
Explore
We believe our enrvironment should provide open ended experiences that support exploration.
Belong
We aspire to provide an inclusive environment that creates a sense of belonging through valuing and respecting all cultures, abilites and challenges.
Growth
We believe that all educators should continue their pursuit of knowledge of research training and discussions with peers.
Vision
To provide a safe, loving, educational environment where children build relationships with their peers, teachers and beyond. To incorporate environmental elements and sustainable practices. To build strong partnerships with families and involvement in the community for the wellbeing and education of the children.
Welcome
We aspire to provide a welcoming environment that is creative, imaginitive, Inspiring and challenging.
Connect
We believe our relationships with families and community are paramount and assist with the development of our programing, practices and environment.
Trust
We believe that our relationships with the children, staff and families are based on mutual trust and respect.

Nature's Scholars Enrichment Center, Inc. 4400 Beck Lane, Ringwood, IL 60072
Phone 815-653-0240 or Fax 815-653-0390

Admittance Form – (please complete both sides)

***For my child's safety, I agree to inform Nature's Scholars Enrichment Center, Inc. in writing of any changes to the following information. Nature's Scholars Enrichment Center, Inc. assumes no liability if not advised in writing. (initial please)_____

Name of Child_____
(last) (first) (middle)

Child's nickname if preferred_____
(name to be taught/used for everyday interactions)

Child's date of birth (month/date/year)_____Sex: ( ) Male ( ) Female

Mother/Guardian Name_____
(last) (first) (middle)

Requested PIN# # __X__ __X__ __X__ __X__ _____ _____ _____ _____ First four digits are auto assigned.

Home address_____
(street) (City) (state) (zip)

Home phone _____( ) Cell phone _____( )
Please number top 3 contact #'s in order of accessibility, 1 being easiest to reach

Email_____

Employer _____
(company name) (city) (state)

Employer's main phone _____( )Direct work line _____Ext._____( )

Father/Guardian name _____
(last) (first) (middle)

Requested PIN#__X__ __X__ __X__ __X__ _____ _____ _____ _____ First four digits are auto assigned.

Home address _____

Home phone _____( )Cell phone _____( )
Please number top 3 contact #'s in order of accessibility, 1 being easiest to reach

Email_____

Employer _____
(company name) (city) (state)

Employer's main phone _____( )Direct work line _____Ext____( )

Marital Status of Parent(s): Married Single Divorced Separated Deceased
(circle one)

Child lives with: Both parents Mother Father Guardian Other (specify) _____
(circle one)

Special Dietary Release Signature _____
(additional Special Diet Authorization form to be filled out)

Unless stated otherwise it will be presumed that both mother/guardian and father/guardian (listed on front side of form) can pick up the child and/or be contacted in case of an emergency. We also need a minimum of 3 other people authorized to handle these duties if the parents/guardian cannot be reached.

Please list at least 3 people **authorized to pick up** child from center (do not list yourself, within 30 minute drive)

1)_____
(name) (address) (daytime phone) (relationship to child)

2) _____
(name) (address) (daytime phone) (relationship to child)

3) _____
(name) (address) (daytime phone) (relationship to child)

Please list at least 3 people to call in case of an emergency if parents/guardian cannot be reached.

1)_____
(name) (address) (daytime phone) (relationship to child)

2) _____
(name) (address) (daytime phone) (relationship to child)

3) _____
(name) (address) (daytime phone) (relationship to child)

Name(s) of person(s) who may **NOT** take child from center:_____

Is the custody/guardianship of your child affected by a court order? YES NO (circle one)

If yes, please refer to the ***Court Orders* section in the handbook on page 19.**

Siblings' names and ages _____

Has your child attended any other preschool, day care, home care? YES NO (circle one)

Name of Provider _____How Long?_____

Does your child have any special needs? (allergies, naps, handicaps, special diet, toileting etc.)

_____

_____

Is there any additional information that would be helpful in getting acquainted with you or your child/children?

_____

_____

****Note: Signature of legal parent(s)/guardian(s) required for admission. ****

Print Name: _____ Print Name: _____

Relationship to child: _____ Relationship to child: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

***Office use only ***

Days Enrolled: AW M T W R F Start Date: _____ Before After School Care

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Checklist for Enrollment

In order for your child to attend Nature's Scholars Enrichment Center, Inc., the following items must be at the center at least one (1) day prior to the child's first day of attendance. However, returning these items does not ensure your child's enrollment. Availability and start date needs to be confirmation with the director or administrator.

