CAOS Student Personal Information Sheet

Child's Name:_____ Birth Date:_____

Grown Up 1:_____ **Grown Up 2:**_____

In the event that the school needs to communicate with you during the day, please rank your preferred method of communication in the spaces provided below. Please initial to indicate your permission for staff to communicate about your child using non-secure text messaging. _____

Please put an asterisk beside the address and phone number you would like your child to practice (beginning in Pre-K).

Name:_____	Name:_____
Address:_____	Address:_____
City/Zip:_____	City/Zip:_____
_____Home Phone:_____	_____Home Phone:_____
_____Cell Phone:_____	_____Cell Phone:_____
_____Text OK? Y/N List Carrier:_____	_____Text OK? Y/N List Carrier:_____
_____Work Phone:_____	_____Work Phone:_____
Employer:_____	Employer:_____
_____E-mail:_____	_____E-mail:_____

Family: Please list all persons living in the household(s) with the student. Please provide ages of other children in the home:

Name	Nickname	Relationship	Gender	Age

Pets: Please list names and types of your child's pets:_____

_____

Attendance Plan (for DHH students only):

Start Date:_____

Days of Attendance: M T W TH F (circle)

Full Day Part Day (circle)

If Part Day, list arrival time:_____ departure time:_____

EMERGENCY INFORMATION

Pediatrician's Name:_____ Pediatrician's Phone Number:_____

Preferred Hospital:_____

CAOS | CARLE AUDITORY ORAL SCHOOL

CarleHealth

X5470-0425

In-area emergency contacts when parents cannot be reached:

Emergency contacts will be asked for photo ID at pick up

Name:_____ Relationship to Child:_____ Can pick up child? Y N

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Name:_____ Relationship to Child:_____ Can pick up child? Y N

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Name:_____ Relationship to Child:_____ Can pick up child? Y N

Home Phone:_____ Cell Phone:_____ Work Phone:_____

It is your responsibility to inform us in writing if you need to add or remove authorized persons to pick up your child. Please indicate below other persons authorized to pick up your child. Authorized contacts will be asked for photo ID upon pick up.

Name:_____ Relationship to Child:_____ Contact #:_____

Name:_____ Relationship to Child:_____ Contact #:_____

Name:_____ Relationship to Child:_____ Contact #:_____

Known Allergies (Food Allergies will be reported separately):_____

_____

Medical/physical factors that may impact participation in school activities:_____

_____

Please confirm receipt of the tuition policy. I/We plan to:

_____Use Tuition Express (debit or credit cards) _____Apply for exemption

I/We have read and understand the following information.

_____Illness policy
_____Attendance policy
_____Tuition policy
_____Weather closure process
_____Understanding of HIPAA regulations regarding communications
_____Parent handbook
_____University student placements
_____Offsite walks

Please confirm you have read and understand the above:

_____ _____

Signature 1 Signature 2

CAOS Child Fact Sheet

805 W. Park St., Urbana, IL 61801

Child's Full Name (including middle)_____/_____
Nickname

Form Completed By:_____

Family interests and hobbies:_____

Facts about your child:

What are some of your child's likes?_____

What are some of your child's dislikes?_____

Are there some things that can generally make your child mad or sad?_____

What helps calm your child when he/she is upset?_____

Are there any situations that may be difficult for your child?_____

Please list any additional concerns/behaviors specific to your child that the teacher/therapist should know about:_____

Please list any special goals or areas of focus for your child this year:_____

Food Information Form (FIF)

Child's Name:_____ Date Completed:_____

Person Completing the Form/Relationship:_____/_____

Please complete the sections below to provide guidance on your child's interactions with food while enrolled at our school. Please mark in each box to indicate your child's dietary restrictions in each category. Please mark 'none', rather than leaving a box blank, if you do not have dietary restrictions to report in any of the listed areas.

Children may be exposed to a variety of foods during learning activities at the school. Under the family preferences section, please let us know how you would like us to support your child in trying new foods.

