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																											
<b>Hepatitis A</b>																											
<b>HPV</b>																											
<b>Influenza</b>																											
<b>Other: Specify Immunization Administered/Dates</b>																											
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.																											
<b>Signature</b>						<b>Title</b>						<b>Date</b>															
<b>Signature</b>						<b>Title</b>						<b>Date</b>															
<b>ALTERNATIVE PROOF OF IMMUNITY</b>																											
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> <b>*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR</b>																											
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> 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. <b>Date of Disease Signature Title</b>																											
<b>3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella Attach copy of lab result.</b> *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.																											
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b> Physician Statements of Immunity MUST be submitted to IDPH for review.																											

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



Last First Middle			Birth Date Month/Day/ Year		Sex	School	Grade Level/ ID
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes No	List:		<b>MEDICATION</b> (Prescribed or taken on a regular basis.)		Yes No
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	Hospitalizations?		Yes	No
Birth defects?		Yes	No	When? What for?		Yes	No
Developmental delay?		Yes	No	Surgery? (List all.)		Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes	No	When? What for?		Yes	No
Diabetes?		Yes	No	Serious injury or illness?		Yes	No
Head injury/Concussion/Passed out?		Yes	No	TB skin test positive (past/present)?		Yes*	No
Seizures? What are they like?		Yes	No	TB disease (past or present)?		Yes*	No
Heart problem/Shortness of breath?		Yes	No	Tobacco use (type, frequency)?		Yes	No
Heart murmur/High blood pressure?		Yes	No	Alcohol/Drug use?		Yes	No
Dizziness or chest pain with exercise?		Yes	No	Family history of sudden death before age 50? (Cause?)		Yes	No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?		Yes	No	<b>Parent/Guardian</b>			
Bone/Joint problem/injury/scoliosis?		Yes	No	<b>Signature</b> <span style="float:right"><b>Date</b></span>			
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI	B/P
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE)</b> BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>LEAD RISK QUESTIONNAIRE:</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)							
<b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Blood Test Date</b>		<b>Result</b>	
<b>TB SKIN OR BLOOD TEST</b> 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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test:</b> <b>Date Read</b> / / <b>Result:</b> <b>Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test:</b> <b>Date Reported</b> / / <b>Result:</b> <b>Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____							
<b>LAB TESTS (Recommended)</b>		Date	Results		Date	Results	
Hemoglobin or Hematocrit			Sickle Cell (when indicated)				
Urinalysis			Developmental Screening Tool				
<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs		
<b>Skin</b>				<b>Endocrine</b>			
<b>Ears</b>		Screening Result:		<b>Gastrointestinal</b>			
<b>Eyes</b>		Screening Result:		<b>Genito-Urinary</b>		LMP	
<b>Nose</b>				<b>Neurological</b>			
<b>Throat</b>				<b>Musculoskeletal</b>			
<b>Mouth/Dental</b>				<b>Spinal Exam</b>			
<b>Cardiovascular/HTN</b>				<b>Nutritional status</b>			
<b>Respiratory</b>		<input type="checkbox"/> Diagnosis of Asthma		<b>Mental Health</b>			
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				<b>Other</b>			
<b>NEEDS/MODIFICATIONS</b> required in the school setting				<b>DIETARY</b> Needs/Restrictions			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
<b>MENTAL HEALTH/OTHER</b> 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							
<b>EMERGENCY ACTION</b> 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.)							
<b>PHYSICAL EDUCATION</b>		Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>	<b>INTERSCHOLASTIC SPORTS</b>		Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		
Print Name (MD,DO, APN, PA)				Signature		Date	
Address				Phone			

