BLAIR EARLY CHILDHOOD CENTER
2025-2026 ENROLLMENT PAPERWORK

PROVIDE COPIES OF THE FOLLOWING:

- ☐ BIRTH CERTIFICATE
- ☐ PROOF OF RESIDENCY
- ☐ PICTURE ID

PLEASE COMPLETE THE FOLLOWING DOCUMENTS:

- ☐ SCHOOL ENROLLMENT FORM
- ☐ REQUEST FOR EMERGENCY AND HEALTH INFO
- ☐ HOME-LANGUAGE SURVEY
- ☐ RACE & ETHNICITY SURVEY
- ☐ STUDENT MEDICAL INFORMATION
- ☐ MEDIA CONSENT AND RELEASE FORM
- ☐ PERMISSION SLIP FOR WALKING TOUR
- ☐ BLAIR RELEASE FORM
- ☐ FAMILY INCOME INFORMATION FORM
- ☐ SCHOOL MESSAGING CONSENT FORM
- ☐ DONORS CHOOSE
- ☐ RELEASE/EXCHANGE OF INFORMATION

HEALTH/MEDICAL FORMS:

- ☐ PHYSICAL/IMMUNIZATION RECORD - **No later than 10/15/25**
- ☐ SCHOOL-BASED ORAL HEALTH PROGRAM DENTAL CONSENT
- ☐ VISION SERVICES CONSENT
- ☐ PROOF OF DENTAL EXAMINATION FORM - **Kindergarten Students**
- ☐ EYE EXAMINATION REPORT - **Kindergarten Students**
- ☐ OTHER HEALTH FORMS IF NECESSARY (i.e. Doctor's Orders, Allergies, Asthma, Major Health Problem, etc.)

TRANSPORTATION FORMS IF RIDING BUS:

- ☐ WHITE FORM
- ☐ PURPLE FORM
- ☐ YELLOW FORM

Welcome to the School Year!

Please complete the enrollment paperwork to the best of your ability. If you have any questions, we'll be happy to assist you when you return the completed forms. You may leave the **Room #** section blank — we will fill it in once your child is assigned to a classroom.

When returning paperwork, please bring the following so we can make copies:

- **Your child's birth certificate**
- **Your photo ID**
- **Proof of residency** (e.g., a utility bill or official mail)

Health Requirements

A physical examination is required within 12 months prior to your child's entry into Preschool. We must receive a **copy of the completed physical no later than October 15, 2025.**

Supplies and Clothing

We do **not require school supplies** at this time. Students are expected to have:

- A **backpack**
- An **extra change of clothes** to be kept at school
- If your child wears diapers, please provide a supply of **diapers and wipes**. Teachers will let you know when more are needed.

Teachers will provide a classroom-specific **wish list** once school begins.

Please note: **Students do not wear uniforms.**

Important Dates

- **Back-to-School Bash**: Thursday, August 14th — Come meet the staff!
- **Google Meet Enrollment Meetings**: Scheduled with your child's teacher during the week of August 11th
- **First Day of School**: **Monday, August 18th**

It's going to be a **fantastic school year** — we can't wait to welcome you and your child!

School Enrollment Form

Chicago Public Schools

Please print or type:

Student Information

SCHOOL NAME BLAIR EARLY CHILDHOOD CENTER

STUDENT ID#	**School Use Only:** Prevent duplicate student records. Search in Student Information System (SIS) for an existing Student ID before creating a new one.	REGISTRATION GRADE LEVEL *(when first entering CPS)*

LEGAL LAST NAME	LEGAL FIRST NAME	LEGAL MIDDLE NAME

GENERATION (Jr., etc)	BIRTH DATE *(mm/dd/yyyy)*	LEGAL SEX (F/M/N)

***AFFIRMED GENDER (F/M/N/U)**

***Optional.** For more information regarding affirmed gender and affirmed name, please visit: Supporting Gender Diversity Toolkit

***AFFIRMED FIRST NAME**

***AFFIRMED MIDDLE NAME**

***AFFIRMED LAST NAME**

STUDENT'S SIBLINGS' NAMES IF CURRENTLY ENROLLED IN CPS:

Personal Information

BIRTH CERTIFICATE ON FILE ☐ YES ☐ NO

BIRTH VERIFICATION TYPE (BIRTH CERTIFICATE, PASSPORT, MEDICAL CARD ETC.)

*BIRTH COUNTRY	BIRTH STATE	BIRTH CITY

*Complete if student was not born in the United States (US) or one of its Territories:

DATE OF FIRST ENROLLMENT IN ANY US SCHOOL:

FULL YEARS COMPLETED SCHOOL IN US:

School Use Only: Note that *"Date of first enrollment in any US School"* becomes a required field in SIS if *"Birth Country"* is not the US or one of its Territories.

Student Address/Phone

PHYSICAL (HOME) ADDRESS (include unit number if applicable) | City | State | Zip | **HOME PHONE #**

MAILING ADDRESS (include unit number if applicable) (if different than Home) | City | State | Zip | ☐ **HOMELESS/TEMPORARY LIVING CONDITIONS**

Enrollment

LAST CHICAGO PUBLIC, OPTIONS, CHARTER, OR CONTRACT SCHOOL ATTENDED

***SCHOOL TRANSFERRING FROM (If not a Chicago Public, Options, Charter, or Contract School)** | **CITY, STATE, ZIP**

***IS THE STUDENT IN GOOD STANDING?** ☐ YES ☐ NO

***(Instructions to school:** for out-of-state public school or any private school students, a certification of "good standing" should be received from the Parent/Guardian. Refer to CPS Policy 702.1 for more information.)*

IS THE STUDENT RECEIVING ANY TYPE OF SPECIAL EDUCATION SERVICES? ☐ YES ☐ NO **IF YES, PROVIDE DETAILS**

***(Instructions to school:** if yes, please notify the Case Manager.)*

STUDENT ENROLLED BY (Print Last Name, First Name and Middle Name and Relationship)

Included Information

FEDERAL ETHNIC AND RACE CATEGORIES: *(Enter information into SIS from the current Race and Ethnicity Survey form)*

HOME LANGUAGE SURVEY: *(Enter information into SIS from the current Home Language Survey form)*

PARENT/GUARDIAN CONTACTS: *(Enter information into SIS from the current Request for Emergency and Health Information form)*

EMERGENCY/HEALTH INFORMATION: *(Enter information into SIS from the current Request for Emergency and Health Information form)*

Enrollment Status Codes:

01 – No Former School
02 – Chicago Public School (to incl. Options/Charter/Contract)
03 – Chicago Private School
04 – IL Public Schl, not Chicago
05 – IL Private Schl, not Chicago
06 – US Public Schl, not Illinois
07 – US Private Schl, not Illinois
08 – Not in USA

Signature of Parent/Guardian
Must have an original signature, an electronic signature is not acceptable

Date of Enrollment

School Use Only:	ENROLLMENT STATUS CODE *(insert a # from the left)*	GRADE LEVEL	HOMEROOM/DIVISION #

CUMULATIVE FOLDER

CPS Enrollment and Leave Code User Guide

Request for Emergency and Health Information

Chicago Public Schools

PARENTS/GUARDIANS: The school must have on file emergency information that can be used to contact you. Please print clearly. Whenever there is a change in this information, immediately notify the school in writing.

