750 Fountains Parkway
Fairview Heights, IL 62208
Phone: 618-624-5624
Fax: 618-624-5677

Email: TheEarlyYears@sbcglobal.net

Website: www.theearlyyearsinc.com

Family Enrollment Forms

Follow us on FaceBook

Registration Fees

A non-refundable registration fee is required upon enrollment. The registration fee is $75 per child and $140 per family. In addition, one week's tuition is due to hold a position in any classroom. Tuition is charged one week in advance. Certain discounts apply to families with multiple children or active in the military. Tuition is charged every Monday for the next following week. Once a year an activity fee of $35 will be charged per child enrolled. The Early Years, Inc. serves children 6 weeks to 12 years old.

Classroom	Full-Time Weekly	Monthly	Part-Time 2 days	Part-Time 3 days	Drop – In Daily Rate
Infant	$245	$1040	N/A	N/A	N/A
Jungle Room	$235	$997	N/A	N/A	N/A
Farm Room If under two, toddler rates* apply.	$215 / *$225	$910/ *$954	$110	$165	$55
Circus Room	$205	$867	$100	$150	$50
Blue & Purple Room	$195	$824	$90	$135	$45
Private Kindergarten (8 a.m. -10:30 a.m.)	$95	N/A	N/A	N/A	N/A
Private Kindergarten plus Before/ After School Care	$195	$824	N/A	N/A	N/A
School- Age **(6 years – 12 years)**	$170	$716	$80	$120	$40
Before & After School **(6 am– 8 am) & (3 pm—6 pm)**	$100	$413	$40	$60	$20

Revised: 9/2010

CHILDREN'S RECORD

(File In This Order)

- Application/ Record of Child Information -*CFS 428* ◊
- Consent Agreement Form- *CFS 593* ◊
- Health Certificate- *CFS 600* (DATE)___________ ◊
    - TB Test (DATE)______________________ Results: ____________
    - Lead Screen/Test (DATE)______________ Results: ____________
    - Health Professional Signature
- Verification Slips-Standard-Signature ◊
- Discipline Policy – Signature ◊
- School Consent (School Age Children) ◊
- Late Pick-Up Policy - Signature ◊
- Enrollment/ Family Handbook - Signature ◊
- Copy of Birth Certificate ◊

CFS 428
Rev. 4/2001

State of Illinois
Department of Children and Family Services

APPLICATION/RECORD OF CHILD INFORMATION

Name of Child ______________________ Birthdate ____________ Sex ______

Address ____

Date Child Received ______________________ Date Child Left ______________________

PARENT OR OTHER PERSONS(S) PLACING THE CHILD

Name ______________________

Relation to child ______________________

Home address ______________________

____

Phone Number ______________________

Place of employment ______________________

____

Address ______________________

Phone Number ______________________

Working hours ______________________

Name ______________________

Relation to child ______________________

Home address ______________________

____

Phone Number ______________________

Place of employment ______________________

____

Address ______________________

Phone Number ______________________

Working hours ______________________

OTHER PERSON TO NOTIFY IF PERSON PLACING THE CHILD CANNOT BE REACHED

Name ______________________ Address ______________________

Phone Number ______________________ Relationship ______________________

PHYSICIAN TO CALL IF CHILD BECOMES ILL OR INJURED

Name ______________________ Address ______________________

Phone Number ______________________ Hospital or Clinic ______________________

PROGRAM

Days per week______________________ Hours of care ______________________

Rate of pay (optional) ______________________

______________________ ______________________ ______________________
Signature of parent or other person placing child **Signature of caregiver** **Date**

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

If the child has any of the following, please explaining:

Medical problems ____

____

Physical handicaps ____

____

Restrictions for play—outdoors ____

____

Restrictions for play—indoors ____

____

Allergies ____

____

Food likes ____

____

Food dislikes ____

____

Fears ____

____

Does the child take a nap? ________________ Time ____________ Length ____________