## ILLINOIS STATE BOARD OF EDUCATION

## Annual Enrollment Form

## Child and Adult Care Food Program

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

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

**Parents/Centers:** This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents or guardians to complete or review a CACFP Annual Enrollment Form when enrolling their child(ren) and every year thereafter. This information will help ensure all children receive appropriate meals during their care. The parent or center may complete Sections 1 through 4. The parent must review to ensure accuracy; then complete Section 5, sign and date Section 6. 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
<b>First Child</b>	Name	<input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		<input type="checkbox"/> Early Morning Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> A.M. Snack <input type="checkbox"/> Lunch <input type="checkbox"/> P.M. Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack	
	Birth Date		AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center		
	Age		<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours									
<b>Second Child</b>	Name	<input type="checkbox"/> Same Days as Above <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> Early Morning Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> A.M. Snack <input type="checkbox"/> Lunch <input type="checkbox"/> P.M. Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack	
	Birth Date		AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center		
	Age		<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours									
<b>Third Child</b>	Name	<input type="checkbox"/> Same Days as Above <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday <input type="checkbox"/> Sunday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		<input type="checkbox"/> Same Meals as Above <input type="checkbox"/> Early Morning Snack <input type="checkbox"/> Breakfast <input type="checkbox"/> A.M. Snack <input type="checkbox"/> Lunch <input type="checkbox"/> P.M. Snack <input type="checkbox"/> Supper <input type="checkbox"/> Evening Snack	
	Birth Date		AM	PM	TIME	AM	PM	TIME	Leaves Center	Returns To Center		
	Age		<input type="checkbox"/> Yes <input type="checkbox"/> No I work multiple shifts and child(ren) may be in care different days/hours									

Please answer both questions. This information is voluntary.

<b>5</b>	<b>ETHNIC/RACIAL CATEGORIES—</b>	A. Ethnic data of child(ren) — Mark only one.	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
		B. Racial data of child(ren) — Mark one or more that apply.	<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
			<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaska Native

<b>6</b>	<b>SIGNATURE</b>	I certify the information above is correct.	Signature of Parent or Guardian	Date	Telephone Number of Parent or Guardian

<b>CHILD CARE REPRESENTATIVE USE ONLY</b>
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%20Form-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](mailto: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

**FOSTER CHILD**

Foster children are a legal responsibility of  
DCFS or court. If all are foster children,  
skip to Section 6

**SNAP OR TANF CASE NUMBER** Skip to Part 6 if you list a SNAP or TANF  
case number. At least one SNAP/TANF must be provided below.

		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	
		<input type="checkbox"/>	

**4. Homeless, Migrant, or Runaway**

☐ Homeless ☐ Migrant ☐ Runaway ☐ Head Start

Signature of Homeless Liaison, 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  
☐ White ☐ American Indian or Alaska Native

☐ Native Hawaiian or Other Pacific Islander

**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.						
<b>TOTAL INCOME \$</b> _____	<b>Per:</b> <input type="checkbox"/> Week <input type="checkbox"/> Every 2 Weeks <input type="checkbox"/> Twice a Month <input type="checkbox"/> Month <input type="checkbox"/> Year	<b>NUMBER IN HOUSEHOLD:</b> _____										
<table border="0"><tr><td><input type="checkbox"/> <b>Free based on:</b> <input type="checkbox"/> foster child <input type="checkbox"/> SNAP or TANF <input type="checkbox"/> homeless</td><td><input type="checkbox"/> <b>Reduced based on:</b> <input type="checkbox"/> household's income</td><td><input type="checkbox"/> <b>Denied — Reason:</b> <input type="checkbox"/> income too high <input type="checkbox"/> incomplete application <input type="checkbox"/> Non-qualifying SNAP/TANF</td></tr><tr><td><input type="checkbox"/> migrant <input type="checkbox"/> runaway <input type="checkbox"/> household's income <input type="checkbox"/> Head Start</td><td></td><td></td></tr></table>							<input type="checkbox"/> <b>Free based on:</b> <input type="checkbox"/> foster child <input type="checkbox"/> SNAP or TANF <input type="checkbox"/> homeless	<input type="checkbox"/> <b>Reduced based on:</b> <input type="checkbox"/> household's income	<input type="checkbox"/> <b>Denied — Reason:</b> <input type="checkbox"/> income too high <input type="checkbox"/> incomplete application <input type="checkbox"/> Non-qualifying SNAP/TANF	<input type="checkbox"/> migrant <input type="checkbox"/> runaway <input type="checkbox"/> household's income <input type="checkbox"/> Head Start		
<input type="checkbox"/> <b>Free based on:</b> <input type="checkbox"/> foster child <input type="checkbox"/> SNAP or TANF <input type="checkbox"/> homeless	<input type="checkbox"/> <b>Reduced based on:</b> <input type="checkbox"/> household's income	<input type="checkbox"/> <b>Denied — Reason:</b> <input type="checkbox"/> income too high <input type="checkbox"/> incomplete application <input type="checkbox"/> Non-qualifying SNAP/TANF										
<input type="checkbox"/> migrant <input type="checkbox"/> runaway <input type="checkbox"/> household's income <input type="checkbox"/> Head Start												
<b>SECTION B</b>	Signature of Determining Official: _____ Date: _____											



