Dear family,

Thank you for choosing Bright Horizons at Evanston. I would like to take this opportunity to introduce you to the administrative team. My name is Lori Kiser, I am the Director. Our Business Manager, Juli Chandler, and Aretina Smith, Education Coordinator, have offices on the second floor. Danni MacClure, our Administrative Assistant will greet you as you enter the center. All of us can be reached by phone at 847-491-9032 or by email, evanston@brighthorizons.com.

Do not hesitate to contact us if you have any questions about your paperwork. If you do not already have your child’s birth certificate, information for acquiring is available at www.idph.state.il.us/vitalrecords/birth.htm.

One of the documents necessary for enrollment is the State of Illinois Certificate of Child Health Examination. Please check that all necessary information has been completed. We are including a chart of the immunization schedule as required by DCFS. Any variations should be noted by your child’s doctor. Each time your child visits the doctor, to receive immunizations, we will ask for documentation. A nurse will be helping us with our files and may send you a request for updated information.

<table>
<thead>
<tr>
<th>Age</th>
<th>POLIO</th>
<th>DPT</th>
<th>HEP B</th>
<th>HIB</th>
<th>MMR</th>
<th>Varicella</th>
<th>Lead</th>
<th>TB test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 months</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 months</td>
<td>X</td>
<td>X</td>
<td>*</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months</td>
<td>X</td>
<td></td>
<td>X**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>15 months</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 months</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*not always a necessary dose-get confirmation from doctor ** If PedVaxHIB or ConVax is administered at 2&4mos, a 6 mos dose not required

Sincerely,

Lori Kiser

Lori Kiser
Center Director
BRIGHT HORIZONS

CHILD’S INFORMATION

Child’s Name: ____________________________ Date of Birth: ___/___/___
Place of Birth: __________________________ Primary Language: ______________
Child’s Schedule: MON ______ TUE ______ WED ______ THU ______ FRI ______

Parent/Guardian Information

Name: ____________________________ Name: ____________________________
Relationship: __________________________ Relationship: __________________________
Address: __________________________
Home E-mail Address: __________________________
Cell Phone: __________________________
Home Phone: __________________________
Others in Family Relationship: __________________________

Parent/Guardian Business Information

Company Name: __________________________ Company Name: __________________________
Address: __________________________
Business Phone: __________________________
E-mail Address: __________________________

Medical Information

Eye Color: ______________ Hair Color: ______________ Sex: ______
Height: ______________ Weight: ______________ Race: ______________
Identifying Marks: __________________________
Identified Allergies: __________________________
Health Insurance Provider: __________________________

Physician Information

Name of Physician/Clinic: __________________________ Phone: __________________________

(Parent/Guardian Signature) __________________________ (Date) __________________________

FOR CENTER USE

Center: __________________________ Date of Admission: ______________ Age of Admission: ______________
Date Registration Fee Received: ______________ Director’s Initials: __________________________
Date of Disenrollment: ______________ Director’s Initials: __________________________
Please plan on bringing your child’s birth certificate so we can make a copy for your child’s file and return the original to you as soon as possible.

According to the Department of Children and Family Services under licensing regulation number (407.250, i, 4) A-D:

“Any parent or guardian enrolling a child in a child care program must provide a certified copy of the child’s birth certificate or other reliable proof of identity and age of the child. If a certified copy of the birth certificate is not available, the parent or guardian must submit a passport, visa or other governmental documentation as proof of the child’s identity and age and an affidavit or notarized letter explaining the inability to produce a certified copy of the birth certificate.

If the parent or guardian should fail to submit the required proof of identity within 30 days, the child care program is required to notify the Illinois State Police or local law enforcement agency. The program is also required to notify the parent or guardian that law enforcement has been notified.”

Child’s name and date of birth: ____________________________

Parent/Guardian name (please print): ____________________________

Parent/Guardian signature: ____________________________

Today’s date: ____________________________
# State of Illinois Certificate of Child Health Examination

## Student's Name
- Last
- First
- Middle

## Date of Birth
- Month/Day/Year

## Sex

## Race/Ethnicity

## School/Grade Level/ID#:

### IMMUNIZATIONS:
To be completed by health care provider. Note the month/day/year 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.