Is the child toilet trained? ____

Does the child have special names for objects? (potty, cookies, drinks, etc.) ____________________

____

Does the child regularly take medication? ________ If so, what kind and directions ________________

____

If the child is an infant, what are the feeding instructions? ______________________________

Time ____________ Amount ________________ Temperature ____________

Diaper changes: Powder ________________ Ointment ________________

Other information that will help in caring for the child ______________________________

____

____

Comments:

____

____

____

____

____

____

____

ALL INFORMATION SHALL BE REGARDED AND HANDLED CONFIDENTIALLY

CFS 593
Rev 7/2007

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD ____

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

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

EMERGENCY MEDICAL CARE

This authorizes ____
to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement. ______________________________ is the preferred doctor/clinic/hospital.

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize ______________________________ to administer prescribed medicine to my/our child as specified in the prescription's directions for administration.

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

ADMINISTER OVER-THE-COUNTER MEDICINE

(Administer only in accord with the appropriate standards for licensure)

I/we authorize ______________________________ to administer over-the-counter medicine to my/our child as specified in written instructions.

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

Date ____________________ ______________________________
Signature of parent/guardian

____
Relationship to child

CHILD PICKUP

(Use additional sheet of paper if more than 3 people are authorized to pick up child)

I/we authorize ____

Name Address Phone

and/or

____

Name Address Phone

and/or

____

Name Address Phone

to pick up my/our child when I am/we are unavailable.

Date ______________________ ______________________

Signature of parent/guardian

____

Relationship to child

Date ______________________ ______________________

Signature of parent/guardian

____

Relationship to child

TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES

I/we authorize ______________________________ to take my/our child on walking trips, special excursions, and to nearby public park facilities. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the above-named person(s). I/we understand all such trips are under the supervision of the above-named person(s) and that health and safety precautions are taken in compliance with DCFS standards for licensure.

Date ______________________ ______________________

Signature of parent/guardian

____

Relationship to child

Date ______________________ ______________________

Signature of parent/guardian

____

Relationship to child

SWIMMING

I/we consent to my/our child using the swimming pool of ______________________________

Name of Provider

at ____.

Address

Date ______________________ ______________________

Signature of parent/guardian

____

Relationship to child

Date ______________________ ______________________

Signature of parent/guardian

____

Relationship to child

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 5/2006

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

Please Print

Student's Name Last First Middle	Birth Date	Sex	Grade Level	ID#
Address Street City ZIP code	Parent/ Guardian		Telephone # Home	Work

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

VACCINE/DOSE	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)				Comments		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23
Check specific type (PCV7, PPV23) Date						
Other (Specify hepatitis A, meningococcal, etc.)						

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

Signature **Title** **Date**

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

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

ALTERNATIVE PROOF OF IMMUNITY

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

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

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

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

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

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

VISION AND HEARING SCREENING DATA

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

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

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

IL444-4737 (R-01-05)

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

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing?	Yes No Yes No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth complications/prematurity?	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 Other concerns?		
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				

Entire section below to be completed by MD/DO/APN/PA

PHYSICAL EXAMINATION REQUIREMENTS **HEAD CIRCUMFERENCE** **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (Not required for daycare.) **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 QUESTIONAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionairre Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** .
(If child resides in Chicago, blood test is required.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. ☐ No Test Needed ☐ Test performed **Date Read** / / **Result** **mm**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____________ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in **(If No or Modified,please attach explanation.)**

PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)

Dear Physician/ Advanced Practical Nurse/ Physician Assistant:
In pursuant of Section 407-310 of the Licensing Standards for Day Car Centers, any preschool age or school age at high risk for lead poisoning and or tuberculosis in attendance at the Department of Children and Family Service licensed day care facility must be tested. In addition to completing the IDPH certificate of Child Health Examination please indicate your response to these additional questions.