SCHOOL NAME	STUDENT ID#
BLAIR EARLY CHILDHOOD CENTER	

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

STUDENT HOME ADDRESS (include unit number if applicable) City State Zip

BIRTH DATE *(mm/dd/yyyy)*	HOMEROOM #	HOME/PRIMARY PHONE #

CONFIDENTIAL INFORMATION BOX 1

Complete this box only if (1) it reflects your child's current living situation; OR **(2)** it reflects your living situation if you are a youth not living with a Parent or Guardian. (Your answer will help school staff with enrollment and may enable the student to receive additional services.)
Check one box:

- ☐ in a car/park/other public place/abandoned building/substandard housing
- ☐ doubled-up
- ☐ in a hotel/motel/trailer park/camping ground
- ☐ in a shelter
- ☐ in transitional housing

School Note: If any box is checked, see the CPS Policy 702.5.

CONFIDENTIAL INFORMATION BOX 2

Is there a current Order of Protection or Civil No Contact Order which concerns this student?
☐ YES ☐ NO

Is there a current Temporary Restraining Order or Injunction which concerns this student?
☐ YES ☐ NO

School Note: If "Yes," follow CPS Policy 704.4 procedures. Enter information in *Legal Alert* field and update contact information, as needed, in SIS.

PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION: *Add extra contacts on additional page, if needed.*

	PRIMARY PARENT/GUARDIAN CONTACT ☐ DCFS Contact	PARENT/GUARDIAN CONTACT ☐ DCFS Contact	PARENT/GUARDIAN CONTACT ☐ DCFS Contact
Contact First Name, Last Name			
Relationship to Student			
Check all that apply:	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pick up	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pick up	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pick up
Home Address, if different from student's ***(include unit number if applicable)***			
Primary Phone Number	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Secondary Phone Number	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
Third Phone Number	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work
E-mail Address			
***Communication Language**			
Requires Translator	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

* CPS communicates via phone calls. Select the language that should be used to communicate with you. Languages available for mass communication at this time are English and Spanish (note: other languages upon availability).

List the name of a relative, neighbor, family friend, or trusted adult who can also be notified in an emergency and has permission to pick up the student:

NAME	RELATIONSHIP	TELEPHONE #

ADDRESS

FAMILY DOCTOR'S NAME, ADDRESS, AND PHONE NUMBER:

I authorize you to call my family doctor, if necessary, in an emergency: ☐ YES ☐ NO

NAME	ADDRESS (include unit number if applicable) City State Zip
TELEPHONE #	

STUDENT HEALTH INSURANCE: (select only one of the three)

- ☐ Illinois Medical Card/All Kids: provide student's medical ID # _____ *(9-digit number located on back of card).*
- ☐ No Insurance: are you interested in applying for the Illinois Medical Card/All Kids? ☐ YES ☐ NO
- ☐ Private/Employer Health Insurance: no additional information needed.

CHILDREN OF MILITARY PERSONNEL (optional)

As the Parent or Guardian, are you a member of a branch of the armed forces of the United States? ☐ YES ☐ NO

If yes, are you either deployed to active duty or expect to be deployed to active duty during the school year? ☐ YES ☐ NO

_____ _____

Parent/Guardian Signature **Date**

Must have an original signature. An electronic signature is not acceptable

RETAIN 1 YEAR AFTER SUPERSEDED OR STUDENT HAS PERMANENTLY WITHDRAWN

Home Language Survey

Office of Multilingual-Multicultural Education (OMME)

Chicago Public Schools

Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency and may be eligible for English Learner services.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

SCHOOL NAME
BLAIR EARLY CHILDHOOD CENTER

STUDENT ID #	NETWORK	ROOM #
	10	

English

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

1. Is a language other than English spoken in your home? ☐ Yes ☐ No Which language?
2. Does the student speak a language other than English? ☐ Yes ☐ No Which language?

Spanish/Español

Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la competencia de su niño en inglés.

1. ¿Se habla algún otro idioma que no sea inglés en su hogar? ☐ Sí (yes) ☐ No (no) ¿Cuál idioma?
2. ¿Habla el estudiante algún otro idioma que no sea inglés? ☐ Sí (yes) ☐ No (no) ¿Cuál idioma?

Chinese / 中文

如果兩個問題中有任何一題的答案為"是"，根據法律要求，學校將評測您子女的英語水平。

- 语之外的其他語言？ ☐ 是的 (yes) ☐ 不是 (no) 什么语言？
- 女是否說英語之外的其他語言？ ☐ 是的 (yes) ☐ 不是 (no) 什么语言？

Arabic / العربية

إذا كانت الإجابة على أي من السؤالين نعم، فإن القانون تطلب من المدرسة تقييم إتقان طفلك للغة الإنجليزية .

- هل تُستخدم لغة أخرى غير اللغة الإنجليزية في منزلك؟ ☐ نعم (yes) ☐ لا (no) اي لغة؟
- هل يتحدث الطالب لغة أخرى غير اللغة الإنجليزية ؟ ☐ نعم (yes) ☐ لا (no) اي لغة؟

Polish/Polski

Jeśli udzielili Państwo twierdzącej odpowiedzi na którekolwiek z pytań, przepisy wymagają aby szkoła sprawdziła poziom znajomości języka angielskiego waszego dziecka.

1. Czy mówi się w domu językiem innym niż angielski? ☐ Tak (yes) ☐ Nie (no) Jakim językiem?
2. Czy uczeń mówi innym językiem niż angielski? ☐ Tak (yes) ☐ Nie (no) Jakim językiem?

