Student Information

Child's Name: _____ **Birth Date:** _____ **Program:** _____

What previous experience has your child had with other children (preschool, play group, camp, sports, extracurricular activities, Sunday school)? Is this your child's first school experience? If no, please list the programs your child attended in 2025–2026.

How does your child typically adjust to new situations?

Tell us about your child's temperament, personality, needs, abilities, etc.

How does your child react when upset (aggressive, withdrawal, cling)? What's the best way we can comfort him/her during this time (like to be held or left alone?)

When your child is not feeling well, what are they typical symptoms you notice? Does he/she usually run a fever, fuss, cling? Does your child have reoccurring illnesses (ear infections, strep throat, colds)?

When did your child begin to eat solid foods, talk and walk?

What are your child's sleeping habits? Does your child still take naps? On average, how many hours of sleep do they get per night?

Does your child have any fears we should be aware of?

Does your child have any attachment items? If so, what are they? Any special names?

Is your child visiting a therapist? If so, for what reason? Is there a therapy program you would like us to support?

Does your child have a sibling(s)? If yes, please describe your child's relationship with him/her.

Are there other relatives or persons especially close to your child?

Do you have pets at home? How does your child relate to them?

What are some of your child's interests or favorite activities?

Are there any family customs, traditions or celebrations you would like to share with your child's class?

May your child join us for grace at snack time?

What are your expectations of our school as a preschool experience for your child?

What are your concerns and or questions about the school year?

Which elementary school will your child attend?

Both parents/guardian(s) please sign below.

Signature **Date**

Signature **Date**

Permission for Walking Trips

My child, _____, has my permission to accompany the class on walking trips in the vicinity of the church. The children will be accompanied by the teaching staff and will not be traveling in any vehicle. I understand that this does not give blanket permission for my child to leave the school premises for the purpose of school field trips. Individual permission slips will be issued before all field trips when children will be traveling by school bus.

Both parents/guardian(s) please sign below (required).

_____

Signature **Date**

_____

Signature **Date**

Emergency Authorization

Should the staff of the school deem it necessary to administer First Aid procedures to my child, I authorize them to do so and will not hold them responsible for the consequences of such treatment. Should it become necessary for my child to be transported and/or treated by licensed medical personnel, I authorize such action and agree to be responsible for all costs incurred. Every reasonable attempt to contact the parents, and if necessary, the child's doctor will be made before initiation of any treatment. However, I understand this may only be possible after the fact.

Name of Child's Doctor/Group: _____

Address: _____

Phone: _____

Medical Information

Allergies (please list all known allergies and reactions)

_____

_____

_____

_____

_____

Please provide any additional information regarding chronic illness, surgeries or other factors that could affect your child's health or behavior at school:

_____

_____

_____

_____

_____

Both parents/guardian(s) please sign below (required).

_____

Signature **Date**

_____

Signature **Date**

If your pediatrician does not agree with the need for a Mantoux TB test for your preschooler, the pediatrician must provide a written waiver notice. The notice must accompany the medical form (page 4–5) per DCFS regulations.

Parents must fill out and sign the health history section on the back page of the medical form.

Your pediatrician must sign the lead questionnaire (page 6).

Thank you!

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of DCFS Children & Family Services

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. 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
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						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles** / **Rubella** / **Mumps**					
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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 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 result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																					
Age/ Grade																					
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																					
Hearing																					

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

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

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

ALLERGIES (Food, drug, insect, other)				**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during the night	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 **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.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

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. **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			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**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 Antagonist) ☐ 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** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

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

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 prior to 12 months of age and 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 responses to all the questions are "No":

- re-evaluate at every well child visit or more often if deemed necessary

Child's name _____ Today's date _____

Age_____ Birthdate_____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**		
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 of 10 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? (see reverse side of page for list)	Yes	No	Don't Know

If there is any **"Yes"** or **"Don't Know"** response; **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), **and**
- there has been no change in the child's living conditions, 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 _____

_____ _____

Signature of Doctor/Nurse *Date*

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

Photo Release Form

The First Presbyterian Preschool (heretofore referred to as Preschool), its representatives and employees are seeking the right to videotape and/or take photographs of students in connection with the Preschool program.

Please choose one of the options below.

My child _____ **may** be included in unidentified (no names will be shown) photographs and/or video recordings for any lawful purpose, including, for example, such purposes as publicity, illustration, advertising and web content, including social media.

_____

Signature **Date**

-OR-

My child _____ **may not** be included in any unidentified (no names will be shown) photographs and/or video recordings for the Preschool.

_____

Signature **Date**

Verification of Receipt of DCFS Summary of Licensing Standards

For new families only:

Please read the DCFS Summary of Licensing Standards for Day Cares booklet on our website, in the Parent Resources Page, and sign this verification of receipt to be kept in your child's file.

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.

Late Pick-up Agreement

The following agreement is made between _____
and the First Presbyterian Preschool for the pick-up of their child _____
_____ from the Preschool.

I/we agree to pick up the above named child before 11:30 AM every day he/she is in Preschool.

If I/we fail to pick up our child by the appointed time, I/we understand that a late fee of $5.00 per quarter-hour (or portion thereof) will begin to accrue after the above stated pick-up time.

If we fail, without notice to pick up my/our child at the above stated time, or arrange for someone else to pick them up, the provider will make 3 attempts to contact me/us. If the provider is unable to contact me/us, the provider should contact the emergency person listed on the Application/Record of Child Information sheet, or person on the contingency list, to advise them my/our child is still in their care without a notice from me/us. If, for any reason, there is not telephone service the provider will contact police to request assistant in contacting me/us or my/our emergency persons.

Provider agrees to keep my/our child for 1 hour after the above stated pick-up time, with late fees accruing, before contacting the local police and/or the Child Abuse Hotline if contact cannot be made with parents/guardian or emergency persons.

Provider will continue normal responsibilities for the child's protection and well-being and agrees not to discuss the tardiness in arriving with your child/children beyond reassuring them you or someone known to them will be there soon to pick them up.

Parents/Guardians agree to advise provider immediately of any changes regarding their personal contact information, including addresses and phone numbers for home and work and cell phone numbers. Parents/Guardians agree to provide immediate notice to the provider of any changes for their emergency contact or contingency persons.

_____ _____

Parent/Guardian **Provider**

_____ _____

Date Signed **Date Signed**

This form meets the requirements of Rule 406.12 (h), Rule 407.260 (f) and Rule 408.60 (j).

Financial Agreement

This agreement is made between the First Presbyterian Preschool ("The Preschool") and the family of _____ . Please be aware that the Preschool is a non-profit organization that operates solely on income received from tuition.

The following is the tuition schedule for the 2026 – 2027 year:

Class	Tuition	One Payment	Four Payments
Explorer	**$3,740**	$3,740	$935
Discovery	**$4,850**	$4,850	$1,212.50
Voyager 4-Day	**$6,050**	$6,050	$1,512.50
Voyager 5-Day	**$7,160**	$7,160	$1,790
Odyssey	**$7,160**	$7,160	$1,790

Based on the above tuition schedule and enrollment in the _____ class, the undersigned agree to pay **$_____ total** tuition for the 2026 – 2027 school year. The following payment plans are available. Please choose the one that best meets the needs of your family:

Payment Plans:

___ Option A: One payment due April 17, 2026*.

___ Option B: Four payments due April 17, 2026*, September 18, 2026, November 19, 2026 and January 14, 2027.

Payment Options:

Payments are accepted as follows:

1. **Check** - Personal checks are accepted. Automatic check payments can also be set up through your bank. Checks may be scheduled to be sent for the appropriate amounts and dates based on the schedules above. Please have checks sent to: First Presbyterian Preschool, 700 N. Sheridan Rd., Lake Forest, IL 60045 **Attn: Director**

   Please write the student's name and class in the memo field of all checks.

2. **Credit Card** - Credit card payments can be made through the Preschool website at *preschool.firstchurchlf.org*. There is no additional charge or convenience fee for paying by credit card.

A $25.00 late fee will be added to payments not made within 10 days following the due date. After a tuition payment is over 30 days past due, your credit card on file will be charged the outstanding payment plus the $25 late fee. (See attached Credit Card Authorization form which must be completed as part of the Financial Agreement.) We reserve the right to remove children from the program whose families are not in good financial standing with the Preschool.

Based on need, alternative payment plans are available at the discretion of the Preschool's Financial Committee. If no effort is made to communicate a need and make alternative financial arrangements, then we reserve the right to remove children from the Program whose families are not in good financial standing with the Preschool.

There will be a $25.00 charge for returned checks. All late fees go toward the purchase of materials for the classrooms. No exceptions to this policy.

In the event of a withdrawal before the school year starts, a full refund will be issued as soon as the vacancy is filled. If a student withdraws from the Preschool after the school year begins, the parent/guardian shall provide the Preschool Director written notice for withdrawal at least two weeks prior to date. Upon such a withdrawal, a pro-rated refund will be issued as soon as the opening can be filled. *Registration fees will not be refunded.*

Limited financial aid is available. Please contact the Preschool Director for information and confidential application materials.

Please sign below to indicate that both parents/guardians agree to the above tuition payment schedule and terms.

_____	_____
Parent/Guardian	**Parent/Guardian**
_____	_____
Date Signed	**Date Signed**

Accepted:

_____	_____
Preschool Director	**Date Signed**

***Return this agreement along with the first tuition payment by April 17, 2026.**
If payment is not received by this date, the family will forfeit its class placement.

This form will be held on file at the Preschool.

Credit Card Authorization Form

CARD HOLDER INFORMATION

Name: _____

Billing Address: _____

City: _____ **State:** _____ **Zip:** _____

PAYMENT AUTHORIZATION

Card Type ☐ **Visa** ☐ **MasterCard** ☐ **American Express**

Card Number _____ **Expiration Date** _____

Card Identification Number (3 or 4 digit number) _____

I, _____, authorize First Presbyterian Preschool to process a charge against my credit card in the amount of 1/4 the total tuition for 2026 – 2027 for the _____ class in the event my tuition payment is over 30 days past due.

_____
Parent/Guardian Signature

_____
Date Signed

Please note: **This credit card information will only be used to charge tuition that is over 30 days past due. It will NOT be used to make regular tuition payments.**