## INSTRUCTIONS FOR APPLYING - COMPLETE ONE APPLICATION PER HOUSEHOLD

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

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### FOSTER CHILD(REN)

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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)

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### SNAP OR TANF BENEFITS - HOUSEHOLDS RECEIVING

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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)

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### HOMELESS, MIGRANT, RUNAWAY, OR HEAD START

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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)

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### INCOME - HOUSEHOLDS REPORTING

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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)

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### PRIVACY AND DISCRIMINATION STATEMENT

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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 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](mailto:program.intake@usda.gov)

**PARENT LETTER  
FOR CHILD CARE CENTERS**  
July 1, 2023 Through June 30, 2024

Parent or Guardian:

This child care center participates in the USDA Child and Adult Care Food Program (CACFP) and receives Federal funds to provide healthy meals and snacks to all of the enrolled children. The amount of reimbursement the center receives is based on the information you provide on the attached Household Eligibility Application. Part of the USDA requirement is to ask you to complete the application. If your income is equal to or less than the income listed in the chart below for your household size, the center will receive a higher level of reimbursement. Read the attached instructions carefully and fill out all required information. We cannot approve an application that is not complete. Please return the completed application back to our center as soon as possible.

If a member of your family (child or adult) receives Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) benefits; or you care for a foster child that is the legal responsibility of the State through 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 listed below, 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 center. 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.

**Income Eligibility Guidelines  
Effective from July 1, 2023 to June 30, 2024**

**Reduced-Price Meals  
185% Federal Poverty Guideline**

Household Size	Annual	Monthly	Twice Per Month	Every Two Weeks	Weekly
1	26,973	2,248	1,124	1,038	519
2	36,482	3,041	1,521	1,404	702
3	45,991	3,833	1,917	1,769	885
4	55,500	4,625	2,313	2,135	1,068
5	65,009	5,418	2,709	2,501	1,251
6	74,518	6,210	3,105	2,867	1,434
7	84,027	7,003	3,502	3,232	1,616
8	93,536	7,795	3,898	3,598	1,799
For each additional family member, add	9,509	793	397	366	183

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.

By signing the section on the application for the Illinois All Kids Health Insurance, 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).

If you have any questions or need help, please contact our center.

The USDA Household Income Eligibility Guidelines are listed for families who do not receive TANF or SNAP benefits. If a household's income falls within or below the listed guidelines, they should contact their child care center or day care home provider for the benefits of the program. They may be required to complete an application and provide income, TANF, or SNAP information.

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, audiotope, 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](mailto:program.intake@usda.gov)

This institution is an equal opportunity provider.

## **Tots Land**

### **Day Care –Learning Center**

#### **Discipline**

The purpose of discipline is to help a child learn and use appropriate behavior, develop self-control and to learn to assume responsibility for own action.

Teachers will try to help the child understand that certain behaviors are inappropriate.

The child will be spoken to, redirected, engaged in something else and teacher will model appropriate behavior. Should a child need more than that, “removal from the group” may be initiated. Child can be removed from the group or activity for 1 minute per year of age.

We appreciate your help and ideas in dealing with your child.

If a child is dangerous to himself or other children, or to school property, we reserve the right to request the removal of your child.

Absolutely no physical and emotional punishment will be used with any child.

-----  
Parent Signature

## Late Pick-Up Policy

**Tots Land** closes at 6:00 pm Monday through Friday. It is the parents' responsibility to ensure that children are picked up no later than 6:00 p.m.

A late fee of \$1.00 per minute will apply if a child remains in care after 6:00 pm unless prior arrangements have been made. This late fee is due and payable upon pick-up or prior to the next days care.

In the event that a parent cannot be contacted, it is the policy of **Tots Land** to call an emergency contact should a child remain in care after 6:00pm. We will make five attempts of phone calls.

If we can not reach anyone by 6:30 pm we will call the Police or DCFS.

Three occurrences of being 5 or more minutes late will be grounds for termination of enrollment.  
Temporary hours due to covid restrictions 7:30-5:30

-----  
Parent Signature

## **PERMISSION FORM**

Name of child \_\_\_\_\_ Birthdate \_\_\_\_\_

### **EMERGENCY MEDICAL CARE**

I hereby grant permission for the staff of Tots Land to seek and obtain emergency medical care for my child, if needed. I will be responsible for the emergency medical charges upon receipt of the statement.

### **ADMINISTER PRESCRIPTION MEDICINE**

Tots Land have my permission to administer prescription medication to my child as specified in the prescription's directions for administration.

### **ADMINISTER PATENT MEDICINE**

Tots Land have my permission to administer patent medicine to my child as specified in written instructions.

### **TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES**

Tots Land have my permission to take my child on walking trips, special excursions, and to nearby public park facilities. I also authorize the child to ride as a passenger in the vehicle owned or rented by Tots Land. I understand, that all such trips are under Tots Land supervision and that health and safety precautions are taken in compliance with DCFS standards for licensure.

### **PHOTOS**

I give my permission for Tots Land to take photos of my child.

### **RELEASE OF INFORMATION**

I authorize Tots Land to give my telephone number and address to other parents.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_



## Guidance and Discipline Signature Sheet

My signature on this form indicates that I have received a copy of the Parents Handbook from my child's school.

I understand that it is my responsibility to review the contents of the Parents Handbook and be familiar with the rules, penalties, procedures, responsibilities and consequences of misbehavior as presented in Tots Land Guidance and Discipline Policy.

\_\_\_\_\_  
Parent/Guardian Signature      Date

\_\_\_\_\_  
Student Name (Print)

This form should be signed and returned to the student's homeroom teacher within the first week of school.

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.**



**Tots Land**  
**D A Y C A R E**  
"Where Your Child Always Comes First"

2635 - 41 N Harlem Ave  
Chicago IL 60707  
Tel / Fax : 773-622-4779  
www.totslandchicago.com  
email : totsland@gmail.com

7460 W Addison St  
Chicago IL 60634  
Tel / Fax : 773-589-0500  
www.totslandchicago.com  
email : totsland@gmail.com

## Credit Card Authorization Form For Tuition Payments

As of January 2020, Tots Land Daycare Will Require and make Mandatory that all parents keep a credit card on file with the center. If you have not paid your tuition in full for last 2 weeks, your account will be charged for the entire balance due along with a additional transaction fee = 4% of unpaid tuition and late fee of \$10.00 for each unpaid week. Parents can still make payments throughout the month , leaving payment envelopes (Cash, Checks or Zelle) with your child's teacher or making them directly to the office. **If your balance due is not greater than one week tuition, your credit card will not be charged.** However, if we try to process your card and it is declined your child will not be able to return to the center until payment in is received.

Please complete all fields.

### Credit Card Information

**Card Type:**      **MasterCard**      **VISA**      **Discover**      **AMEX**

**Cardholder Name (as shown on card):**

**Card Number:**

**Expiration Date (mm/yy):**

**Cardholder ZIP Code (from credit card billing address):**

**CVV (Security number from back of card):**

I ..... authorize **Tots Land Inc** to charge my credit card above for Child Care Tuition for my child :.....if I have not already made my payment in full. I understand that my information will be saved on file for future transactions on my account.

**Customer Signature**

**Date**

To keep your credit card data safe and for verification this form must be completed at the office in the presence of a Tots Land employee

## Child Care Waiver

1<sup>st</sup> Child's name : \_\_\_\_\_

Date of Birth \_\_\_\_\_

2<sup>nd</sup> Child's name : \_\_\_\_\_

Date of Birth \_\_\_\_\_

Parent / Guardian #1 name: \_\_\_\_\_

Parent / Guardian #2 name: \_\_\_\_\_

I/We, the undersigned, are the parent(s) ☐ guardian(s) ☐ (check one of the above) named child and we agree, in taking advantage of child care service provided by TOTS LAND INC, a corporation under the laws of the State of Illinois ("TOTS"), to release and hold harmless TOTS, its officers, directors, agents, employees and volunteers, from any and all claims, demands, suits, costs and charges, in connection with or arising out of the child care service, including, but not limited to, bodily harm or injury to our children, except only for loss, harms or injury occasioned by gross negligence or intentional misconduct by the TOTS and/or its officers, agents, employees and volunteers and further authorize TOTS and/or its officers, agents, employees and volunteers to administer, or cause to be administered, at my/our sole cost and expense, medical treatment and/or medication to the above named child/children in the event of any emergency.

In the event of emergency or medical attention, I authorize the person in charge to take my child to the closest available medical treatment facility or call an ambulance and I give my consent for any and all treatment for my child when the child is in this individual's care.

Signature of parent or guardian: \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_ Date \_\_\_\_\_



**3/26/2018**

## **Tots Land Inc**

7460 W Addison St  
Chicago IL 60634

### **IMPORTANT WELLNESS REMINDER**

Children experiencing FEVER or OTHER SYMPTOMS may not attend the center until they have been FEVER-FREE OR SYMPTOMS-FREE FOR OVER 24 HOURS – for temperatures 99.2 – 100.2 degrees Fahrenheit; and FEVER-FREE FOR OVER 48 HOURS – for observed temperatures over 100.2 degrees Fahrenheit. AND that's FEVER FREE ON THEIR OWN, not counting use of Tylenol or Ibuprofen. These medications only mask the symptom for a few hours; they do not cure the infection.

Children who are ill may NOT return to the center without a signed STATEMENT FROM A PHYSICIAN indicating the child is no longer contagious and can return to the center.

The above rules are final and will be strictly enforced by our administration and the staff to ensure the well-being of all children cared for by our facility. THE FAILURE TO COMPLY WITH THE ABOVE WILL RESULT IN THE CHILD BEING SENT HOME IMMEDIATELY ON THE DAY IT IS OBSERVED THAT THE ILL CHILD IS IN ATTENDANCE, AS WELL AS IN PERMANENT DISCHARGE FROM THE CENTER.

Please understand that this has been an extremely severe flu season, with severe health implications experienced by many affected by the flu, and our center cannot risk the health and well-being of some children due to incompliance and ignorance of others.

Warmest regards,  
Tots Land Administration



## **DEAR PARENTS !**

WE WOULD LIKE TO INFORM YOU THAT WE ARE USING A

**MINERALIZED REVERSE OSMOSIS WATER SYSTEM TO PURIFY ALL WATER USED FOR COOKING AND DRINKING AT OUR FACILITY.**

As you know, today's tap water can contain a broad range of impurities and contaminants. Reverse Osmosis systems tackle the broadest spectrum of water impurities possible. Only Reverse Osmosis filtration is capable of reducing impurities ranging from bacteria and viruses to agricultural run-off products like pesticides and fertilizers, to dissolved metals like lead, arsenic and iron.

## **DRODZY RODZICE !**

**INFORMUJEMY, ZE NASZE PRZEDSZKOLE UZYWA SYSTEMU OCZYSZCZANIA WODY DO PICIA I GOTOWANIA POPRZEZ PROCES MINERALIZOWANEJ ODWROCONEJ OSMOZY.**

Woda "z kranu" może zawierać szerokie spektrum zanieczyszczeń i bakterii. Proces Odwroconej Osmozy radzi sobie z najszerszym spektrum zanieczyszczeń w wodzie i jest w stanie usunąć wiele rodzajów zanieczyszczeń z wody jak bakterie i wirusy, pestycydy i nawozy, aż po metale takie jak ołów, arszenik i żelazo, oraz inne trujące związki chemiczne.