_____$50 registration fee

_____Payment to cover one (1) week of childcare

_____completed *Admittance Form*

_____ *Checklist for Enrollment,* with signed *Parent Handbook Agreement* statement below

_____completed *Consent Forms (if needed Pet Release, Transportation Form, Medical Permission Form and Special Diet Authorization)*

_____Illinois Department of Public Health *Child Health Examination* form-both sides completed, signed by a physician and dated within last six (6) months- (*original form-not copied or faxed)*

_____Illinois Department of Public Health *Childhood Lead Risk Assessment Questionnaire*-Complete with a signature by a physician.

_____Copy of child's *Certified Birth Certificate*

_____Back page of "*Summary of Licensing Standards*" published by DCFS

_____ *Tuffo Rental Agreement Form* & $25.00 rental fee (sizes 12 Mo. – 5T available only)

_____*Customer Acknowledgement & Release Form Coronavirus Notice*

_____ *Sick Child Policy Amendment: COVID-19*

Parent Handbook Agreement

I/we _____, the parents(s)/legal guardian(s) of

_____, acknowledge that I/we have received a copy of Nature's Scholars Enrichment Center, Inc. Parent Handbook and have been given the opportunity to read the manual and ask questions about and understand the policies contained therein. Furthermore, I/we agree to abide by the policies set forth in the manual.

I/we understand that the policies described in the Parent Handbook are not conditions of enrollment, and the language does not create a contract between Nature's Scholars Enrichment Center, Inc. and the parents. Nature's Scholars Enrichment Center, Inc. reserves the right to alter, amend, or otherwise modify these guidelines, in its sole discretion, without prior notice.

Print Name: _____ Print Name: _____

Relationship to child: _____ Relationship to child_____

Signature: _____ Signature: _____

Date: _____ Date: _____

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Consent Forms

Medical

I, _____as parent/legal guardian, give my permission for Nature's Scholars Enrichment Center, Inc. to secure medical care for my child_____. This may include, but is not limited to, first aid, care by a paramedic, Physician, or hospital. I agree to be responsible for any and all costs of such treatment and/or medication.

Signature of parent/guardian_____Date_____

First Aid

I, _____as parent/legal guardian, give my permission for Nature's Scholars Enrichment Center, Inc. staff to administer first aid to my child_____ in the event of a minor injury while in our care.

Signature of parent/guardian_____Date_____

Sunscreen and Insect Repellant Application

I, _____as parent/legal guardian, give my permission for Nature's Scholars Enrichment Center, Inc. to apply sunscreen and/or insect repellant, to my child_____when supplied.

Signature of parent/guardian_____Date_____

Photographs

I, _____as parent/legal guardian, give my permission for Nature's Scholars Enrichment Center, Inc. to take photographs of my child_____. Other than display of my child's photographs inside the center or on the centers website www.NaturesScholars.com, I will be notified if such photographs will be used for publicity or used outside the center.

Signature of parent/guardian_____Date_____

Leaving Nature's Scholars Enrichment Center, Inc. Property

I, _____as parent/legal guardian, give my permission for the staff of Nature's Scholars Enrichment Center, Inc. to take my child _____ on walks and/or special excursions.

Signature of parent/guardian_____Date_____

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Pet Release Form

I, _____as parent/legal guardian, give my permission for the staff of Nature's Scholars Enrichment Center, Inc. to let my child _____ interact with center pets or other animals used at the center for learning purposes. This may include but not be limited to, handling, feeding & cleaning of animals and their habitat.

All safety precautions and hand washing will be strongly practiced.

Animals/Pets that may be at center include; Rabbits, fish, butterflies or other form of, insects, worm and ant farms, hermit crabs or other pets similar.

.....

Transportation Authorization Form

STUDENT INFORMATION:

_____

Student's Last Name **Student's First Name**

_____

Address

_____

City **State** **Zip**

AGREEMENT:

- I understand that District #12 offers busing to and from Johnsburg schools with a pick up and drop off at Nature's Scholars Enrichment Center, Inc.., or nearest location. Our Van transports to/from Richmond Elementary School District 2 & from Harrison School District #36.
- I agree to be responsible for transporting my child to and their school if my child misses the bus/van route at Nature's Scholars Enrichment Center, Inc., or nearest location.
- I understand a qualified staff from Nature's Scholars Enrichment Center, Inc. will be walking my child safely to the bus stop/van and staying with my child until the bus arrives or van drops off at location.
- I understand a qualified staff from Nature's Scholars Enrichment Center, Inc. will be at the bus stop/van to help my child get safely off the bus/van and walk him/her inside the center
- I understand that once my child gets safely on the bus he/she is the responsibility of District #12 until he/she is returned to Nature's Scholars Enrichment Center, Inc.
- I agree to be responsible for picking up my child at their school if for any reason he/she gets ill and/or needs to be picked up before the end of the school day.
- I agree to notify Nature's Scholars Enrichment Center, Inc. if my child's daily transportation schedule should change or is absent and will not be going to or returning from their school.
- I agree to be responsible for transporting my child to and from Nature's Scholars Enrichment Center, Inc. if my child displays harmful or continual inappropriate behavior, as seen by the Director, at any time while being transported to and from schools.

_____

Parent/Guardian Signature **Date**

Date: _____

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Special Diet Authorization Form

I, _____as parent of _____ authorize the staff of Nature's Scholars Enrichment Center, Inc. to give my child the food items I have prepared and/or supplied for them. I request that the staff of Nature's Scholar's Enrichment Center, Inc. serve the items in place of what the center is serving for the specified meal(s) and/or times I have listed below. I hereby certify that Nature's Scholars Enrichment Center, Inc. or staff of Nature's Scholars Enrichment Center, Inc. is not held responsible if my child develops a reaction or illness symptoms after consuming what I have prepared or supplied for them. I agree to train the director/administrator and staff member directly involved with my child on any special procedures related to my child's needs.

Print Parent Name: _____

Signature of Parent: _____

Date: _____

.....

Please provide a brief description below.

Type of food provided _____

_____

Time food should be supplied to my child_____

_____

Reason food is substituted _____

_____

_____

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Medical Permission Form

This original form,(not a copy), needs to be on file at Nature's Scholars Enrichment Center, Inc. before staff may dispense any medication to your child; this applies to prescription and/or over-the counter medication.

Physician's Certification and Authorization

I hereby certify that it is **absolutely necessary** that our patient, _____, receive the following medication while in attendance at Nature's Scholars Enrichment Center, Inc.

Medication_____Dosage_____

Specify day/dates to be dispensed_____
(i.e. M-01/01/14, T-01/02/14, W-01/03/14)

Specific times to be dispensed_____
(i.e. 8:00am, 12:00 noon, 4:00pm)

Prescribed for (diagnosis) _____

Observe for these side effects_____

Physicians Signature_____Date_____

Print Physicians Name_____ Phone (____)_____

Parent/Guardian Authorization

My signature on this form authorizes staff of Nature's Scholars Enrichment Center, Inc., to dispense the above medication to my child and releases Nature's Scholars Enrichment Center, Inc. and its employees of liability associated with it. I understand that the medication must be in the original container and labeled with my child's name, the name of the medication, dosage and frequency of administration: the dosage on the medication must be the same as the Physician's authorization above. I also understand it is my responsibility to remove any unused medication from the center. If not picked up within 10 days of last date listed above, the medication will be disposed of.

Parent Name: _____

Parent Signature_____

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

																					Code:
Date																					
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**
Vision																					**U = Unable to test**
Hearing																					**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 Yes	No 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)

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.	**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 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

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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

High-Risk ZIP Codes for Pediatric Blood Lead Poisoning

Adams	62567	Effingham	62367	Knox	62526	61466	62976	60942
62301	62570	None	62373	61401	62537	61476	62992	60960
62320	Clark	Fayette	62379	61410	62551	61486	Putnam	60963
62324	62420	62458	62380	61414	Macoupin	Monroe	61336	61810
62339	62442	62880	Hardin	61436	62009	None	61340	61831
62346	62474	62885	62919	61439	62033	Montgomery	61363	61832
62348	62477	Ford	62982	61458	62069	62015	Randolph	61833
62349	62478	60919	Henderson	61467	62085	62019	62217	61844
62365	Clay	60933	61418	61474	62088	62032	62242	61848
Alexander	62824	60936	61425	61485	62093	62049	62272	61857
62914	62879	60946	61454	61489	62626	62051	Richland	61865
62988	Clinton	60952	61460	61572	62630	62056	62419	61870
Bond	62219	60957	61469	Lake	62640	62075	62425	61876
62273	Coles	60959	61471	60040	62649	62077	Rock Island	61883
Boone	61931	60962	61480	LaSalle	62672	62089	61201	Wabash
61038	61938	61773	Henry	60470	62674	62091	61236	62410
Brown	61943	Franklin	61234	60518	62685	62094	61239	62852
62353	62469	62812	61235	60531	62686	62538	61259	62863
62375	Cook	62819	61238	61301	62690	Morgan	61265	Warren
62378	All Chicago	62822	61274	61316	Madison	62601	61279	61412
Bureau	ZIP Codes	62825	61413	61321	62002	62628	St. Clair	61417
61312	60043	62874	61419	61325	62048	62631	62201	61423
61314	60104	62884	61434	61332	62058	62692	62203	61435
61315	60153	62891	61443	61334	62060	62695	62204	61447
61322	60201	62896	61468	61342	62084	Moultrie	62205	61453
61323	60202	62983	61490	61348	62090	61937	62220	61462
61328	60301	62999	Iroquois	61354	62095	Ogle	62289	61473
61329	60302	Fulton	60911	61358	Marion	61007	Saline	61478
61330	60304	61415	60912	61364	None	61030	62930	Washington
61337	60305	61427	60924	61370	Marshall	61047	62946	62214
61338	60402	61431	60926	61372	61369	61049	Sangamon	62803
61344	60406	61432	60930	Lawrence	61377	61054	62625	Wayne
61345	60456	61441	60931	62439	61424	61064	62689	62446
61346	,60501	61477	60938	62460	61537	61091	62703	62823
61349	60513	61482	60945	62466	61541	Peoria	Schuyler	62843
61359	60534	61484	60951	Lee	Mason	61451	61452	62886
61361	60546	61501	60953	60553	62617	61529	62319	White
61362	60804	61519	60955	61006	62633	61539	62344	62820
61368	Crawford	61520	60966	61031	62644	61552	62624	62821
61374	62433	61524	60967	61042	62655	61602	62639	62835
61376	62449	61531	60968	61310	62664	61603	Scott	62844
61379	62451	61542	60973	61318	62682	61604	62621	62887
Calhoun	Cumberland	61543	Jackson	61324	Massac	61605	62663	Whiteside
62006	62428	61544	62927	61331	62953	61606	62694	61037
62013	DeWitt	61563	62940	61353	McDonough	Perry	Shelby	61243
62036	61727	Gallatin	62950	61378	61411	62832	62438	61251
62070	61735	62934	Jasper	Livingston	61416	62997	62534	61261
Carroll	61749	Greene	62432	60420	61420	Piatt	62553	61270
61014	61750	62016	62434	60460	61422	61813	Stark	61277
61051	61777	62027	62459	60920	61438	61830	61421	61283
61053	61778	62044	62475	60921	61440	61839	61426	Will
61074	61882	62050	62480	60929	61470	61855	61449	60432
61078	DeKalb	62054	Jefferson	60934	61475	61929	61479	60433
Cass	60111	62078	62883	61311	62374	61936	61483	60436
62611	60129	62081	Jersey	61313	McHenry	Pike	61491	Williamson
62618	60146	62082	62030	61333	60034	62312	Stephenson	62921
62627	60550	62092	62063	61740	McLean	62314	61018	62948
62691	Douglas	Grundy	Jo Daviess	61741	61701	62323	61032	62949
Champaign	61930	60437	61028	61743	61720	62340	61039	62951
61815	61941	60474	61075	61769	61722	62343	61044	Winnebago
61816	61942	Hamilton	61085	61775	61724	62345	61050	61077
61845	DuPage	62817	61087	Logan	61728	62352	61060	61101
61849	60519	62828	Johnson	62512	61730	62355	61062	61102
61851	Edgar	62829	62908	62518	61731	62356	61067	61103
61852	61917	62859	62923	62519	61737	62357	61089	61104
61862	61924	Hancock	Kane	62548	61770	62361	Tazewell	Woodford
61872	61932	61450	60120	62543	Menard	62362	61564	61516
Christian	61933	62311	60505	62635	62642	62363	61721	61545
62083	61940	62313	Kankakee	62643	62673	62366	61734	61570
62510	61944	62316	60901	62666	62688	62370	Union	61760
62517	61949	62318	60910	62671	Mercer	Pope	62905	61771
62540	Edwards	62321	60917	Macon	61231	None	62906	
62546	62476	62330	60954	62514	61260	Pulaski	62920	
62555	62806	62334	60969	62521	61263	62956	62926	
62556	62815	62336	Kendall	62522	61276	62963	Vermilion	
62557	62818	62354	None	62523	61465	62964	60932	

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.

Rental Agreement Form

I/we as parent/guardian _____ would like our
parent/guardian name

child_____ to have use of a Nature's Scholars Enrichment Center Tuffo all-weather suit. I understand that it is property of Nature's Scholars Enrichment Center and that the suit is not to leave the premises. I/we understand that I am responsible for paying a $25.00 rental fee that is good for as long as my child attends at the center and can fit comfortably in the largest size available. I understand that Nature's Scholars will make the best accommodations to supply my child with an appropriate fitting suit while my child is in attendance at the center and when center's staff deem necessary to wear per weather conditions.

_____ _____

parent/guardian signature date

Nature's Scholars Enrichment Center, Inc. 4400 Beck Lane, Ringwood, IL 60072
Phone 815-653-0240 or Fax 815-653-0390

CUSTOMER ACKNOWLEDGEMENT & RELEASE FORM
CORONAVIRUS NOTICE

I, _____ and parent/guardian of _____ acknowledge that I have voluntarily entered NSEC for childcare services and acknowledge that by doing so waive and release any claims against NSEC, it's employees, fellow parents/guardians and classmates and hold harmless to any claims, suits, charges, or costs relating to any diagnosis or treatment of COVID-19. That I or a member of my household or workforce (and any guests visiting my household or workplace) receive following the date the services started by NSEC.

I recognize that a national emergency has been declared related to the Coronavirus (COVID-19) pandemic. In response to this emergency, numerous state, and federal public health agencies, including the Centers for Disease Control and Prevention, have promoted "social distancing" from other individuals.

I recognize, acknowledge, and accept the health risks of allowing my child(ren) in NSEC given the current COVID-19 pandemic, and acknowledge the recommendations of state and federal public health agencies, including the Centers for Disease Control and Prevention.

_____ Date:_____
Printed Name of Parent/Guardian

_____
Signature of Parent/Guardian

Sick Child Policy Amendment: COVID-19

The safety and wellbeing of all staff, children, and the families at NSEC continues to be of utmost importance to us. We always commit to taking all precautions toward keeping children and staff safe and healthy, including the current time of the COVID-19 outbreak. The following is an additional sick child policy that will help NSEC do this.
Children will be monitored for signs or symptoms of COVID-19 daily. **Children will be required to stay home or return home if any of the following applies with no exception:**

- Have a fever of 100.4 or higher
- Have had a fever of 100.4 or higher or other potential symptoms of COVID-19, such as shortness of breath or persistent dry cough, within the last 72 hours.
- Have come in contact with others who have COVID-19.

To prevent the spread of COVID-19:

- Children with signs/symptoms of COVID-19 or who have been exposed to others with COVID-19 will be asked to stay home.
- Children who develop signs/symptoms of COVID-19 while at the program will be immediately separated from others and the program staff will contact the family member and/or emergency contact to pick the child up. (restricted to directors' office on cot)
- We encourage families to practice frequent handwashing at home.
- NSEC will practice handwashing upon arrival to the program, before meals and snacks, after outdoor play, after using the bathroom, prior to going home, after nose blowing or assisting a child with blowing their nose, coughing, or sneezing.
- Cover cough and sneezes with tissues, throw tissues in the trash, and clean hands with soap and water or hand sanitizer (if soap and water is not readily available).
- Clean and disinfect frequently touched surfaces at least four times daily, including tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, and sinks.
- Require face coverings for persons over age 2 to the extent practicable, staff either masks or face shields. This will be optional while outdoors.
- Require children and staff to change shoes upon arrival or use shoe covers while indoors.

If an enrolled child or employee tests positive for COVID-19:

- The local public health department and the Department of Children and Family Services will be contacted. NSEC will follow their guidance for next steps.
- The program will post and notify families of any confirmed staff or child cases of COVID-19.
- Payment will be required at 50% tuition for duration of required absence or vacation week can be used as well.

Returning to a childcare facility after suspected COVID-19 symptoms:
If a staff member or child has symptoms of COVID-19 or is in close contact of someone with COVID-19, they can return to the childcare facility if the following conditions are met:

- If an individual has a fever, cough or shortness of breath and has not been around anyone who has been diagnosed with COVID-19, they can return to the center no sooner than 72 hours after the fever is gone (without the use of fever-reducing medication) and symptoms get better. If the person's symptoms worsen, they should contact their healthcare provider to determine if they should be tested for COVID-19.
- Any child suspected of having COVID-19, diagnosed with COVID-19, or having been in contact with persons suspected of or diagnosed with COVID-19 shall be excluded from the facility until written documentation is provided by the child's physician that the child is no longer communicable and may return to childcare.

I, (family member name)_____, parent/guardian of,

_____, have read and agree to the above sick child policy amendment.

Family member signature:_____Date:_____