1. Is a lead test required? □ yes □ no, not at risk

If yes, date given ______________ Results ______________

2. Is TB skin test required? □ yes □ no, not at risk

If yes, date given ______________ Results ______________

Child's Name			DOB
Physician/ Advanced Practical Nurse/ Physician Assistant Print Name	Signature		Date
Address			Phone Number

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING (410 ILCS 45/6.2)

Name ____________________________ Today's Date __________________________________

Age _____________ Birthdate ________________ ZIP Code _________________

Respond to the following questions by circling the appropriate answer.	**R E S P O N S E**
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes No Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher?	Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area?	Yes No Don't Know

---

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _______ Test 2: Blood Lead Result_____mcg/dL Date ______

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

______________________________________ ______________________________________

Signature of Doctor/Nurse Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

Illinois Department of Public Health
Guidelines for Blood Lead Screening and Lead Risk Assessment

- **Blood lead screening** is defined as obtaining a blood lead test. **Lead risk assessment** is defined as evaluation of potential for exposures to lead based on questionnaire responses.

- **It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or potential exposure to lead has been identified, regardless of child's age.**

- Illinois has defined ZIP code areas at high risk and low risk for lead exposure based on housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.

- In Illinois, all children from **low-income families** (i.e., Medicaid-eligible children) should receive a blood lead test at ages 12 and 24 months, even if they live in a low-risk ZIP code area. If the child is 3 through 6 years old and has not been tested, a blood lead test is required.

Childhood Lead Risk Assessment Questionnaire

- Complete the Childhood Lead Risk Assessment Questionnaire during a health care visit at ages 12 and 24 months.

    - If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.
    - If any response is "YES" or "DON'T KNOW," obtain a blood lead test

- Consider evaluating children before 12 months of age, depending on the area.

- If the child is age 3-6 years ***and***
    1) there is any "YES" or "DON"T KNOW" ***and***
    2) has had two successive blood lead test results that were each less than < 10 mcg/dL with one of these tests at age 2 years or older ***and***
    3) risks of exposure to lead have not changed, **further blood lead tests are not necessary.**

- If the child is 1) 3-6 years, ***and*** 2) all answers to the Childhood Lead Risk Assessment Questionnaire are "NO," ***and*** 3) risks of exposure to lead have not changed, a blood lead test is not necessary.

- If the child is 3-6 years of age and risks of exposures to lead have increased, obtain a blood lead test.

- Continue to use the Childhood Lead Risk Assessment Questionnaire through age 6.

For children living in Chicago:

- A blood lead test for children age 3 and younger should be obtained at 6, 12, 18, 24 and 36 months **OR** at 9, 15, 24 and 36 months.

- Children 4 through 6 years of age with prior blood lead levels <10 mcg/dL should have an annual risk assessment. A blood lead test should be performed if risk increases or if the child exhibits persistent oral behaviors.

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

Regulation Regarding Discipline

The Early Years, Inc provides a caring environment that encourages growth in discipline, self-control, and respect for others' rights. A child's attempt to learn, participate and respond to people and activities in the center are respected as an important part of his or her overall development. Children are protected from hurting themselves and others. Discipline should be a process of teaching, which allows socialization to take place. Adults are the models for children. We practice techniques that are fair, consistent, and respectful of children and their needs. In this way, a child will know the importance of similar behavior in his or her own life. The purpose of discipline is to instruct children in good conduct and to help them develop inner control so that they can live according to the principles of our sociality.

The following children's behavior is considered inappropriate in the center:

- Causing physical harm to another child or adult by hitting, biting, kicking throwing objects, or any other physical action.
- Using inappropriate language, spitting or other form of verbal abuse or degradation by children directed at other children or adults.
- Repeated refusal by a child to comply with center or room rules and/or failure to listen to teacher.
- Child's behavior that is potentially harmful to them.