Ukrainian / Українська

Якщо ви відповіли «Так» на будь-яке з цих запитань, школа буде зобов'язана за законом оцінити рівень володіння вашою дитиною англійською мовою.

1. Чи розмовляєте Ви вдома іншою мовою окрім англійської? ☐ Так (yes) ☐ Ні (no) Якою мовою?
2. Чи розмовляє Ваша дитина іншою мовою окрім англійської? ☐ Так (yes) ☐ Ні (no) Якою мовою?

Signature of School Offici	Date	Parent/Guardian Signature	Date

Must have an original signature, an electronic signature is not acceptable

OFFICE USE ONLY

Please make sure both questions are answered completely and that the parents/guardians sign and date the form.

If the language spoken by the parent/guardian is not included on either page of this form, please visit the OMME Employee Intranet Page, Forms, and click on "Home Language Survey in Additional Languages" which will take you to ISBE's HLS page.

If the parent/guardian does not speak English and the school does not have staff who speaks the parent/guardian's language, identify the language spoken by the parent/guardian through any assistance available in the school, i.e. using interpretation services from a vendor.

ASPEN REGISTRATION PROCESS

All five fields have to be entered on Aspen: date, answer to question 1, Home language, answer to question 2, and Native language.

When a language other than English is reported for only one of the questions on the form, that Non-English language has to be listed as both Home and Native Language in Aspen.

If there are two different languages other than English listed, enter the language identified in question 2 as both Home and Native language. If there is more than one language listed in question 2, check with the family, since only one of the languages can be entered on Aspen.

English can be entered as the Home language ONLY if both questions are answered No and English is listed for both questions.

If the language is not included on the list of languages available on Aspen, enter "Other" temporarily, but contact OMME as soon as possible so that the district can ask ISBE to add the new language. An Student Reclassification Recommendation (SRR) will have to be submitted to OMME to correct the language at a later date.

Maintain Home Language Survey in the Student Cumulative Folder. If the student is an English Learner (EL), maintain the original survey in the

Race and Ethnicity Survey

Chicago Public Schools

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER	SCHOOL NAME
	BLAIR EARLY CHILDHOOD CENTER
BIRTH DATE	SCHOOL ID (6 digits) to be completed by school staff
	610087

Instructions

Please answer the questions below. Both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

PART A

Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) Choose only one.

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to PART B below by marking one or more boxes to indicate what you consider this student's race to be.

PART B

What is the student's race? Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

Student Medical Information 2025-2026

Chicago Public Schools

This form must be updated and returned to school each school year.

Please let your school know about your child's health and health care. This is a good way to keep your child safe. The information is CONFIDENTIAL and will be shared only with CPS staff who need to know (Nurse, Principal, Designee, or Clerk).

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER (F/M/X/N)	STUDENT DATE OF BIRTH	SCHOOL NAME
		BLAIR EARLY CHILDHOOD CENTER

STUDENT ID #	GRADE	ROOM #

1. DOES YOUR CHILD HAVE ANY KNOWN HEALTH CONDITIONS?

☐ YES ☐ NO

If your child has a health condition, please schedule an appointment with your school nurse. Please check all that apply:

☐ Allergies (food or other)

List Allergies: _____

☐ Asthma

Year Diagnosed _____

☐ Seizures/Epilepsy

Year Diagnosed _____

☐ Diabetes (please select one) ☐ Type 1 ☐ Type 2 ☐ Other

Year Diagnosed _____

☐ Sickle Cell Disease

Year Diagnosed _____

☐ Other _____ Year Diagnosed _____

2. MY CHILD HAS A PRIMARY CARE PROVIDER ☐ YES ☐ NO

If yes, please provide the healthcare provider's name and phone number:

Name _____ **Phone number** _____

☐ **I give permission for my child's school nurse or designee to talk to the doctor about my child's health.**

3. MY CHILD IS COVERED BY HEALTH INSURANCE: ☐ YES ☐ NO

If your child needs health insurance call Healthy CPS 773-553-KIDS (5437).

This form is NOT the same as a medical order, action plan, or plan of care. If your student has a health condition listed above, please visit cps.edu/oshw to view the CPS Health Forms required for that particular health condition. CPS Health Forms must be completed by a medical provider and submitted to the school nurse in order to keep your student healthy and safe at school. If you have any questions about required medical forms, please schedule a call or meeting with your school nurse.

Please return the form to the school nurse. If the student has a health condition, parents must schedule a meeting with the school nurse.

Parent/Guardian Name _____ **Date** _____ **Phone Number** _____

Parent/Guardian Signature _____ **Email** _____

Must have an original signature. An electronic signature is not acceptable.

Nurses Use Only **Reviewed by (Initials)** _____ **Date** _____

Revised February 2025

RETAIN IN THE STUDENT HEALTH RECORD

Media Consent Form and Release

Chicago Public Schools

Consent/Release

I hereby consent to have my child photographed, digitally recorded, video taped, audio taped and/or interviewed by the Board of Education of the City of Chicago (the "Board") or the news media when school is in session, either in person or hosted remotely, or when my child is under the supervision of the Board. Further, I consent for these photos, digital recordings, video tapes, audio tapes and/or interviews to be shared with third parties who have received written approval from the Office of Communications. I understand in the course of the above described activities that the Board might like to celebrate my child's accomplishments and work. Therefore, I further consent for the Board's release of information on my child's name, academic/non-academic awards and information concerning my child's participation in school-sponsored activities, organizations and athletics.

I also consent to the Board's use of my child's name, photograph or likeness, voice or creative work(s) on the Internet or on a CD or any other electronic/digital media or print media which may include honorary banners/signs displayed in, near, or around the school building or community. I understand and agree that the Board and/or its authorized representatives retain the right to use any digital or print capture (including video, audio, photographs or likeness) for any purposes stated or related to the above and may be used by the District in subsequent years.

As the child's parent or legal guardian, I agree to release, indemnify and hold harmless the Board, its members, trustees, agents, officers, contractors, volunteers and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child's name, photograph or likeness, voice or creative work(s), on television, radio or motion pictures, or on the Internet, or any digital file, or any other electronic/digital media or print media or in connection with my child's participation in virtual school events and/or celebratory activities.

It is further understood and I do agree that no monies or other consideration in any form, including reimbursement for any expenses incurred by me or my child, will become due to me, my child, our heirs, agents, or assigns at any time because of my child's participation in any of the above activities or the above-described use of my child's name, photograph or likeness, voice or creative work(s).

I understand that I may cancel this consent by providing written notice to the principal. I also understand that my consent is valid for one school year, including the following summer.

Instructions: Check Box #1 or Box #2

☐ **1. I consent as outlined in the above consent/release section.**

☐ **2. I DO NOT consent as outlined in the above consent/release section.**

Please print or type:

Student Last Name	First Name	Middle Name	Birth Date (mm/dd/yyyy)

Name of Parent/Guardian / Student if age 18 or older

BLAIR EARLY CHILDHOOD CENTER

School Name	Grade	Student ID #

Signature of Parent/Guardian / Student if age 18 or older — **Date**

Must have an original signature. An electronic signature is not acceptable

I understand that I have the right to inspect and copy my student's records, challenge the contents of such records, and limit my consent to the designated records or designated portions of information within the records. Department of Education Policy and Procedures 06.01.20.

2025-2026

Blair Permission Slip for Walking Trips

Dear Parent:

When the weather permits, the staff would like to take your child on a neighborhood walk to get fresh air and movement. This walk would be contained in an area limited to surrounding blocks of the school and would not include the crossing of any major roads. If you will allow your child to take a neighborhood walk with his/her classmates and teachers/staff, please sign below.

Thank you,

Bess & Julie

Querido padre:

Cuando el clima lo permite, el personal le gustaría llevar a su hijo a caminar por el vecindario para tomar aire fresco y moverse. Esta caminata estaría contenida en un área limitada a las cuadras circundantes de la escuela y no incluiría el cruce de las carreteras principales. Si le permite a su hijo dar un paseo por el vecindario con sus compañeros y maestros, firme a continuación.

Gracias,

Bess y Julie

I give my permission for my child to go on a neighborhood walk as stated above. The permission slip is valid for the current academic year.

Doy mi permiso para que mi hijo valla a una caminata por el vecindario como se indicó anteriormente. La hoja de permiso es válida para el año académico actual.

Student Name/Nombre del estudiante:

_____

Room/Habitacion #:

_____

Parent Signature/ Firma de los padres:

_____

2025-2026

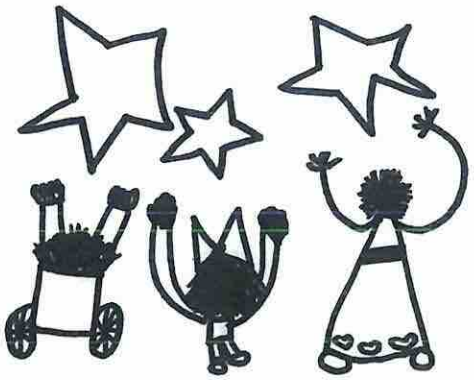
BLAIR RELEASE FORM/FORMULARIO DE AUTORIZACION

CHILD'S NAME/NOMBRE DEL NINO _____

ROOM #/SALON _____

PARENT/GUARDIA/NOMBRE DEL PADRE/TUTOR _____

PARENT SIGNATURE/FIRMA DEL PADRE _____



THE FOLLOWING PEOPLE HAVE PERMISSION TO PICK UP MY CHILD FROM THE PRESCHOOL PROGRAM/LAS SIGUIENTES PERSONAS ESTAN AUTORIZADAS A RECOGER A MI NINO DEL PROGRAMS PREESCOLAR:

NAME/NOMBRE	RELATIONSHIP TO CHILD/ RELACION CON EL NINO

CPS Family Income Information Form 2025-2026

Chicago Public Schools

The purpose of this form is for CPS to obtain information about families' incomes to determine school funding. CPS and your school may receive additional funding based on the number of low-income families enrolled. Please complete this form and return it to the school's main office.

Parents—Please return form to school by October 30, 2025.
Schools—Please enter into ODA by November 20, 2025.

please print or type.

STUDENT LAST NAME	STUDENT FIRST NAME	STUDENT MIDDLE NAME
SCHOOL NAME BLAIR ECC	STUDENT ID	DOES YOUR FAMILY HAVE INTERNET SERVICES AT HOME? ☐ YES ☐ NO

PART 1: Household Information — List all members of your household living with you.

**Foster Children (legal responsibility of welfare agency or court)*

PART 2: SNAP/TANF number of any member of your household *(go to part 6)*

FOSTER CHILD?	CPS STUDENT?	ALL HOUSEHOLD MEMBER NAMES Last	First	M.I.	DATE OF BIRTH	DHS SNAP OR TANF CASE NUMBER (LAST 9 DIGITS)
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					
☐	☐					

PART 3: Homeless, Runaway Child, or child enrolled in Head Start

☐ HOMELESS
☐ RUNAWAY
☐ HEAD START

Homeless, Runaway or Head Start Liaison Signature _____ Date _____

PART 4: List Household Members With Income *(SKIP THIS if you answered any of parts 2 or 3)*

Enter the amount of income and how often it is received for each household member.
Frequency: Weekly, Every 2 Weeks, Twice Monthly, Monthly, Annually

OTHER INCOME can be but not limited to Welfare, Child Support, Retirement, Social Security, Worker's Compensation, and Unemployment.

HOUSEHOLD MEMBER NAMES WITH INCOME First	Last	M.I.	GROSS INCOME *(before deductions)*	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually	OTHER INCOME	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually
			$	○	○	○	○	○	$	○	○	○	○	○
			$	○	○	○	○	○	$	○	○	○	○	○
			$	○	○	○	○	○	$	○	○	○	○	○
			$	○	○	○	○	○	$	○	○	○	○	○
			$	○	○	○	○	○	$	○	○	○	○	○

PART 5: Opt in for information about other benefits.

☐ **YES!** I am interested in applying for a waiver of instructional fees.

☐ **YES!** I am interested in applying for the Supplemental Nutrition Assistance Program (SNAP) and/or the Medicaid Program. *Or call 773-553-5437*

☐ **YES!** This student/these students have a parent who is a veteran or active military member. *Students with a parent who is a veteran or active military may qualify for a fee waiver.*

Signature _____

PART 6

Signature: I certify that all above information is true and all income is reported. I understand that information gathered from this form will be used to calculate Federal funding and screen CPS students for eligibility for other benefits and that school officials may verify (check) the information as being accurate; and that if I purposely give false information, I may be prosecuted. I consent to the district sharing eligibility status in order to receive benefits based on eligibility status.

Signature of adult household member _____ Parent / Guardian First Name _____ Parent / Guardian Last Name _____

Address _____ Zip Code _____ Date _____

Must have an original signature. An electronic signature is not acceptable.

