LITTLE FRIENDS

27555 Diehl Road
Warrenville, Illinois 60555
630.355.6533
www.littlefriendsinc.org

Dear Parent or Guardian,

Welcome to Little Friends, Inc (LFI) schools; Krejci Academy and Mansion High School!
Attached with this letter is a Registration Packet for your student. Registration for Krejci or Mansion students is required at both Little Friends' schools, and at your home school district. We require registration for all students new to LFI Schools by the time of the Intake Meeting, and for all returning students by August 1.

All registration forms, including the "Parent and Student Handbook Policy Sign Offs" must be returned to Little Friends schools' main office BEFORE your student can start school. Completed and signed forms may be returned electronically to registration@lilfriends.com or by mail.

LFI Schools Registration
Little Friends, Inc.
27555 Diehl Road
Warrenville, IL 60555

Once registration materials are processed, you will receive electronic communications about how to set up a Talking Points and a School Pass account. These two tools are used to support day-to-day school communications and safety matters. Talking Points is multilingual texting app that allows school staff and families to connect in the development of your student's success at school. School Pass is an app that allows us to maximize student safety through specified Visitor Management, School Dismissal, Emergency Drill and Student Attendance procedures.

If you have questions or would like any assistance in completing the registration packet please contact, Amy Fudurich at 630-281-6928 or by email at afudurich@lilfriends.com to schedule a time to complete paperwork together.

We look forward to serving your student, and your family throughout your time at Krejci Academy or Mansion High School.

Sincerely,

Lori Deichstetter
Vice President of Educational Services LFI Schools

Liz Cochiaro
Principal, LFI Schools

Parent Registration Process Checklist

If you have questions or would like any assistance in completing the registration packet please contact, Amy Fudurich at 630-281-6928 or by email at afudurich@lilfriends.com to schedule a time to complete paperwork together.

- ☐ Completed Student Enrollment Information
- ☐ Completed Consent for Emergency Treatment
- ☐ Completed Physician and Parent Medication Information/Authorization (Part One) (Physician signature required.)
- ☐ Completed Physician and Parent Medication Information/Authorization (Part Two) Physician signature required.
- ☐ NEW students and students entering grades Kindergarten, 5th grade and 9th grade ONLY --- Proof of School Dental Exam & State of Illinois Child Health Exam forms (two-pages) due no later than September 30.
- ☐ Completed Student Handbook Policy Sign-off

NEXT STEPS for PARENTS:

- ☐ I have called or will call my student's home school district to arrange transportation on (date)._____
- ☐ LUNCH: Please be sure to send your student with a lunch and a drink each day. Refrigerators and microwaves are available to store or heat food as needed.

Student Enrollment Information

Today's Date

Child's Name _____ _____ _____
First Middle Last

Birthdate

Home Address _____ _____ _____ _____ _____
Address City/Town State Zip Code County

School District _____ Special Ed Coop (if applicable) _____

Parent/Guardian Contact Information

Are student's parent(s): ☐Married ☐Divorced ☐Single

	Parent/Guardian 1 ☐Legal Guardian	**Parent/Guardian 2** ☐Legal Guardian
RELATIONSHIP TO CHILD		
NAME		
HOME PHONE		
CELL PHONE		
EMAIL ADDRESS		
HOME ADDRESS	☐Same as child	☐Same as child
EMPLOYER		
JOB TITLE		
WORK ADDRESS		
DAILY WORK HOURS		
WORK PHONE		

Please indicate the preferred contact phone number _____
Please indicate the preferred contact email address for communication: ☐ Parent/Guardian 1 ☐Parent/Guardian 2

I give Little Friends Inc. permission to communicate information about my child via:
Parent/Guardian 1 ☐Email ☐Phone Parent/Guardian 2 ☐Email ☐Phone

For students who are 18 years of age or older, please indicate and provide documentation of legal guardianship. My child is their own guardian: ☐ Yes ☐No Parents have obtained guardianship: ☐Yes ☐No

Is the student eligible for Free/Reduced Lunch Program? ☐Yes ☐No

Parent/Guardian Name Parent/Guardian Signature

Consent for Emergency Treatment

Child's Name _____ Birth date _____

EMERGENCY NOTIFICATION:
If a parent/guardian cannot be reached, we must have the name and number of friends or relatives who would be available:

1. Name _____ Relationship to Child _____
   Phone _____ Address _____
2. Name _____ Relationship to Child _____
   Phone _____ Address _____
3. Name _____ Relationship to child _____
   Phone _____ Address _____

Our procedure for handling emergencies of accidents is as follows:

1. We will make every effort to contact a parent/guardian, then the emergency numbers listed in the event a parent cannot be reached.
2. We will seek out the closest medical attention available.

Child's Primary Physician

Name _____ Phone _____

Address _____

Child's Dentist

Name _____ Phone _____

Address _____

Insurance Company _____ Group Number _____

I hereby authorize any medical hospital physician to administer treatment to my child, named above, arising from illness or accident. I understand that if my insurance does not cover the cost, I will be responsible for paying.