Acceptable discipline techniques used by all staff included:

- Limits and consequences shall be clear and understandable to the child, consistently enforced and explained to the child before and as part of disciplinary action.
- Discipline shall be developmentally appropriate and logically related to the child's act and shall not be out of proportion to the particular inappropriate behavior. The child shall be made aware of the relationship between the act and final consequences.
- Firm positive statement about behavior or redirection of behavior should be the accepted techniques for use with infant and toddlers.
- Removal form the group to help a child gain control shall not exceed one minute per year of age. Removal from the group will not be used for children less than 24 months of age.

Humiliating or frightening punishment is strictly forbidden. This includes;

- Corporal punishment, including hitting, spanking, swatting, beating, shaking, pinching and other measures intended to induce physical pain or fear:
- Threatened or actual withdrawal of food, rest or use of the bathroom;
- Abusive or profane language;
- Any form of public or private humiliation, including threats or physical punishment; and
- Any form of emotional abuse, including shaming, rejecting, terrorizing or isolation of a child.

Should a child repeatedly behave in a way that is not detrimental to him/her, other children, or adults, the teacher will bring the problem to the attention of the director. At the time, parents will be contacted to discuss the problem. The director may suggest professional guidance or temporary removal from the program. (Example: repeated incident of aggression or any other behavior considered inappropriate in the center). Parents are required to follow the center's approved discipline methods while in the center.

It is also our policy that we will handle ALL discipline situations that may arise with the children while they are at the Center, according to the stated philosophy. If a parent has concerns regarding another child's behavior, we ask that you discuss you concern with the appropriate teacher. Under NO circumstances will parents be allowed to approach a child or his/her parents in an effort to deal with the situation. We consider this method completely inappropriate and will not be tolerated.

All violation of the guidance policy by staff are reported in writing to the director. Staff that violates the child guidance policy is not permitted access to the children until retained, assigned to a position not in childcare, or terminated.

Methods of discipline and means of managing the behavior of a child, which are not cited in this section, will be handled by the Director and the teacher in consultation with parents and other professionals as available and appropriate.

__________________________________ __________________
Parent/Guardian Signature Date

__________________________________ __________________
Staff Member Date

The Early Years, Inc
Late Pick-Up Policy Form

The Early Years, Inc hours of operation are from 6:00 a.m. to 6:00 p.m., Monday through Friday. Do not attempt to leave your child prior to our 6:00 a.m. opening time or pick-up after our 6:00 p.m. closing time. A late pick-up fee will be assessed at the rate of $1.00 per each minute after 6:00 p.m. This fee will be taken from your Tuition Express account the same week.

Also, it is imperative that we have current, up-to-date emergency contact number on file. It is the parent's/guardian's responsibility to report any changes to the staff.

The following information explains The Early Years, Inc procedures and consequences for late pick-up:

1. At 5 minutes past 6:00 p.m., a phone call will be made to parent or guardian.
2. At 10 minutes past 6:00 p.m., a phone call will be made to contacts on file who are authorized to pick up child.
3. At 15 minutes past 6:00 p.m., step 1 and 2 will be repeated until 7:00 p.m.
4. At 7:00 p.m., the Fairview Heights Police Department will be notified.
5. The caregiver will be responsible for the child's protection and well-being until the parent /guardian or outside authority arrives.
6. The staff shall not hold the child responsible for the situation. The discussion of this issue will only be with the parent or guardian and never with the child.

We are mandated by the Abused and Neglected Child Reporting Act, as amended to report when a parent has failed to pick up their child and we are unable to reach them.

This written agreement shall be signed by the parent or guardian at the time of enrollment. My signature acknowledges that I have read and understood the Late Pick-Up Policy

______________________________ ____________________

Parent/Guardian Signature Date

______________________________ ____________________

Parent/Guardian Signature Date

The Early Years, Inc
Emergency Contact Information

Child's Name_________________________________ Date of Birth_________________________

Mother's Name_______________________________ Best Phone Number___________________

Social Security Number: ______-____-_________

Father's Name ________________________________ Best Phone Number___________________

Social Security Number: ______-____-_________

Name of other persons to be contacted in case of an emergency:

1.________________________________ Home #: __________________
Work #: ___________________
Cell #: ___________________

2. ________________________________ Home #: __________________
Work #: ___________________
Cell #: ___________________

Authorization is hereby given for The Early Years, Inc to release the above named child to the following persons, provided proper identification is first established Please list all names of authorized persons including immediate family and security codes for the door. To enter the front door, each authorized person must have 2 codes that are 4-8 numbers long.

1.____________________________________ ___________________ ___________________
(name) (1st code) (2nd code)

2.____________________________________ ___________________ ___________________
(name) (1st code) (2nd code)

3.____________________________________ ___________________ ___________________
(name) (1st code) (2nd code)

4.____________________________________ ___________________ ___________________
(name) (1st code) (2nd code)

In event that unpaid tuition is turned over to a collection agency, you will be responsible for any late fees, court fees, and attorney fees that accrue from the procedure.

____
(Signature of Parent or Guardian)

Revised: 8/03/2010

Emergency Treatment Policy

Please keep us informed of personal contact and up to date telephone numbers in case of an emergency so we can readily contact you. Staff certified in first aid, cardio-pulmonary resuscitation (CPR), and Choking Techniques are on duly daily to assist in injures, sudden illnesses, minor scrapes and bruises using universal precautions. We have first aid kits, which contain items listed in the Standard. A monthly inventory is done to replace used items.

An accident report will be completed for all injures. Parents will be notified. In case of minor illness, your child will be separated from other children and will be made as comfortable as possible. If a child needs emergency care because of an accident or illness that occurs while the child is in care, the following procedures will be taken:

1. The Early Years, Inc staff will render aid needed in order to sustain life in accordance with their certified training in basic life support;
2. The Center will call 911 to notify and request immediate service;
3. Emergency cases shall be transported to Memorial Hospital or a specific hospital designed by the parents;
4. Parent(s) or legal guardian shall be contacted. A staff member will remain with the child until the parent or legal guardian arrives. If the Center is unable to locate the parent or legal guardian, we will continue trying until contact is made.

In cases where a parent has requested that a child be exempt form medical care on religious grounds, the parent or guardian shall supply the Center with the name, address and phone number of a certified practitioner for the child, as well as written instruction for the Center, should a emergency health care situation arise.

5. DCFS will also be notified and the child’s file will be documented. An incident report will be completed by the person responsible for the child at the time of the occurrence.

Yes, I have read the emergency treatment procedure and agree to abide by the guidelines that are listed. I understand that failure to do so will result in action taken by the Director.

______________________________ ________________________

Signature Date

The Early Years, Inc.
Child Care Schedule

Your Name: ________________ Date: _______________

Child Name: _______________

Time	Monday	Tuesday	Wednesday	Thursday	Friday
6:00 am					
6:30 am					
7:00 am					
7:30 am					
8:00 am					
8:30 am					
9:00 am					
9:30 am					
10:00 am					
10:30 am					
11:00 am					
11:30 am					
12:00 pm					
12:30 pm					
1:00 pm					
1:30 pm					
2:00 pm					
2:30 pm					
3:00 pm					
3:30 pm					
4:00 pm					
4:30 pm					
5:00 pm					
5:30 pm					
6:00 pm					
Total Hrs					

Please indicate the hours your child will typically attend the Early Years by writing the name of the person who will typically drop off in the first time slot your child will attend, and then writing the name of the person who will typically pick up in the last time slot your child will be at the center.

The Early Years, Inc

Permission to Use Sunscreen

My child, ___________________________________, may have sunscreen applied to exposed skin areas before going outside on warm sunny days.

I will provide a sunscreen with a sun protection factor (SPF) of 15 or more (without PABA is recommend). Paba gives some children blotchy rashes.

I will mark my child's name on his/her sunscreen PLASTIC container with a permanent marker.

______________________________ __________

Signature of Parent/Guardian Date

Photograph Release Form

I hereby grant The Early Years, Inc, the following rights in consideration of their possible use of my photo or my child's photo, video footage, digital imagery, etc or any material supplies by me or my child to be printed by The Early Years, Inc.

1. The Early Years, Inc may use my name or my child's name & likeness for all photo or printing purpose. The Early Years, Inc will have total ownership of the photos, video footage, digital imagery, etc or that which is printed and the right to license others to copy of use materials.

2. The Early Years, Inc may use my name or my child's name & likeness for the purpose of adverting, publicity and promotion, but not as a direct endorsement of any products or service.

3. The Early Years, Inc use of my photograph or my child's photograph, video footage, digital imagery, etc will not violate rights of any person or organization and will not incur liability for payment to any person of organization.

4. Any photos included on social media like on FaceBook will be pictures of the children during their daily activities. We will be using pictures of the children from the side or behind.

5. Photos posted the parents' Early Years Shutterfly account will be separated by classrooms & parents will be able to share and order pictures that we take at the center. This account is invite only and not available to the public.

By signing below I accept and agree with the terms stated above:

_______________________ _________________________ ________

Parent/Guardian Signature Parent/Guardian Signature Date

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time! It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

For Bank Account Authorization, complete and return to center management.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) authorize ____ , (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

______________________ ______________ ______________________________
Your Name Phone # DEPOSITORY - Bank or Credit Union Name

__________________________________ ______________________________
Address Bank or Credit Union Address

__________________________________ ______________________________
City State Zip City State Zip

Type: ☐ Checking ☐ Savings

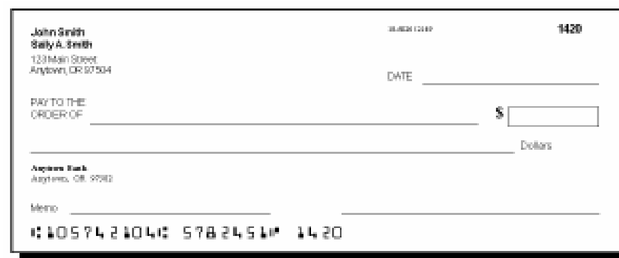
__________________________________ ______________________________
Routing Transit Number (see sample below) **Account Number** (see sample below)

This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

__________________________________ ______________________________
Signature Date

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

*Tuition Express is an assumed business name of Blum Investment Group, Inc.



Routing Transit Number | Account Number | Check Number

Please attach a copy of a voided check here. Deposit slips not accepted.

For Credit Card Authorization, complete and return to center management.

CREDIT CARD PAYMENT AUTHORIZATION

I (we) hereby authorize ________________________________ (called "CENTER" in this Authorization) to initiate recurring credit card charges to the below referenced credit card account for the purpose of collecting childcare related payments. I (we) understand that the charges to the below referenced credit card account will be based on charges that are due and payable at the time of the credit card transaction. I (we) understand that this agreement is between myself (us) and the below referenced "CENTER". I (we) authorize CENTER to utilize Tuition Express* to capture, create, and transmit all credit card information. I (we) indemnify and hold harmless, Tuition Express from any and all liability resulting from any and all transactions. All disputes will be directed to and addressed by and between CENTER and the below signed cardholder. **I (we) understand that to properly affect the cancellation of this agreement, I (we) are required to give CENTER written notice of revocation. A minimum of 5 business days is required to affect revocation.**

PLEASE CONTACT CENTER REPRESENTATIVES FOR CREDIT CARD TYPES ACCEPTED BY CENTER.

____ ______________________________
Cardholder Name Phone #

____ ______________________________
Cardholder Billing Address Account Number

____ ______________________________
City State Zip Expiration Date

____ ______________________________
Cardholder Signature Date

*Tuition Express is an assumed business name of Blum Investment Group, Inc.

For Official Use Only:

Date Received: ________________________________

Employee Signature: ____________________________

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.