RETAIN IN FIIF FOLDER FOR 4 YEARS

CPS Family Income Information Form 2025 - 2026

Chicago Public Schools

PART 7: Children's Racial and Ethnic Identities *(Optional)*

MARK ONE ETHNIC IDENTITY:

- ☐ Hispanic / Latino
- ☐ Not Hispanic / Latino

MARK ONE OR MORE RACIAL IDENTITIES:

- ☐ Asian
- ☐ Black / African American
- ☐ Native Hawaiian / Other Pacific Islander
- ☐ White
- ☐ American Indian / Alaska Native

Instructions For Completing Family Income Information Form

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SNAP/TANF, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students). (Attach another application if necessary.)

Part 2: List the DHS case number (SNAP or TANF) of any household member that corresponds with their name in Part 1. Do not use your Medicare card number.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A HOMELESS, RUNAWAY, OR HEAD START CHILD, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students).

Skip to Part 3: Check the appropriate box; obtain date and signature of Homeless, or Runaway Liaison/Coordinator.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

If all children in the household are foster children:

Part 1: List student's name, date of birth and check the box for "Foster Child" to the left of your foster child's name.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

IF SOME CHILDREN IN THE HOUSEHOLD ARE FOSTER CHILDREN:

Part 1: List student's name, date of birth and check the box for "Foster Child" to the left of your foster child's name.

Skip to Part 4: Follow the instructions under ALL OTHER HOUSEHOLDS INSTRUCTIONS (Part 4) below.

Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students).

Skip to Part 4: Follow these instructions to report total household income:

Column 1: Name
List the first and last name of each person in your household who receives income, related or not (such as grandparents, other relatives, or friends. Attach another sheet of paper if necessary.).

Columns 2 & 3: Gross Income Amounts and Frequency
The Gross Income is the amount earned before taxes and other deductions. It should be noted on pay stubs. This is not the same as take-home pay. List the amount each person receives from these sources. Round to the nearest dollar. All other sources of income should also be noted on this application. Next to each amount fill in the circle that indicates how often the person receives their stated income (weekly, every other week, twice a month, monthly, or annually). If you do not wish to disclose your income, please note "decline to answer" in this section. Be aware that if you are low-income, failure to share household income information could reduce the funds your school may otherwise receive.

Part 5: If you are interested in sharing application information with Medicaid or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

SCHOOL USE ONLY

Initial Determination: ☐ **ELIGIBLE (Free or Reduced)** ☐ **INELIGIBLE (Denied, N/A or ?)**

CONFIRMATION *(Only for those applications selected for verification)*

Signature of Confirming Official (Required) _____ **Date** _____

Must have an original signature. An electronic signature is not acceptable

RETAIN IN FILE FOLDER FOR 4 YEARS

School Messaging Consent Form

Chicago Public Schools

Dear Parent/Guardian/Student if age 18 or older:

Your school and the district will periodically want to send information regarding school or district events, updates or initiatives. We will utilize a phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, COVID-19 information and screenings, and more. To ensure you receive periodic school- or district-related notifications and reminders, your consent is needed below.

In the event of an emergency, whether or not consent is on file, you will be informed through all contact information provided. Emergency calls include weather closures, health risks, threats, unexcused absences, and other situations affecting the health or safety of students and faculty. Emergency calls will be sent to all phone numbers, including cellular numbers, listed on the student's record. Please make sure these numbers are updated with your school.

Please fill out and return this form to ensure you receive informational calls and texts.

By signing this form, you are authorizing Chicago Public Schools to use an automated system to periodically deliver automated informational calls or text messages to the phone number(s) provided below. If you change your phone number or no longer wish to receive automated calls and texts, you agree to inform Chicago Public Schools immediately. By signing below, you agree that this consent will remain valid and you will continue to receive automated phone calls and text messages unless or until you revoke your consent. Standard messaging rates and data may apply.

☑ **I CONSENT as outlined in the above section.**

☐ **I DO NOT CONSENT as outlined in the above section.**

please print or type:

Student Last Name | **First Name** | **Middle Name** | **Birth Date (mm/dd/yyyy)**

Name of Parent/Guardian/Student if age 18 or older

BLAIR EARLY CHILDHOOD CENTER

School Name | **Grade** | **Student ID #**

Signature of Parent/Guardian/Student if age 18 or older | **Date**

Must have an original signature. An electronic signature is not acceptable

PRIORITY #1

Last Name | **First Name**

Primary Phone ☐ Cell ☐ Home ☐ Work | **Secondary Phone** ☐ Cell ☐ Home ☐ Work | **Third Phone** ☐ Cell ☐ Home ☐ Work

PRIORITY #2

Last Name | **First Name**

Primary Phone ☐ Cell ☐ Home ☐ Work | **Secondary Phone** ☐ Cell ☐ Home ☐ Work | **Third Phone** ☐ Cell ☐ Home ☐ Work

PRIORITY #3

N/A

Last Name | **First Name**

Primary Phone ☐ Cell ☐ Home ☐ Work | **Secondary Phone** ☐ Cell ☐ Home ☐ Work | **Third Phone** ☐ Cell ☐ Home ☐ Work

RETAIN IN THE STUDENT CUMULATIVE FOLDER

Photo Release Form

Name of Child Participant: _____

Name of Parent or Guardian (Releaser): _____

Name of Teacher: _____

This teacher is seeking or has earned a funded project through **DonorsChoose**, a nonprofit organization serving public school students. On the website, www.DonorsChoose.org, teachers create projects that request resources and experiences for their students, and individual donors can choose a project they want to fund.

If the project is successfully funded, this teacher's class may receive resources or student experiences. In this event, DonorsChoose may show photographs of the activities taking place or resources being used to the donor(s) and/or partner corporation(s) who funded the request(s). To help generate donor interest for this teacher's project(s), DonorsChoose may also display a picture featuring this teacher's class on our website for potential donors to view. In addition, we may allow partner corporations to 1) display all photographs on their websites and social media channels, 2) to otherwise use the photographs on their websites and social media channels, and 3) to otherwise use the photographs for publicity and promotional purposes.

With your signature below, you consent as follows:

- I am the legal parent or guardian (releaser) of the child participant named above. I hereby give permission for the participant to be photographed and recorded (with or without other classmates).
- I understand, agree, and give permission for DonorsChoose to display the photographs on the DonorsChoose website.
- I understand, agree, and give permission for DonorsChoose, its partners, and its donors to otherwise use photographs for promotional purposes.
- I understand, agree, and give permission for this consent form to be stored and referenced by teacher and DonorsChoose for the next 5 school years.