Parent/Guardian Signature _____ Date _____

My child is 18 or older and is their own guardian: ☐ YES ☐ NO
This consent is valid for one year.

Physician and Parent Medication Information/ Authorization (Part One)

THIS FORM MUST BE COMPLETED EVERYTIME THERE IS A CHANGE IN MEDICINE EITHER AT HOME OR AT SCHOOL.

It is very important that school personnel are kept informed about any medications that your child takes and that our records are kept current.

1. The child's physician must complete their authorization below.
2. Medication/s must come in a prescription labeled container.
3. Medication/s cannot be given on an "AS NEEDED" basis.

Child's Name _____

☐ No medication is needed.

☐ Medication/s are only required at home, please list all medications below.

☐ Medication/s are required at home and AT SCHOOL, see below for instructions.

Name of Medication	Taken at *School or Home	Dosage	*Time(s) Taken	How is the medication taken?	Purpose of medication
	☐School ☐Home				
	☐School ☐Home				
	☐School ☐Home				
	☐School ☐Home				
	☐School ☐Home				
	☐School ☐Home				

*We cannot give medication on an "as needed" basis. **We must have a written order from the physician**.
I authorize Little Friends Certified Staff to administer the above medication to my child.

Parent/Guardian Signature Date

For Medication Taken at School: Physician Authorization

Physician's Name Phone _____

Side effects to be look out for, and/or other drugs or food NOT to be taken while using any of the above medicine?

How will this child's medication be monitored/follow up?

_____ _____

Physician Signature (Page 1 of 2) Date

Physician and Parent Medication Information/ Authorization (Part Two)

THIS FORM MUST BE COMPLETED EVERYTIME THERE IS A CHANGE IN MEDICAL INFORMATION.

Please return to LFI Schools via email at:
regsitration@lilfriends.com or by mail or fax

27555 Diehl Rd. Warrenville, IL
Phone (630) 355-6870 Fax (630) 281-6937

Child's Name _____ Birthdate _____

Medical History

Does your child have the following:

Seizures	☐ YES ☐NO	Uses medication to stop seizures ☐YES ☐NO Medication Name:
Diabetes	☐YES ☐NO	Uses Insulin Pump ☐YES ☐NO Uses Insulin Injections ☐YES ☐NO Additional Notes:
Asthma	☐YES ☐NO	Uses Inhaler ☐YES ☐NO If yes, when is it needed, generally:
Allergies	☐YES ☐NO	☐Environmental ☐Medication ☐Food Uses Epi Pen ☐YES ☐NO List Allergies:

If any of the above conditions have been indicated as a 'yes,' the school nurse will reach out to parents/guardians to complete an additional action plan.

Please provide contact information for follow-up:

Child's Medical Diagnosis_____

Additional Information School Staff and Emergency Personnel Should Know:

_____ _____

Physician Signature (Page 2 of 2) Date

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address: Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):		

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries -** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note_____

Signature of Dentist _____ Date of Exam _____

Address_____ Telephone_____

State of Illinois
Certificate of Child Health Examination

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

IMMUNIZATIONS: **To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine / Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:**		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

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

3. Laboratory Evidence of Immunity (check one) ☐ **Measles*** ☐ **Mumps**** ☐ **Rubella** ☐ **Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

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

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

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

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

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

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

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

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed ☐** **Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm_____**

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

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

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		
NEEDS/MODIFICATIONS required in the school setting			**DIETARY** Needs/Restrictions		

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

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

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

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

Yes ☐ No ☐ If yes, please describe.

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

PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐**

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

Address **Phone**

LFI Schools Handbook Policy Sign Offs

Completion and Return of this sign off sheet is required for both new and returning students at Krejci Academy or Mansion High School.

Waiver of Financial Responsibility for Property (Student Handbook Page 9) Parent initials ____

Media Consent Release Consent (Student Handbook Page 10)
I give permission for Little Friends, Inc. to use my child's photo. ☐ Yes ☐ No

AAC Device Photo Consent (Student Handbook page 10)

YES - Both my child's name and photo ☐
NAME ONLY ☐
NO ☐

Technology Property Damage Agreement (Student Handbook page 11) Parent Initials ____

Rights of Student Confidentiality (Student Handbook page 12) Parent Initials ____
Student initials (if over 18 and own guardian) ____

Acceptable Use Agreement Policy for Internet Access and Related Technology Use Inc. (Student Handbook page 15) Prent initials ____

Agreement and Waiver Release Part One (Student Handbook Page 16) Parent initials ____

Consent of Parent / Guardian Part Two (Student Handbook page 16) Parent Initials ____

Vision and Hearing permissions granted to Little Friends, Inc., good for entire time my child is enrolled in Little Friends Programs. (Student Handbook page 20) ☐ Yes ☐ No

Health / Sex Education curriculum permission (Student Handbook page 22)

Yes, my child may participate ☐
No, I do not want my child to participate ☐

By signing this document you are acknowledging that you have read and understand the policies indicated in the Student and Parent Handbook for placement at Little Friends, Inc. - Krejci Academy or Mansion High School.

_____ _____
Parent Signature Date completed