Potentially Life-Threatening Food Allergy: ingestion and/ or contact with the food trigger causes an immune system reaction resulting in respiratory distress that is treated using epinephrine. A Food Allergy Emergency Action Plan must be completed by a physician for each life-threatening food allergy. Family will complete the Food Allergy History. Additionally, the staff and family will work together to develop an Individual Health Care Plan.	**Food Sensitivity/ Intolerance:** ingestion of the food triggers undesirable gastrointestinal, skin or behavioural symptoms. A Physician Statement for Food Substitution form is required for each food sensitivity/ intolerance. Family will complete the Food Sensitivity History as well.
Religious Belief: the family's faith dictates avoidance of certain foods or food combinations; examples include avoiding meat on Fridays during Lent for a Catholic family or avoiding pork for a Jewish family. A Family Statement for Food Restriction/ Substitution form is required.	**Family Preference:** any dietary restriction determined by the family; examples include a family's choice to follow a vegetarian diet, avoid food dyes, or choking hazards or limit sugar intake. A Family Statement for Food Restriction/ Substitution form is required. How would you like us to support your child in trying new foods? Please indicate your choice below: ☐ Encourage child to taste food before saying 'no thank you'. ☐ Child can say 'no thank you' without first tasting.

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

Carle Auditory Oral School/Carle Foundation Hospital
Physician Authorization And Permission For Medication Administration

Student's Name:_____ _____ Today's Date:_____
(Last) (First) Birth Date

Student attends the following days/times:_____

Medication is administered following these guidelines:

- Physician/Prescriber signed, dated authorization to administer the medication
- Parent signed, dated authorization to administer the medication
- Medication is in the original labeled contained as dispensed (or the manufacturer's labeled container)

PHYSICIAN AUTHORIZATION:

Medication:	Dosage:
Time to be administered:	Intended effect of this medication:
Expected side effects, if any:	Administration instructions:
Other medications student is taking:	Discontinue/Re-Evaluate/Follow-up Date (circle one):
Physicians Signature:	Date Signed:
Physicians Name:	Physician's Emergency Phone #:

PARENT AUTHORIZATION AND PERMISSION FOR MEDICATION ADMINISTRATION

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorization Carle Auditory Oral School and its employees and agents, on my behalf, to administer or attempt to administer to my child lawfully prescribed medication or over-the-counter medications that I have provided. These medications must be labeled appropriately as follows:

- Prescription medication is administered in accordance with the pharmacy label directions as prescribed by the child's health care provider. Instructions from the child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider.
- Over the Counter medications may be administered in accordance with the product label directions on the container with physician authorization. The instructions from the child's parent/guardian shall not conflict with the product label directions on the container.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Carle Auditory Oral School or Carle Foundation Hospital or its agents and employees arising out of the administration of said medication.

Child's Name:	Date Signed:
Parent/Guardian Signature:	Contact Phone #:

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

CAOS Family Involvement Expectations

Child's Name:_____

Many private schools require parents to commit to a certain number of volunteer hours each year, helping in the classrooms, lunch room, school library or at after school events as part of their tuition agreement. Families who are unable to meet this requirement are often charged an additional fee. CAOS families are spared this requirement, largely due to the tremendous volunteer support that we receive from Carle's Volunteer Office and University of Illinois students. In lieu of this, we ask that families commit to each of the listed activities by initiating each expectation and signing below. Please see the handbook for additional information about each commitment statement.

ALL PARENTS:

_____Read with your children 5 – 7 days per week. Check and respond to information in your child's folder each night.

_____Review your child's journal each night, making entries as requested by your child's teacher.

_____Send morning snack for the school, approximately once every two months, for each enrolled student.

_____Share 3 traditions/ experiences with your child's class per school year.

_____Communicate with your child's teacher, school office or the program director if you have questions, suggestions or concerns about your child's educational program.

_____Participate in Parent Teacher Conferences two to three times per school year.

PARENTS OF CHILDREN WITH HEARING LOSS:

_____Ensure that your child arrives with functioning hearing device(s) on each day of attendance.

_____Ensure that you send extra batteries for your child's hearing device.

_____Ensure that you send troubleshooting equipment, such as earmold cleaning brushes, cochlear implant cables and headpieces, if applicable.

_____Observe or participate in 2 therapy session and 2 classroom lessons per year.

_____Participate in monthly Parent Professional Collaboration Meetings.

We greatly appreciate your support in these areas and realize that our school could not function successfully without you!

_____ _____

Signature 1 Date Signature 2 Date

FAMILY ENGAGEMENT

Please list three traditions you will share with your child's class this school year, the time of year most meaningful for sharing and whether you will be coming into class or providing materials to be shared at school. Please contact your child's teacher or the school office if you have any questions.

Tradition	When?	Provide materials only/provide materials & able to lead the activity

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

CAOS Nap/Quiet Time Information

Child's Name:_____

CAOS staff knows that getting adequate rest is an important part of being ready to learn and play each day. Because of this, a 90 minute nap time is built into the daily schedule for Side 1/**PS students** enrolled in Carle Auditory Oral School. Nap time is not built into the daily schedule for PreK, kindergarten or primary students. If Side 2 kids opt in to nap, they will miss class/learning activities scheduled to occur during their 30 or 60 minute nap time. We will continually monitor the napping procedures and napping behaviors of the children. If requested, families can receive daily notification about sleeping behaviors.

Napping behaviors include whether or not the child fell asleep during the allotted nap time as well as a description of their behavior during the time they are awake in the nap room.

Some children fall asleep quickly, and others more slowly. Some children sleep every day; others only sleep one or two times per week. These normal variances are okay as long as behaviors and noise levels do not detract from other students' ability to fall asleep. As with all processes and procedures at CAOS, nap time management is continually adapted to ensure maximal benefit. Staff will track napping behaviors and if concerns arise, the napper's family will be consulted to develop a plan moving forward. This plan may include development of a behavior plan for individual children, requests for support from home, or exclusion from nap at CAOS, if warranted.

Does your child typically nap? ☐ Yes ☐ No

If yes, what time does your child lay down for a nap?_____

If yes, how long does your child tend to nap?_____

I/We understand the napping procedures.

I/We understand that we may request a summary of my/our child's napping behavior.

I/We understand that CAOS staff will provide this summary if they have a concern about my/our child's napping behaviors.

_____ _____

Signature 1 Date

_____ _____

Signature 2 Date

CAOS | CARLE AUDITORY ORAL SCHOOL

CarleHealth

CAOS Tuition Policy Exception Request Form

Child's Name:_____ Child's Date of Birth:_____

Reason for Tuition Policy Exception Request:_____

_____

Details of Exception Request (I.E. Alternate Date Of EFT Withdrawal, Date/Method of Prepayment, Etc):_____

_____

Course of Action if Exception is Not Granted:_____

_____

_____

I/We understnd that if this exception is granted, that:

_____ Failure to comply with this payment plan will result in my/our child's suspension from the school and child-care programs until tuition is paid in full.

_____ If back tuition is not caught up within one week of suspension, my/our child's spot may be taken by another family.

Parent Signature:_____ Date:_____

Parent Signature:_____ Date:_____

OFFICE USE

Tuition Policy Exception Request:

☐ Approved ☐ Approved with Modifications ☐ Approved

Modifications, if Applicable:_____

_____

OUTLINE OF APPROVED EXCEPTION PAYMENT PLAN

Due Date:_____

Invoice to be Sent?	☐ Yes	☐ No	
Receipt Provided?	☐ Yes	☐ No	
Receipt Provided?	☐ Check	☐ Money Order	☐ Cash

I/We Agree to the Terms Outlined Above:

Signature 1:_____ Date:_____

Signature 2:_____ Date:_____

Staff Signature:_____ Date:_____

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

TUITION Express
ProCare Software

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time! It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

For Bank Account Authorization, complete and return to center management.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) authorize _____, (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

Your Name _____ Phone # _____

Address _____

City _____ State _____ Zip _____

DEPOSITORY - Bank or Credit Union Name _____

Bank or Credit Union Address _____

City _____ State _____ Zip _____

Type: ☐ Checking ☐ Savings

Routing Transit Number (see sample below) _____

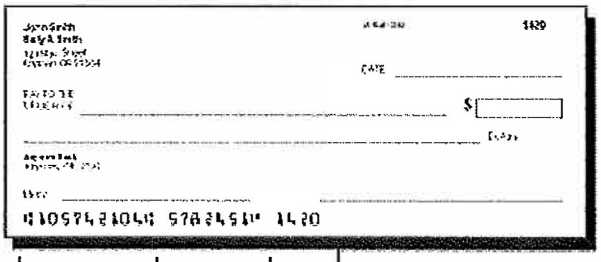
Account Number (see sample below) _____

This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

Signature _____ Date _____

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

*Tuition Express is an assumed business name of Blum Investment Group, Inc.



Please attach a copy of a voided check here. Deposit slips not accepted.

TUITION Express
ProCare Software

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check, or remember your checkbook, as you're picking up your child at the end of a hectic day. Your account will be safely and securely debited by Tuition Express, giving you peace of mind, knowing your tuition is being paid when it's due. It's easy to enroll and even easier to participate. You'll join millions who already pay mortgages, car payments, and childcare tuition automatically. Tuition Express is convenient and safe for you, and it helps us do a better job caring for your child.

Frequently Asked Questions

When I pay my tuition automatically, how secure is my account information?

Very secure – more secure than when you write checks. The checks you write every day have your name, address, phone number, and sometimes your driver's license number on them. With this information, criminals have all they need to access your account or worse, *steal your identity*. Automatic payments greatly reduce this potential problem by limiting the amount of information available and who has access to it. Tuition Express also incorporates additional security procedures, utilizing 128 bit encryption.

What if the childcare center makes a mistake and takes out too much money?

Report the error to your childcare center immediately – it was most likely an honest mistake. The childcare center will then adjust your account accordingly.

What if my childcare center and I disagree about a payment?

If you feel that the payment should not have been made, you have the right to dispute the charge. Contact your bank or credit card company. Tuition Express and your childcare provider will work closely to resolve the issue in a timely manner.

Does this form of payment give the childcare center access to my account?

Nobody at the childcare center has access to your account. When you sign up for Tuition Express, you only authorize *your* bank or credit card company to release the exact amount owed to your provider when it is due and payable.

How will I know when a payment was taken out of my account?

Your childcare expenses will be taken out of your account on a schedule that you and the childcare center agree upon. Your childcare center has the ability to print statements for your records prior to the withdrawal of any money. Additionally, the charges will show up on your monthly statement as "Tuition Express".

When I sign up for Tuition Express, how will this help my childcare provider?

Your childcare provider has chosen to offer Automatic Payments for several reasons. First, it will give you the convenience of not having to write a check every time tuition and fees are due. Second, it allows regular scheduling of your payments. Most importantly, Automatic Payments reduce the amount of time your childcare center spends on management activities, giving staff more time to spend with the children.

How do I get started?

Simply complete the "Payment Authorization" form and return it to your childcare provider. They will do the rest! For more information on automatic payments, visit www.directpayment.org. This is an excellent resource explaining the system and its benefits.

Where can I learn more?

For more information on the benefits of Tuition Express, please visit us at www.tuitionexpress.com.

TuitionExpress.com

Your provider will issue you a unique Tuition Express account number: → **6288-6773-032**

What is Tuition Express?

Tuition Express™ is the premier payment processing service in the childcare industry. As one of the many benefits offered by Tuition Express, parents have the ability to receive their payment receipts via email. TuitionExpress.com keeps parents in-touch with their childcare center and their personal finances. Here are some of the features of TuitionExpress.com:

- Receive all your Payment Receipts via email.
- Email notification of all Non Sufficient Fund (NSF) items or Declined Credit Card transactions.
- View and print Transaction History reports.
- Re-generate past email payment notifications.
- All receipts are Flexible Spending Account qualified (provided center has submitted required data).
- Easy access to change email addresses notifications are sent to.

How to Register at TuitionExpress.com

- Your childcare provider will issue you a unique Tuition Express ID number.
- Go to http://www.tuitionexpress.com and click on "My Account".
- Click the "Click here to Register" link to begin the account set up.
- Enter the Tuition Express ID number and the Last 4 digits of your bank or credit card account number.
- Create a User Name and Password
- Type in your email address and check the box "Receive Notification"
- Click "Submit". When you receive an email from Tuition Express click on the link to confirm your email address.

Facts about Automatic Payments

- Automatic Payments have been around for more than 30 years and uses the same network as Automatic Deposits. More than 2 billion transactions a year are made via Automatic Payment.
- Each Automatic Payment is deducted from your account on the due date of each payment cycle so it is easy to track..
- Automatic Payments are confidential transactions. Just one or two people see them. In contrast, checks pass through three to nine hands as they are processed. PLUS, they have all the information available for a criminal to steal your identity.
- Automatic Payments help you maintain a good credit rating because bills are paid on time, every time.
- Record keeping is easy. Each bill paid automatically from your checking account or credit card is listed on your monthly statement.
- Consumers who use Automatic Payment are protected by the Electronic Funds Transfer Act of 1978, known as Federal Regulation E. www.bankersonline.com/regs/205/205.html
- Automatic Payment saves you money. It costs consumers close to $100 a year in time and Automatic costs, such as postage, to pay bills by check instead of using Automatic Payment.
- Automatic Payments is great for travelers — since bills are paid automatically, you do not have to worry about them when you are out of town.

Media Authorization Consent to Release Information (CAOS)

Name:_____ MRN/Badge#:_____ Date of Birth:_____/_____/_____

Phone:_____ E-mail Address:_____

Street Address:_____ City:_____ State:_____ Zip:_____

Throughout this document the reference to "Carle" collectively refers to Carle Health including Carle Foundation Hospital, Carle Physician Group, Carle Hoopeston Regional Health Center, Carle Richland Memorial Hospital, Carle BroMenn Medical Center and Carle Eureka. I authorize **Carle** to **release information** about me as follows:

1. **Carle** may use and/or disclose the information described below to the general public, through media, Carle publications or in other public venues including, but not limited to, print materials, social media, radio, television, and the internet.

2. I understand that the **purpose** of the disclosure(s) is for Carle's own marketing activities and/or general public information, awareness, education, and/or fundraising.

3. **Specific Records and/or Information** to be disclosed verbally, in writing or electronically, as the case may be: photos, videos, and/or audio recordings and transmissions of me/my child and reproductions of the same, beginning on date of enrollment at Carle Auditory Oral School.

4. **Revocation, Re-disclosure, & Expiration.** I understand that I may revoke this authorization at any time by submitting a written request to the Marketing & Communications department at 611 W. Park Street, Urbana, IL 61801, unless Carle has already acted upon my authorization. I understand that my revocation only applies to uses and disclosures of my personal information by Carle. I further understand that any information already disclosed pursuant to this authorization is no longer protected by the laws and regulations applicable to Carle, and may be subject to re-disclosure. Unless specified otherwise by me, this Authorization will have no expiration date.
   (Optional expiration date/event:_____).

5. I understand that my authorization to disclose the above information is **voluntary**, and Carle will not condition the provision of treatment or payment on this authorization.

6. **I waive any right to inspect or approve** the material prior to its use. All reproductions of my medical or personal information shall remain the property of Carle and may be edited prior to use. Furthermore, I release Carle, their licenses, agents, successors and assigns from any and all claims for damages for libel, slander, invasion of privacy or any other claim based upon the use and/or disclosure of my information.

COPY OF THIS AUTHORIZATION: I have been offered a copy of this authorization for my records.

_____ _____

Signature (Parent/Guardian/Authorized Signature where applicable) *Date*

_____ _____

Authority to Sign, if not the Patient/Employee *Date*

Carle

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

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

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **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**

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten, second, sixth, and ninth grades of any public, private, or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign, and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that require attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy, and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print)

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)

Address: Street	City	ZIP Code

Name of School:	ZIP Code	Grade Level:

Parent or Guardian: Last Name First Name

Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races

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To be completed by dentist

Date of Most Recent Examination:_____ (Check all services provided at this examination date)
☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

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

Treatment Needs (check all that apply). Please list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Dental Office Address: _____ Office phone number: _____

Signature of Dentist _____ Date _____

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ☐ Normal or Positive for _____

Medical history: ☐ Normal or Positive for _____

Drug allergies: ☐ NKDA or Allergic to _____

Other information _____

Examination

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	☐	☐	☐	_____
Internal exam (vitreous, lens, fundus, etc.)	☐	☐	☐	_____
Pupillary reflex (pupils)	☐	☐	☐	_____
Binocular function (stereopsis)	☐	☐	☐	_____
Accommodation and vergence	☐	☐	☐	_____
Color vision	☐	☐	☐	_____
Glaucoma evaluation	☐	☐	☐	_____
Oculomotor assessment	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other _____

Continued on back

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes
   Comments _____
   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months
   ❑ Other _____

4. _____

5. _____

Print name _____
Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number _____

Address _____
_____

Phone _____

Consent of Parent or Guardian
I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois

IOCI 15-391

CAOS Permission for Emergency Treatment (Must be Notarized)

Please do not sign yet. Your signature must be witnessed by the notary.

You have my permission to proceed with any treatment necessary to care for my child in case of illness or injury including treatment related to the standing protocols for non-designated epinephrine and non-designated albuterol while attending Carle Auditory Oral School.

Signature of Parent/Guardian:_____ Date:_____

In the state of _____, and the county of _____, on this_____day of _____, 20____, before me personally appeared,_____known to be the person described in and who executed the foregoing instrument, and acknowledged that he/she executed that same as his/her free deed and act.

In testimony whereof, I hereunto subscribe my name and affix my official seal at my office in_____ _____, the day and year first above written.

My commission expires: _____
Signature of Notary Public:_____

CAOS | CARLE AUDITORY ORAL SCHOOL

CarleHealth

CAOS Academic Tuition and Summer Camp Costs 2025-2026

Academic Tuition Costs for First Child

Academic tuition covers participation in class activities between approximately 9 a.m. and 3 p.m. Monday through Friday.

	Number of Days	Annual Cost	Biweekly Cost	Daily Cost
School Program Preschool through Second Grade for the First Child	200	10,703.76	535.19	53.52
Snack Fee	200	$110.00	$5.50	$0.55

Summer Camp Costs for First Child

	Number of Days Care is Available	Annual Cost	Monthly Cost	Biweekly Cost	Daily Cost
Summer Camp ($56.81/day) Open for 17 days in July. Hours of Summer Camp are 7 a.m. - 5:15 p.m.	17	N/A	994.74	497.37	58.51

Tuition billing is processed every two weeks on Fridays. Automatic payments through Tuition Express are deducted at this time.

Carle employees receive a 10% discount for each child who attends Carle Auditory Oral School. The sibling discount is available to Carle employees, though it should be noted that the ten percent sibling discount is calculated after the employee discount is applied.

Sibling Discounts - All families will receive 10% off tuition and summer camp for any additional children attending the school.

Child Care Resource Service offers financial support so that families with lower incomes can access high quality programs for their children while they work or attend school. Our school is credentialed with CCRS. Individual families can apply to CCRS to determine whether their income and family size qualifies for CCRS support. Eligible families will be assigned a monthly family co-pay. The CCRS payment, and assigned co-pay, are deducted from the cost of attendance. The family pays the difference between the full cost and the CCRS payment and co-pay. For example, if CCRS paid $35/day and family co-pay covered $5/day, the family would be responsible for the remaining $11.96/day plus any needed before / after care.

Academic Tuition Costs for Additional Children

Academic tuition covers participation in class activities between approximately 9 a.m. and 3 p.m. Monday through Friday.

	Number of Days	Annual Cost	Biweekly Cost	Daily Cost
School Program Preschool through Second Grade for the First Child	200	$9,633.38	$481.67	$48.17
Snack Fee	200	$110.00	$5.50	$0.55

Summer Camp Costs for Additional Children

	Number of Days Care is Available	Annual Cost	Monthly Cost	Biweekly Cost	Daily Cost
Summer Camp Open for 17 days in July. Hours of Summer Camp are 7 a.m. - 5:15 p.m.	17	N/A	$895.77	$447.63	$52.66

*Your actual cost will be determined by the amount, timing and type of child care you reserve.

CAOS | CARLE AUDITORY ORAL SCHOOL

Carle

One Drive Permission Form

Dear CAOS Parents,

CAOS staff created the CAOS One Drive to be an online location where parents and staff can collaborate, share materials and updates with one another. Please sign below to give permission for the creation of a folder for your child. Once permission is granted, access to that folder will be shared with the child's team (i.e., parents, deaf educator, and therapists). Each member of the team can read information, add their own updates and provide input into goal selection. This collaboration used to occur on the Google Drive but has now shifted to Microsoft One Drive.

If you choose to opt out of the CAOS One Drive, you will still receive monthly newsletter updates and can provide input via email or phone calls. If you have questions, please contact Danielle.

Thank you for your time and collaboration!

CAOS Staff

Child's Name:

I understand that a folder for my child will be created and added to the CAOS One Drive, that the drive will contain information about my child's test scores, monthly targets and progress toward achieving those targets, and that my child's team will be invited to read and edit the documents in my child's folder. Further, I understand that the One Drive is outside Carle's encrypted network, but is protected by Microsoft security measures and each user needs to be invited to collaborate by CAOS staff.

Please carefully read the statements below, mark that statement that represents your decision about the CAOS One Drive for the coming school year.

Yes, I grant permission for CAOS staff to create a folder for my child on the CAOS One Drive.	
Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

No, I do not grant permission for CAOS staff to create a folder for my child on the CAOS One Drive.	
Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

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CarleHealth