Signature of Parent or Guardian (Releaser): _____

Date: _____

PLEASE RETURN THE COMPLETED, SIGNED FORM TO THE TEACHER AS SOON AS POSSIBLE. THANK YOU.

DONORS CHOOSE

134 W 37th St | Floor 11 | New York, NY 10018 | (212) 239-3615
DonorsChoose.org is a 501(c)(3) charity incorporated
in the State of New York. EIN# 13-4129457

HEALTHY CPS

OFFICE OF STUDENT HEALTH & WELLNESS

Consent for Release/Exchange of Student Records and Information

Student's Name: _____ Date of Birth: ____/____/_____

I hereby give permission to release/exchange/disclose the following:

☐ **All School Student Records**, including, but not limited to: personally identifying information; cumulative-permanent record; special education records; academic transcript; discipline records; health records; attendance records; and test scores.

Only Specific School Records:

☐ Personally Identifying Information
☐ Special Education Record (e.g. IEP, Evaluations, 504 Plans)
☐ Cumulative/Permanent Record
☐ Health Records
☐ Disciplinary Records
☐ Progress Monitoring Data
☐ Attendance Records
☐ Test Scores
☐ Other (Specify): _____

Health/Medical Information:

☐ Any and all records in the possession of _____ including mental health, HIV and/or substance abuse records
☐ Records regarding treatment for the following condition or injury _____
☐ Records covering the period of time between _____ and _____
☐ Other: _____

This information to be released/exchanged between:

Agency(ies)/School(s): _____
Address: _____ **AND**
Attn: _____

Chicago Public Schools, District #299
School/Department: _____
Attn: _____

Purpose: This information is to be disclosed upon request and will be used for the following purpose(s):

☐ Educational evaluation and program planning
☐ Medical evaluation and treatment
☐ Health assessment and planning
☐ Referral to a separate day school/residential facility
☐ Independent Educational Evaluation
☐ Other: _____

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 et seq.), and the *Illinois Mental Health and Developmental Disability Confidentiality Act* (740 ILCS 110/1 et seq.). I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent to the local school district representative. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district may not be protected by HIPAA Privacy Rules, but will become educational records protected by the *Family Educational Rights and Privacy Act* (20 U.S.C. Section 1232g). I understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I understand that I have the right to inspect and copy educational records and to challenge their contents. †I acknowledge that limiting the release/exchange or disclosure of records to one separate day school/residential facility may impact the District's ability to timely place the Student in a non-public facility.

This authorization is valid for one (1) calendar year from the date of signed consent indicated below.

_____ _____
Parent Signature Date Student Signature* Date

_____ *Student signature required for mental health records if student is 12 years of age or older
Witness Signature Date

School-Based Oral Health Program Dental Consent, Release of Liability and Authorization Form

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER (F/M/X/N)	STUDENT DATE OF BIRTH	SCHOOL NAME

STUDENT ID #	GRADE	ROOM #

PARENT/GUARDIAN NAME	MEDICAID/ALL KIDS — 9 DIGIT RECIPIENT #

PHONE	HOME ADDRESS (include unit number if applicable)	CITY	STATE	ZIP

PRIVATE INSURANCE NAME OF COMPANY

PRIVATE INSURANCE COMPANY POLICY #	GROUP #	PRIVATE INSURANCE COMPANY PHONE #

NAME OF PARENT/GUARDIAN INSURED	DATE OF BIRTH OF THE INSURED

As the parent/guardian of the above named student, I understand that through the City of Chicago Department of Public Health and the Chicago Public Schools' SCHOOL-BASED ORAL HEALTH PROGRAM (the "PROGRAM"), licensed dentists or hygienists will be coming to my child's/ward's school in the near future to assess oral health, gather information on height/weight, to provide a DENTAL EXAM/SCREENING and as needed a DENTAL CLEANING, FLUORIDE TREATMENT, SDF TREATMENT(S), and DENTAL SEALANT(S) at NO COST to students or their families in the school. Dental sealants, in addition to regular brushing and flossing, protect your child's/ward's teeth from DECAY. Dental Sealants are thin, plastic coatings put on the tops of the back-teeth to SEAL OUT food and germs. Sealants are applied on teeth that appear not decayed, and they don't hurt. PROGRAM SERVICES DO NOT INCLUDE DRILLING OR SHOTS.

I understand that in consideration for my child's/ward's participation in the PROGRAM, and as evidenced by my signature below, I hereby release and hold harmless the CITY OF CHICAGO, its departments, including the Department of Public Health, and its employees, officers, volunteers, agents and representatives, and THE BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, agents, officers, contractors, volunteers and employees from any liability which may accrue to me or to my child/ward, for any and all losses, injuries, damages to me or my child/ward, both known and unknown, foreseen and unforeseen, arising in connection with my child's/ward's participation in the PROGRAM whether or not said losses, injuries, damages, or liabilities result in whole or part from the negligence of the CITY OF CHICAGO, its departments, including the Department of Public Health, its employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives.

I further understand that as evidenced by my signature below, I acknowledge that a licensed dentist/hygienist providing medical or dental care, treatment, diagnosis, or advice without charge on behalf of the City of Chicago Department of Public Health is not liable for civil damages resulting from his or her acts or omissions in providing such medical or dental care, treatment, diagnosis, or advice under the Program except for willful or wanton misconduct. To authorize dental providers and the Chicago Department of Public Health to share information relating to PROGRAM dental services provided to your child/ward, please sign the Authorization Form that is on the other side of this page. This signed consent form is valid for 365 days from the date that it is signed by the child's/ward's parent or guardian.

RACE? (Please check one)

☐ White ☐ Black ☐ Asian ☐ Pacific Islander ☐ American Indian ☐ Native Alaskan ☐ Hispanic

MEDICAL INFORMATION: DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

☐ **YES** ☐ **NO**

If YES: Please check all conditions that apply

- ☐ Asthma
- ☐ Diabetes
- ☐ Currently has Heart Murmur
- ☐ Rheumatic Fever or Rheumatic Heart Disease
- ☐ Epilepsy
- ☐ Blood Disorder / Disease
- ☐ Hepatitis

IS YOUR CHILD TAKING ANY MEDICATIONS? ☐ **YES** ☐ **NO**

If YES, Please List Medications:

DOES YOUR CHILD HAVE ANY ALLERGIES? ☐ **YES** ☐ **NO**

DOES YOUR CHILD HAVE A SILVER ALLERGY? ☐ **YES** ☐ **NO**

If YES, Please List Allergies:

ANY OTHER MEDICAL-RELATED CONDITIONS? ☐ **YES** ☐ **NO**

If YES, Please List Conditions:

Must have an original signature. An electronic signature is not acceptable.