<table>
<thead>
<tr>
<th>Vaccine / Dose</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td, Td or Pediatric DT (Check specific type)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio (Check specific type)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hib Haemophilus influenza type b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (HB)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR Combined</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles Mumps. Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.)*

### Meningococcal
- Measles Mumps Rubella
- Varicella
- Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.

- Date of Disease
- Title
- Date

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

Lab Results
- Date

(Attach copy of lab result)

### VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

<table>
<thead>
<tr>
<th>Age/ Grade</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
<th>R</th>
<th>L</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IL.444-4737 (R-01-12)

(COMPLETE BOTH SIDES)
**HEALTH HISTORY**

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

### ALLERGIES
- **Diagnosis of asthma?**
  - Yes
  - No
- **Child wakes during the night?**
  - Yes
  - No
- **Birth defects?**
  - Yes
  - No
- **Developmental delay?**
  - Yes
  - No
- **Blood disorders? Hemophilia, Sickle Cell, Other? Explain.**
  - Yes
  - No
- **Diabetes?**
  - Yes
  - No
- **Head injury/Concussion/Passed out?**
  - Yes
  - No
- **Seizures? What are they like?**
  - Yes
  - No
- **Heart problem/Shortness of breath?**
  - Yes
  - No
- **Heart murmur/High blood pressure?**
  - Yes
  - No
- **Dizziness or chest pain with exercise?**
  - Yes
  - No
- **Eye/Vision problems?**
  - Glasses
  - Contacts
  - Last exam by eye doctor
- **Other concerns?** (crossed eye, drooping lids, squinting, difficulty reading)

### MEDICATION
- **Loss of function of one of paired organs? (eye/ear/kidney/testicle)**
  - Yes
  - No
- **Hospitalizations? When? What for?**
  - Yes
  - No
- **Surgery? (List all)**
  - Yes
  - No
- **Tobacco use (type, frequency)?**
  - Yes
  - No
- **Alcohol/Drug use?**
  - Yes
  - No
- **Family history of sudden death before age 50? (Cause)?**
  - Yes
  - No

### PHYSICAL EXAMINATION REQUIREMENTS

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

### HEAD CIRCUMFERENCE
- **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

### LEAD RISK QUESTIONNAIRE
- **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 tested
  - Test performed

### LAB TESTS (Recommended)
- **Hemoglobin or Hematocrit**
- **Urinalysis**
- **Sickle Cell (when indicated)**
- **Developmental Screening Tool**

### SYSTEM REVIEW
- **Skin**
- **Ears**
  - Amblyopia
- **Nose**
- **Throat**
- **Mouth/Dental**
- **Cardiovascular/HTN**
- **Respiratory**
  - Diagnosis of Asthma
  - Current Prescribed Asthma Medication:
    - Quick-relief medication (e.g. Short Acting Beta Antagonist)
    - Controller medication (e.g. inhaled corticosteroid)
- **NEEDS/MODIFICATIONS**
  - DIETARY Needs/Restrictions

### MENTAL HEALTH/OTHER
- **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)?

### PHYSICAL EDUCATION
- **Print Name**
- **Signature**
- **Phone**
- **Address**

(Complete both sides)
Guidance and Discipline Policy Summary

During the early childhood years, children are learning to be in charge of their own behavior. We believe in establishing consistent, easy-to-understand limits and in having teachers who respond to inappropriate behavior with insight, sensitivity, and skill. When clear, consistent and age-appropriate limits are present; children increasingly become responsible for themselves. When out-of-bounds behaviors do occur, we believe it is important for children to understand why the behavior is inappropriate and how to modify it. Methods for preventing and coping with inappropriate or undesirable behavior in the classroom include:

- Recognizing positive behavior
- Re-directing a child to involvement in another area
- Offering choices
- Planned ignoring of negative behavior
- Offering help
- Limiting space and materials
- Losing privileges

We work to prevent behavior problems by arranging each classroom so that children work in small groups and have a choice of activities. The range of activities will give your child the freedom and ability to experience success and become self-directed. Teachers are also trained to skillfully direct behavior along appropriate channels. Children are encouraged to verbalize their feelings to learn to positively work through strong emotions. Teachers act as role models and encourage children's appropriate behaviors. **Under no circumstances is corporal punishment permitted. Discipline will not be associated with food, rest or toileting.**

Children playing in a group need help and guidance in order to play effectively together. Some of the children may have had little opportunity to play with others. Taking turns and sharing toys are a part of developmental learning. The following are guidelines for both teachers and parents in working with children.

- Speak in a low, pleasant but firm voice
- Always go to child to gain his attention
- Make suggestions positive
- Give real reasons as to why rules are in place
- Offer choices when possible
- Keep your expectations clear
- Give the child only as much help as the child needs
- Help the child to take turns and share materials
- Respect the child’s feelings
- Children should feel accepted for who they are

We believe that it is our responsibility to provide children with positive guidance and in our experience, most children will respond well to our approach. In the event that a child does not respond, we will notify the parents and work closely with them to develop a plan to help the child gain self-control and a positive attitude toward peers and teachers. Should the child’s continued negative behavior put themselves, their peers or their teachers at risk for physical harm or, if the child damages center property, we reserve the right to ask the parent to withdraw the child from the center. While we understand the developmental tendencies of children to experiment with inappropriate language to shock others, withdrawal may also be requested for those children who are verbally abusive, including the repeated use of inappropriate language which other families consider offensive. I have read and understand the above Guidance and Discipline Policy.

Parent/Guardian Signature__________________________ Date_____________
Bright Horizons Informed Consent

I grant my informed consent for my child(ren) to participate in the child care program operated by Bright Horizons.

By signing below, I acknowledge and accept the following program conditions:

Access

I have full access to the center without notification whenever my child(ren) is/are present. However, this access may not be used to supplement any visitation schedule or custody arrangement.

Child Release

For children's safety, Bright Horizons will release a child only to the parent(s)/legal guardian(s) who have signed this form and to those listed below by the parent/guardian.

Bright Horizons will not release my child to any other person unless I notify the center, following the guidelines listed below:

- If the person (spouse, relative, friend) picking up my child is listed on this form but does not regularly pick up my child or has never before picked up my child, I will notify the center verbally, in advance.
- If the person picking up my child is NOT listed on this form, I must notify the center in writing, in advance.
- Photo identification will be required of any person picking up my child.

NAME

ADDRESS

CITY/TOWN

RELATIONSHIP TO CHILD

DAY PHONE

EVENING PHONE

NAME

ADDRESS

CITY/TOWN

RELATIONSHIP TO CHILD

DAY PHONE

EVENING PHONE

E-MAIL

Walk Permission

As part of the program, children will go on walks in the surrounding area supervised by the staff, weather permitting.

Child(ren) may be taken to the locations listed below by Bright Horizons' staff; infants and young toddlers will go in a buggy or stroller. The areas my child may walk to are:

A separate Field Trip Policies and Permission Slip describing the field trip will be sent home if your child will be leaving the center for an extended period of time (for preschool and school-age children only).

☐ I give permission for my child to participate in walks.
☐ I do not give permission for my child to participate in walks.

Photography and Video Permission

Bright Horizons takes photographs and videos of children enrolled at its centers on a regular basis for its business purposes. Bright Horizons retains all rights, title, and interest in these materials and may use and disseminate them in a variety of ways, in its sole judgment. Bright Horizons takes care that any use, display, or dissemination of photographs or videos of children, whether at a particular center where the child attends or for its general business purposes, is accomplished in a thoughtful, safe, and secure manner appropriate under the particular circumstances.

For example, at your center, these materials may be used to better communicate with families and to illustrate the daily curriculum, to chronicle a child's development, or to document center activities. These photos may be shared with you and other families on a secure Bright Horizons' website, by e-mail, posted in the center, or in a parent newsletter.

By signing below, I give permission to Bright Horizons to take photographs and videos of my child during his/her enrollment and to use these materials for its business purposes.

PLEASE CONTINUE ON NEXT PAGE...
Child Illness

In case of illness, I will be called and possibly required to pick up my child(ren) as soon as possible. We ask that for your child's comfort and to reduce the risk of contagion, children be picked up within 1.5 hours of notification. Until then, your child will be kept comfortable and will continue to be observed for symptoms. Children need to remain home for 24 hours without symptoms before returning to the program. This means that the child needs to remain out of the center for the remainder of the day he/she is sent home and the following day (if a child is sent home on Friday, he/she may return on Monday), unless the center receives a note from the child's medical provider stating that the child is not contagious and may return to the center. In the case of a (suspected) contagious disease, rash, or continuing symptoms, a note from the child's medical provider may be required before returning.

Children's Injuries

If my child sustains a minor injury (e.g., scraped knee) during care, I understand that I will receive an Occurrence Report outlining the incident and course of action taken by the staff member when I arrive to pick up.

I will be contacted immediately if the injury produces any type of swelling, is on the face or head, or needs medical attention.

Emergency Medical Care

Every effort will be made to contact me in the event of an emergency requiring medical attention for my child.

If I cannot be reached, the emergency contacts listed above will be called. I authorize Bright Horizons to call an ambulance to transport my child to a hospital or medical facility and to secure for my child the necessary medical treatment. Staff is trained in the basics of first aid and CPR and I authorize them to give my child first aid. In a center, any member of the staff responsible for the care and education of my child may view my child's health information, as well as state licensees for compliance purposes.

CHILD'S HEALTH INSURANCE PROVIDER

NAME OF INSURED

POLICY NUMBER

Family Guide Acknowledgement

I have received the Bright Horizons Family Guide and applicable information specific to center and state policies. I understand and agree that it is my responsibility to read and familiarize myself with the policies and procedures of the Bright Horizons Family Guide. In addition, I understand that this handbook reflects company-wide policies and that supplemental center and state specific policies may apply. By signing below, I acknowledge receipt of these materials, and agree to abide by them.

I understand that it is my responsibility to address any questions I may have regarding the policies and procedures and information contained in the Bright Horizons Family Guide directly with center management.

Information contained in this guide may be subject to change.

I have read, understand, and accept the conditions noted above.

PARENT/GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE