APPLICATION FOR ENROLLMENT

TOTS LAND INC
1080 W LAKE ST ROSELLE IL 60172

Date of Birth: _____ Sex: _____

Date of Enrollment: _____ Date of discharge: _____

Full Name: _____
Last First Middle Nickname

Home Adress: _____
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	Father's
Name: _____	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.		

CONDITIONS FOR REGISTRATION – PLEASE READ CAREFULLY

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

1080 W Lake St
Roselle IL 60172
2246538559

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 feds 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 Is there anything else you would like us to know about your child? _____
_____
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

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

IMMUNIZATIONS: **To be completed by health care provider. The mo/da/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 Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:**		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (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.

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

HEALTH HISTORY **TO 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? Child wakes during night coughing?	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No						

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

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (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		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		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**

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.

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:** _____

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 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

PARENT LETTER
FOR CHILD CARE CENTERS

July 1, 2026- June 30, 2027

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 eligibiy standards.

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

Reduced-Price Meals
185% Federal Poverty Guidelines

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

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.

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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

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

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.

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 PARENT MEDICINE

Tots Land have my permission to administer medicine to my child as specified in my written instructions on form provided by Tots Land**.**

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 , VIDEOS & SOCIAL MEDIA

I understand and agree that my child(ren) may be photographed by Tots Land during normal day care hours, field trips or other activities and that photographs may be used but not limited for the following purposes:

1) Posting in PROCARE APP: Photos & Videos shared with ProCare app are shared only with parents in specific classroom. ProCare photos are not available for anyone else to see.
2) Videos & Photos from events at Tots Land including but not limited to: Mother & Father Day Show, Christmas Show, Santa Claus Visit, Graduation Show. Those will be available to see and download on Tots Land website. Selected videos or photos may also appear on Tots Land social media.
3) Social Media: Tots Land share photos and videos occasionally on social media. Those are focusing on activities or events that are taking place at our day care and never focus on individual children. The purpose of those materials is to advertise our services to potential and future customers.

I understand and agree that my child(ren) presence on photos or videos could be limited but Tots Land can't guarantee that my child(ren) would not be present on some. If you wish to limit your child's presence on photos & videos listed above please talk to you child teachers we will do our best to do that.

Parent/Guardian Signature:_____ Date_____

Tots Land

Day Care – Learning Center

Acknowledgement form

I UNDERSTAND that Tots Land is not responsible for items left in the locker room. Children's clothes and shoes should be labeled with a marker in a visible place. This will make it more difficult for other parents to take it by mistake.

I UNDERSTAND that for any DEBIT or CREDIT CARD Transaction through PROCARE APP a 3% fee will be added by the end of each month (Not at time of payment). To avoid fees please pay using ACH (you need your bank account and routing number) or Pay with Cash.

I UNDERSTAND that 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.

Parent Signature

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.

Child Care Waiver

1st Child's name : _____

Date of Birth _____

2nd 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_____

Therapy Child Care Waiver

1st Child's name : _____

Date of Birth _____

2nd 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 **any type of therapy or outside service that would be provided to my child on TOTS premises by outside therapist or other professional that would be selected by me**, including, but not limited to, bodily harm or injury to our children, 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_____