Please sign front and back

As the parent or guardian of the above named child or ward, I consent for my child or ward to participate in the SCHOOL-BASED ORAL HEALTH PROGRAM, which includes a dental exam/screening and as needed a dental cleaning, fluoride treatment and dental sealant(s) and the receiving of quality assurance exams. I authorize the dental provider to use my child's or ward's Medicaid, ALL KIDS and private dental insurance number for billing purposes only. I understand that if I fail to sign this Dental Consent Form and Release of Liability, my child or ward will not receive any services under this program.

X _____
Parent/Guardian Signature

_____
Date

Chicago Public Schools

RETAIN IN A BINDER FOR 2 YEARS

School-Based Oral Health Program Authorization Form - HIPAA

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

STUDENT DATE OF BIRTH	PARENT/GUARDIAN NAME

SCHOOL NAME

NEW Silver Diamine Fluoride (SDF) Authorization

A new dental treatment to fight cavities!

Before SDF

After SDF

BENEFITS OF SDF: Dental cavities are common in children, but now our dentists have a safe, painless alternative to traditional cavity drilling procedures called Silver Diamine Fluoride (SDF). SDF is an FDA-approved antibiotic liquid used to help prevent cavities from forming, growing, or spreading to other teeth. The dentist simply brushes SDF on back teeth only Reason to avoid SDF treatment: silver allergy, history of mouth sores, or painful sores on the gums.

Alternatives

- No treatment: The tooth may continue to decay and cause pain.
- Other options: fluoride varnish, a filling or crown, or extraction of the tooth.

Risks

- SDF treatment may not eliminate the need for a traditional filling.
- It's normal for SDF to stain the cavity brown or black–it means it's working.
- The healthy parts of the tooth will not be stained.
- SDF can cause temporary staining if it comes into contact with skin. The stain is harmless and should disappear in less than a week.
- SDF may cause a temporary metallic taste.
- For more information, scan the QR Code.

Consent for SDF Treatment

I certify that I have read and fully understand the information for the proposed SDF application(s), or I had discussed this with my dental care provider and have had my questions answered. I understand the possible risks associated with SDF treatment and verify that I have no (or the patient I am representing has no) contraindications for its use. I consent to SDF application.

X _____ _____

Parent/Guardian Signature for Silver Diamine Fluoride (SDF) **Date**

HIPAA Authorization

By signing below, I understand that I am giving my authorization to the dental provider and the City of Chicago Department of Public Health (CDPH) to use and/or disclose my child's/ward's protected health information, to the following person(s) or organization(s) for the purposes of reports, documentation of oral health trends, and Medicaid and grant billing: City of Chicago, Department of Public Health, 111 W. Washington, 4th Floor, Chicago, IL 60602; Individual School Principal; Illinois Department of Healthcare and Family Services, 201 So. Grand Avenue East, Springfield, IL, 62763; Illinois Department of Public Health - Oral Health Section, 535 W. Jefferson Street, 2nd Floor, Springfield, IL, 62761, Chicago Public Schools, Office of Student Health and Wellness, 42 West Madison, Chicago Illinois 60602. Federally Qualified Health Centers (FQHC), Oral Health Forum (OHF), 1100 West Cermak Road, Suite 518, Chicago, IL 60608. Infant Welfare Society of Chicago (IWS), 3600 W Fullerton Ave, Chicago, Oak Park-River Forest Infant Welfare Clinic, 320 Lake Street, Oak Park, IL 60302 and Chicago Public School approved Dental Vans.

CDPH and dental providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization. This Authorization is voluntary, and I may refuse to sign it. I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) and federal privacy regulations. I may revoke this Authorization in writing by sending notice to the HIPAA Privacy Officer, City of Chicago, Department of Public Health, 111 W. Washington, 4th Floor, Chicago, IL 60602. Revocation is not effective with respect to actions taken prior to the revocation.

This authorization is valid for 365 days from the date that it is signed by the child's/ward's parent or guardian.

X _____ _____

Parent/Guardian Signature for HIPAA Authorization **Date**

Must have an original signature.
An electronic signature is not acceptable.

Please sign front and back

Chicago Public Schools

Vision Services Consent, Release of Liability, and Authorization Form

Chicago Public Schools

Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return them to the school as soon as possible.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER (F/M/X/N)	STUDENT DATE OF BIRTH	SCHOOL NAME
		BLAIR EARLY CHILDHOOD CENTER

STUDENT ID #	GRADE	ROOM #

PARENT/GUARDIAN NAME	PARENT EMAIL ADDRESS

PHONE	HOME ADDRESS (include unit number if applicable)	CITY	STATE	ZIP

MEDICAID/MEDICAL CARD/ALLKIDS RECIPIENT #	RACE/ETHNICITY	DATE OF BIRTH

PRIVATE VISION INSURANCE	CARDHOLDER NAME	DATE OF BIRTH	GROUP ID#	ID#

PRIVATE MEDICAL INSURANCE	CARDHOLDER NAME	DATE OF BIRTH	GROUP ID#	ID#

As the parent/guardian of the above named student, I understand that my child will receive a comprehensive eye exam to determine if he/she needs prescription glasses or other treatment by a vision care professional (Provider).

I further understand that this eye exam may be performed by an Optometrist; an Ophthalmologist; qualified specialist; or an intern, a resident, or a student clinician or technician under the supervision of an Optometrist, Ophthalmologist, or another qualified specialist, and I consent to have my child receive a vision exam and/or treatment.

I further understand that neither the school nor the Board of Education of the City of Chicago (Board) are supervising or overseeing any services (such as an eye exam) or materials (such as eye glasses) that may be furnished to my child and that the Board and the school will have no responsibility for the quality of any such services or materials.

In consideration for the services and materials that my child will receive, I hereby agree to indemnify, release and hold harmless, and defend the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers, representatives, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuries, damages to me or my child, both known and unknown, foreseen and unforeseen, arising in connection with my child's receipt of services and materials, whether or not said claims, losses, injuries, damages, or liabilities result in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives. I further agree to release and hold harmless the Providers and Co-Sponsors, their employees, officers, volunteers, agents and representatives from and against any and all claims, demands, actions, complaints, suits or other forms of liability that will arise out of or by reason of, or be caused by any performance of services provided by such Providers or the quality of the eyeglasses or any other materials furnished by them under the Program, unless attributed to their willful or wanton misconduct. In the event that one provision of this form is held unenforceable, that provision shall be severed and the remainder of the form shall remain in effect.

I understand that the Provider will bill any government or private insurance Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable private insurance for any reimbursable services and/or materials.

If you DO NOT want your child to receive the following services, please check the appropriate box. *If your child has an allergy, please consult your primary care physician before selecting dilation.*

I understand that as part of this eye exam, pharmaceutical agents (eye drops) will be used for the purpose of dilating my child's eyes. These drops are an important part of an eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops include blurred vision and sensitivity to light, both of which could restrict my child's mobility making it unsafe for him/her to travel unassisted or to operate a vehicle for the rest of the day.

☐ **At this time I DO consent for my child's eyes to be dilated.**

☐ **At this time I DO NOT consent for my child's eyes to be dilated.**
I understand that by refusing dilation I may limit the doctor's ability to detect and treat certain conditions.

Please note services will be performed unless indicated otherwise.

I understand that my child may be selected to be photographed, video taped, audio taped or interviewed as part of promotional documentation for the Vision Program. I consent to the use of my child's photograph, voice or likeness by the Board or the Provider or CDPH, but not the use of my child's last name. I understand there is no compensation, monies, or reimbursement for my child's participation.

☐ **At this time I DO NOT consent for my child to be photographed or interviewed.**

By signing below, I understand that I am giving my authorization to the City of Chicago Department of Public Health (CDPH) and the Board of Education of the City of Chicago (Board) to release and furnish information regarding past vision screening data in my child's education record to Providers to ensure that the Providers can effectively provide services. I authorize the Providers to release and furnish reports to my child's school, including written and verbal reports concerning the results of any eye exam, for inclusion in my child's education record. I also authorize CDPH to release to the Board, my child's information, the date and type of vision services provided, whether my child was recommend for follow-up services, and other information the State of Illinois requests the Board to report. I understand that such records will be subject to the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinois Department of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization.

*****Please sign and date both signature lines. Complete the medical history on the second page of this form.*****

This authorization is valid for one year. I may revoke this authorization at any time by sending written notification to CDPH, my child's school, or the Board Office of Student Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient.

I hereby give my consent for this child to be examined by a Provider for an eye exam and prescription eyeglasses, if prescribed during the eye exam. This consent does not authorize any treatments or service beyond what is stated. I understand my consent will be valid for one year from the date of signature.

Must have an original signature. An electronic signature is not acceptable.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

RETAIN IN A BINDER FOR 2 YEARS

Vision Services
Student Medical History Form

Chicago Public Schools

Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return them to the school as soon as possible.

please print or type:

STUDENT NAME	STUDENT ID	STUDENT'S DATE OF LAST EYE EXAM

SCHOOL NAME	DOES YOUR CHILD CURRENTLY WEAR GLASSES/CONTACTS? ☐ YES ☐ NO

HOW DID YOU FIND OUT ABOUT THE VISION PROGRAM? (Check all that apply)

☐ School Staff ☐ Failed Vision Screening Letter ☐ Friend ☐ Other Add Details _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS? (Check all that apply)

☐ Asthma	☐ Diabetes	☐ Genitourinary Problems	☐ Heart Disease	☐ Musculoskeletal Problems
☐ Attention Deficit Disorder	☐ Endocrine Problems	☐ Glaucoma	☐ High Blood Pressure	☐ Neurological Problems
☐ Behavioral Problems	☐ Gastrointestinal Problems	☐ Hearing/Ear Problems	☐ Mental Health Illness	☐ Other Condition _____

IS YOUR CHILD TAKING ANY MEDICATIONS? ☐ YES ☐ NO

List Medications:

DOES YOUR CHILD HAVE ANY ALLERGIES? ☐ YES ☐ NO

List Allergies:

DOES YOUR CHILD USE EYE DROPS? ☐ YES ☐ NO

List Eye Drops:

HAS YOUR CHILD EVER HAD EYE SURGERY? ☐ YES ☐ NO

If yes, please explain:

HAVE THEY HAD ANY OF THE FOLLOWING?

☐ Vision Therapy	☐ Blurred/Double Vision	☐ Tearing/Watering	☐ Difficulty Sitting Still	☐ Frustrates Easily
☐ Eye Patch	☐ Loses Place While Reading	☐ Light Sensitivity	☐ Avoids Reading/Writing	☐ Lack of Confidence
☐ Eye Surgery	☐ Eye Injury	☐ Redness	☐ Difficulty Paying Attention	☐ Eye Discharge
☐ Pain in Eyes	☐ Eye Infection	☐ Drooping Lid	☐ Reads Below Grade Level	☐ Lazy/Wandering Eye
☐ Difficulty Tracking	☐ Itching/Burning	☐ Trouble Finishing Work	☐ Poor Handwriting	

☐ Other _____

DOES YOUR CHILD HAVE AN IMMEDIATE FAMILY MEMBER WITH ANY OF THE FOLLOWING? (Check all that apply)

☐ Wears Glasses	☐ Glaucoma	☐ Lazy Eye	☐ High Blood Pressure
☐ Blindness	☐ Macular Degeneration	☐ Diabetes	☐ Wandering Eye
☐ Heart Disease	☐ Cardiovascular Problems	☐ Neurological Problems	☐ Mental Health Illness
☐ Musculoskeletal Problems			

DOES YOUR CHILD HAVE AN IEP (Individualized Education Plan or 504 Plan)? ☐ YES ☐ NO

IS YOUR CHILD PERFORMING AT: ☐ Above Grade Level ☐ Grade level ☐ Below grade level

IF BELOW GRADE LEVEL, PLEASE SELECT THE CLASS (Check all that apply)

☐ Reading ☐ Math ☐ Social Science ☐ Writing ☐ Other _____

IS THE CHILD CURRENTLY RECEIVING ANY OF THE SERVICES BELOW? (Check all that apply)

☐ Special Education ☐ Tutoring ☐ Speech Therapy ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)

LIST ANY OF YOUR CHILD'S HOBBIES OR SPECIAL INTERESTS:

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD?