

# **Application Packet**

**Initial Foster Family Home License:**

**Relative Caregivers**

Revised: November 2014

## **FOSTER FAMILY HOME LICENSE APPLICATION FOR RELATIVE CAREGIVERS**

(Si usted prefiere esta aplicación en Español por favor solicítela a su trabajador)

**Part 402, Licensing Standards for Foster Family Homes**, which is available on the DCFS Website at [http://www.state.il.us/dcfs/policy/pr\\_policy\\_rules\\_PDF.shtml](http://www.state.il.us/dcfs/policy/pr_policy_rules_PDF.shtml), provides a detailed description of the requirements for becoming licensed as a foster family home. Many of the requirements for becoming licensed can be waived, however the requirement to get fingerprinted cannot be waived.

Also enclosed are the forms that must be completed to apply for a foster home license.

- Application Form (CFS 597R) - - - This is the actual application form.
- Authorization for Background Check (CFS 718-RL) - - - Everyone living in the home who is age 13 or older must complete and sign a CFS 718-RL form to authorize a background check of the following records: the Illinois Child Abuse/Neglect Registry, the Illinois Sex Offender Registry, the Illinois Criminal History Records, and the FBI, when needed. (Related children who have been placed in the home do not need to complete a CFS 718-RL or get fingerprinted.)
- Medical Report(s) On All Members of the Household - - - It is the applicant(s)' responsibility to schedule and insure that a medical examination is completed for every member of the household (both adults and children). A **CFS 600, Certification of Child Health Examination**, must be completed for each child in the home; a **CFS 604, Medical Evaluation of an Adult in a Foster or Adoptive Home**, must be completed for each adult in the home. (*Note:* If you have a school medical report on a child and that report is less than one year old, the report of that examination may be attached to the application instead of the CFS 600.)

### **Steps in the License Application Process**

#### **1. Complete and Sign the Application Form (CFS 597R)**

License applicants should read the instructions on page 4 of the Application form, fill in the requested information, answer all questions completely, and sign and date the application form.

#### **2. Make Arrangements to Be Fingerprinted**

Every person living in the home who is age 18 and older must:

- complete and sign a CFS 718-RL (Authorization for Background Check) form; and
- call **1-866-361-9944** to make arrangements to be fingerprinted.

The person being fingerprinted must bring their valid government identification card.

After the fingerprinting is completed, the fingerprint technician will give the individual a receipt to verify that he or she was fingerprinted.

#### **3. Attach ALL Fingerprint Receipts to Application Form and Mail to Licensing**

The CFS 718-RL and every receipt must be attached to the application (CFS 597R), in order for the licensing worker to know that everyone who needs to be fingerprinted has been fingerprinted so the licensing worker can then process the application.



**II. CURRENT AND PREVIOUS LICENSES**

1. Have you ever been convicted for other than a minor traffic violations?  No  Yes  
If yes, explain \_\_\_\_\_
2. Are you currently licensed for child care in Illinois?  No  Yes  
If yes, give type of license(s) and license(s) No(s) \_\_\_\_\_  
Name on license(s) \_\_\_\_\_  
Address on license(s) \_\_\_\_\_
3. Have you ever been licensed for child care outside Illinois?  No  Yes  
If yes, give type of license(s) and the license(s) No(s) \_\_\_\_\_  
Name on license(s) \_\_\_\_\_  
Address on license(s) \_\_\_\_\_
4. If you are not currently licensed for child care, complete the question below:  
Have you ever applied for a child care license?  No  Yes  
Was license issued?  No  Yes  
Name on license \_\_\_\_\_  
Address on license \_\_\_\_\_

**III. HOME**—Check any boxes that apply

- Do You  Own  Rent  
 Apartment  Mobile Home  House  Other (Specify) \_\_\_\_\_
- Do you have landlord approval to care for related children?  Yes  No  
 Water supply  City  Other (Specify) \_\_\_\_\_  
 Directions for reaching your home: \_\_\_\_\_  
 \_\_\_\_\_

**IV. MARITAL STATUS**—Check One Box

- Married \_\_\_\_\_ (Date)  Civil Union \_\_\_\_\_ (Date)  
 Single  Widowed  
 Divorced  Legally Separated

**V. MEMBERS OF HOUSEHOLD** (include Children, Relatives, Others)

NAME	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY or ITIN NUMBER	RELIGION
Applicant A:				
Applicant B:				

**VI. CURRENT EMPLOYMENT**

	Name of Firm	Address	Title or Position	Working Hours
Applicant A				____ to ____
Applicant B				____ to ____

IF APPLICANT(S) WORK OUTSIDE OF HOME, DESCRIBE CHILD CARE PLANS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**VII. REFERENCES:** Persons unrelated to you who know how you care for children

1. Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_
3. Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

**IF EITHER APPLICANT HAS BEEN AN ILLINOIS RESIDENT FOR LESS THAN FIVE YEARS, INCLUDE TWO REFERENCES FROM THE PREVIOUS RESIDENCE STATE:**

4. Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_
5. Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

**VIII. CERTIFICATION**

I (WE), the undersigned, hereby apply for license to operate a foster family home under the Child Care Act of 1969 as amended. I (WE) declare that, I(WE):

1. Have received a copy of the standards for foster family homes, have read them and are familiar with them.
2. Will be subject to and cooperate with the supervising agency in the licensing process to determine my/our compliance with licensing standards.
3. Will be subject to supervision in terms of conformance with minimum standards upon issuance of a license.
4. Affirm that the information provided above is true. I(WE) understand that making materially false statements in order to obtain a license or permit constitutes a Class A misdemeanor and that I(WE) may be prosecuted for such misconduct.

**SIGNATURE(S)**

\_\_\_\_\_  
Applicant A

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Applicant B

\_\_\_\_\_  
DATE

**INSTRUCTIONS FOR APPLICATION FOR FAMILY HOME LICENSE**

**Name of Applicant(s)**

Enter the name(s) of the person(s) who are applying to be licensed as foster parent(s). Enter the social security or individual taxpayer identification (ITIN) number of each person listed in the spaces provided.

**Address**

Enter the complete address of the home’s actual location.

**Mailing Address**

Use ONLY when the mailing address is different from the actual location of the home.

**Telephone Number**

Enter the area code and phone number of the home and work telephone if applicable.

All applicants should verify the statements above and sign.

If there is one applicant, he/she must sign the form. If there are joint/married applicants, both must sign.

<p>DCFS is an equal opportunity employer, and prohibits unlawful discrimination in all of its programs and/or services.</p>
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**FOSTER FAMILY HOME INFORMATION**

I. NAME: Applicant A \_\_\_\_\_  
(Last) (First) (Middle)

Applicant B \_\_\_\_\_  
(Last) (First) (Middle)

ADDRESS: \_\_\_\_\_  
(Street or Rural Route)

\_\_\_\_\_  
(City) (Zip Code) (County) (Telephone)

How long have you been a resident of Illinois? Applicant A: \_\_\_\_\_ Applicant B: \_\_\_\_\_  
(Months) (Years) (Months) (Years)

II. HOME—Check any boxes that apply

DO YOU  OWN  RENT LANDLORD APPROVAL TO CARE FOR UNRELATED CHILDREN  YES  NO  
 APARTMENT  MOBILE HOME  HOUSE  OTHER \_\_\_\_\_

WATER SUPPLY  CITY  OTHER (Specify) \_\_\_\_\_

DIRECTIONS FOR REACHING YOUR HOME: \_\_\_\_\_

III. MARITAL STATUS—Check One Box

MARRIED \_\_\_\_\_  
(Date)

CIVIL UNION \_\_\_\_\_  
(Date)

SINGLE  WIDOWED  
 DIVORCED  LEGALLY SEPARATED

PROVIDER ID# _____
Licensing Rep. _____
R/S/F _____

IV. MEMBERS OF HOUSEHOLD

(include Children, Relatives, Others)

NAME	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY OR ITIN NUMBER	RELIGION
Applicant A:				
Applicant B:				
Other Adult/Child:				

Language(s) Spoken \_\_\_\_\_

V. CURRENT EMPLOYMENT

Name of Firm	Address	Title or Position	Working Hours	Years Employed
Applicant A			_____ to _____	
Applicant B			_____ to _____	

Approximate Annual Income of Total Household, Regardless of Sources: \_\_\_\_\_

\_\_\_\_\_

IF APPLICANT(S) WORK OUTSIDE OF HOME, DESCRIBE CHILD CARE PLANS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VI. DESCRIBE YOUR EXPERIENCE WITH CHILDREN OTHER THAN YOUR OWN. THESE MAY INCLUDE CARE OF RELATIVE'S CHILDREN, TEACHING SUNDAY SCHOOL, WORK WITH SCOUTS OR OTHER GROUPS, ETC.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

WHY DO YOU WANT TO PROVIDE CHILD CARE? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

STATE THE AGE RANGE, SEX, AND NUMBER OF CHILDREN YOU WOULD LIKE TO HAVE IN YOUR HOME:

\_\_\_\_\_  
\_\_\_\_\_

VII. REFERENCES: **You must list at least three (3) persons unrelated to you who know how you care for children**

1. Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

2. Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

3. Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

IF EITHER APPLICANT HAS BEEN AN ILLINOIS RESIDENT FOR LESS THAN FIVE YEARS, INCLUDE TWO REFERENCES FROM THE PREVIOUS RESIDENCE STATE:

4. Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

5. Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

I/WE CERTIFY THAT THE ABOVE INFORMATION IS TRUE. I/WE UNDERSTAND THAT MAKING MATERIALLY FALSE STATEMENTS IN ORDER TO OBTAIN A LICENSE OR PERMIT CONSTITUTES A CLASS A MISDEMEANOR AND THAT I/WE MAY BE PROSECUTED FOR SUCH MISCONDUCT.

\_\_\_\_\_  
Signature (Applicant A)

\_\_\_\_\_  
Signature (Applicant B)

\_\_\_\_\_  
Date

**STATE OF ILLINOIS**  
**DEPARTMENT OF CHILDREN AND FAMILY SERVICES**  
**Medical Evaluation of an Adult in a Foster or Adoptive Home**

Form Distribution  
- Licensing worker/supervisor  
- Kept in a sealed envelop in the  
licensing file and marked  
"CONFIDENTIAL"

Name of Person Examined: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ How long have you been treating this patient? \_\_\_\_\_

**This form will aid the Department in determining the physical wellness and capabilities of adults in foster or adoptive homes who are or may be caring for children. Please complete the following summary of health problems, conditions, and medication use that may affect the adult's ability to maintain alertness, endurance, and performance of tasks and responsibilities associated with caring for up to six children, ages 0 to 18 now and for the foreseeable future (five to ten years). If you have any medical or health questions or concerns, please call the Department of Children and Family Services at 312-814-5693.**

I am available to discuss further health concerns

Concerns or questions about confidentiality issues may be address to:

\_\_\_\_\_  
Name Phone

**I. HISTORY**

1. Check any health problems:

- |  |  |  |                                    |
|--|--|--|------------------------------------|
| <input type="checkbox"/> Heart Problems      | <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Depression        | <input type="checkbox"/> Tremors   |
| <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> Obesity         | <input type="checkbox"/> Sleep Disorder    | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Poor Ambulation | <input type="checkbox"/> Confusion         | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weak/Frail      | <input type="checkbox"/> Dementia          |                                    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Vision          | <input type="checkbox"/> Epilepsy/Seizures |                                    |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Hearing         | <input type="checkbox"/> Strokes/Paralysis |                                    |

Explain *all* medical condition(s) checked and any other chronic conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are there any condition(s) that are progressive in nature? Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next \_\_\_5 years, \_\_\_10 years \_\_\_15 years? If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Medication(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any physical limitations as a result of medication(s)? Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Illness/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

5. Health Habits

Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

Alcohol  \_\_\_\_\_ Drugs  \_\_\_\_\_
Tobacco  \_\_\_\_\_ Other  \_\_\_\_\_

6. Date \_\_\_\_\_ Result of Tuberculin Test (initial exam only): \_\_\_\_\_

7. Date \_\_\_\_\_ Result of Chest X-Ray (if necessary): \_\_\_\_\_

II. PHYSICAL EXAMINATION

Summary of abnormal physical findings that would affect caring for a child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

- 1. Lift a child: Under 6 months Yes  No  6 months to 3 years Yes  No 
2. Walk/maneuver 50-100 feet without major difficulties: Yes  No 
3. Bend/stoop, kneel, reach: Yes  No 
4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes  No 
If Yes, what type? \_\_\_\_\_
5. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to:

Table with 4 columns: Condition, Yes, No, Don't Know. Rows include Lift from a bed to chair, etc., Frequent Feedings, Frequent Suctions, Frequent Monitoring, Frequent Medication, Frequent Nebulizations, Frequent Treatments.

Are any limiting conditions temporary? Yes  No

If yes, which condition(s): \_\_\_\_\_

For each condition, how long will the limitation exist? \_\_\_\_\_

I certify that this individual is found free from symptoms of communicable disease.

Yes  No  If No, explain: \_\_\_\_\_

I certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting.

Yes  No  If No, explain: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

State License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

**STATE OF ILLINOIS**  
**DEPARTMENT OF CHILDREN AND FAMILY SERVICES**  
**Medical Evaluation of an Adult in a Foster or Adoptive Home**

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**I. HISTORY**

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|--|--|--|------------------------------------|
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| <input type="checkbox"/> Lung Problems       | <input type="checkbox"/> Obesity         | <input type="checkbox"/> Sleep Disorder    | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Poor Ambulation | <input type="checkbox"/> Confusion         | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Weak/Frail      | <input type="checkbox"/> Dementia          |                                    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Vision          | <input type="checkbox"/> Epilepsy/Seizures |                                    |
| <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Hearing         | <input type="checkbox"/> Strokes/Paralysis |                                    |

Explain *all* medical condition(s) checked and any other chronic conditions:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Are there any condition(s) that are progressive in nature? Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

3. Is there a terminal illness that could interfere with this person's ability to care for a child in the next \_\_\_5 years, \_\_\_10 years \_\_\_15 years? If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Medication(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are there any physical limitations as a result of medication(s)? Yes  No

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Illness/Injuries, Operations or Hospitalizations during the last 5 years:

Illness/Injury	Operation	Hospitalization	Date	Outcome

5. Health Habits

Is there a history of substances used by the applicant and what degree of impairment exists, if any, from the substance use?

Alcohol  \_\_\_\_\_ Drugs  \_\_\_\_\_
Tobacco  \_\_\_\_\_ Other  \_\_\_\_\_

6. Date \_\_\_\_\_ Result of Tuberculin Test (initial exam only): \_\_\_\_\_

7. Date \_\_\_\_\_ Result of Chest X-Ray (if necessary): \_\_\_\_\_

II. PHYSICAL EXAMINATION

Summary of abnormal physical findings that would affect caring for a child:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

III. PHYSICAL CAPABILITIES

In your medical opinion could your patient physically be able to:

- 1. Lift a child: Under 6 months Yes  No  6 months to 3 years Yes  No 
2. Walk/maneuver 50-100 feet without major difficulties: Yes  No 
3. Bend/stoop, kneel, reach: Yes  No 
4. Is an assistive device needed to walk, bend/stoop, kneel, or reach? Yes  No 
If Yes, what type? \_\_\_\_\_
5. Are there any medical conditions which limit this person's physical ability to care for a medically complex child which may include the ability to:

Table with 4 columns: Condition, Yes, No, Don't Know. Rows include Lift from a bed to chair, etc., Frequent Feedings, Frequent Suctions, Frequent Monitoring, Frequent Medication, Frequent Nebulizations, Frequent Treatments.

Are any limiting conditions temporary? Yes  No

If yes, which condition(s): \_\_\_\_\_

For each condition, how long will the limitation exist? \_\_\_\_\_

I certify that this individual is found free from symptoms of communicable disease.

Yes  No  If No, explain: \_\_\_\_\_

I certify that the individual has no physical or cognitive limitations that would prevent her/him from parenting.

Yes  No  If No, explain: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

State License Number: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_



## State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED  
CHILD CARE FACILITIES  
CFS 600  
Rev 11/2013



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

**IMMUNIZATIONS:** To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA YR		
	<b>DTP or DTaP</b>																	
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>								
<b>MMR</b> Combined Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>											
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> Meningococcal, Hepatitis A, HPV, Influenza																		

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

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**ALTERNATIVE PROOF OF IMMUNITY**

1. Clinical diagnosis is acceptable if verified by physician. \*(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

\*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

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

Date of Disease	Signature	Title	Date
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3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella  
Lab Results Date MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN													
<b>Date</b>													<b>Code:</b> P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
<b>Age/Grade</b>													
	R	L	R	L	R	L	R	L	R	L	R	L	
<b>Vision</b>													
<b>Hearing</b>													

<b>Student's Name</b> Last First Middle	<b>Birth Date</b> Month/Day/ Year	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

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

<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ (Blood test required if resides in Chicago.)				
<b>TB SKIN OR BLOOD TEST</b> 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. <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/>				
<b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____				

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist ) <input type="checkbox"/> Controllor medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> Needs/Restrictions
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**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

**MENTAL HEALTH/OTHER** Is there anything else the school should know about this student?  
If you would like to discuss this student's health with school or school health personnel, check title:  Nurse  Teacher  Counselor  Principal

**EMERGENCY ACTION** needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?  
Yes  No  If yes, please describe.  
On the basis of the examination on this day, I approve this child's participation in \_\_\_\_\_ (If No or Modified,please attach explanation.)

**PHYSICAL EDUCATION** Yes  No  Modified  **INTERSCHOLASTIC SPORTS** (for one year) Yes  No  Limited

Print Name	(MD,DO, APN, PA) Signature	Date
Address	Phone	

(Complete both sides)



## State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED  
CHILD CARE FACILITIES  
CFS 600  
Rev 11/2013



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

**IMMUNIZATIONS:** To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA YR		
	<b>DTP or DTaP</b>																	
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>								
<b>MMR</b> Combined Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>											
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> Meningococcal, Hepatitis A, HPV, Influenza																		

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

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**ALTERNATIVE PROOF OF IMMUNITY**

1. Clinical diagnosis is acceptable if verified by physician. \*(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

\*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

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

Date of Disease	Signature	Title	Date
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3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella  
Lab Results Date MO DA YR (Attach copy of lab result)

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

Date											<b>Code:</b>		
Age/Grade												P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
	R	L	R	L	R	L	R	L	R	L	R		L
Vision													
Hearing													

<b>Student's Name</b> Last First Middle	<b>Birth Date</b> Month/Day/ Year	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

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

<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ (Blood test required if resides in Chicago.)				
<b>TB SKIN OR BLOOD TEST</b> 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. <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/>				
<b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____				
<b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____				

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist ) <input type="checkbox"/> Controllor medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> Needs/Restrictions
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**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

**MENTAL HEALTH/OTHER** Is there anything else the school should know about this student?  
If you would like to discuss this student's health with school or school health personnel, check title:  Nurse  Teacher  Counselor  Principal

**EMERGENCY ACTION** needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?  
Yes  No  If yes, please describe.  
On the basis of the examination on this day, I approve this child's participation in \_\_\_\_\_ (If No or Modified,please attach explanation.)

**PHYSICAL EDUCATION** Yes  No  Modified  **INTERSCHOLASTIC SPORTS** (for one year) Yes  No  Limited

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

**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

(Complete both sides)



## State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED  
CHILD CARE FACILITIES  
CFS 600  
Rev 11/2013



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

**IMMUNIZATIONS:** To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA YR		
	<b>DTP or DTaP</b>																	
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>								
<b>MMR</b> Combined Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>											
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> Meningococcal, Hepatitis A, HPV, Influenza																		

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

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**ALTERNATIVE PROOF OF IMMUNITY**

1. Clinical diagnosis is acceptable if verified by physician. \*(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

\*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

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

Date of Disease	Signature	Title	Date
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3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella  
Lab Results Date MO DA YR (Attach copy of lab result)

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

Date											<b>Code:</b>		
Age/Grade												P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
	R	L	R	L	R	L	R	L	R	L	R		L
Vision													
Hearing													

<b>Student's Name</b> Last First Middle	<b>Birth Date</b> Month/Day/ Year	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

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

<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ (Blood test required if resides in Chicago.)				
<b>TB SKIN OR BLOOD TEST</b> 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. <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/>				
<b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____				

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist ) <input type="checkbox"/> Controllor medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> Needs/Restrictions
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**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

**MENTAL HEALTH/OTHER** Is there anything else the school should know about this student?  
If you would like to discuss this student's health with school or school health personnel, check title:  Nurse  Teacher  Counselor  Principal

**EMERGENCY ACTION** needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?  
Yes  No  If yes, please describe.  
On the basis of the examination on this day, I approve this child's participation in \_\_\_\_\_ (If No or Modified,please attach explanation.)

**PHYSICAL EDUCATION** Yes  No  Modified  **INTERSCHOLASTIC SPORTS** (for one year) Yes  No  Limited

Print Name	(MD,DO, APN, PA) Signature	Date
Address	Phone	

(Complete both sides)



## State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED  
CHILD CARE FACILITIES  
CFS 600  
Rev 11/2013



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

**IMMUNIZATIONS:** To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA YR		
	<b>DTP or DTaP</b>																	
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>								
<b>MMR</b> Combined Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>											
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> Meningococcal, Hepatitis A, HPV, Influenza																		

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

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**ALTERNATIVE PROOF OF IMMUNITY**

1. Clinical diagnosis is acceptable if verified by physician. \*(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

\*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

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

Date of Disease	Signature	Title	Date
-----------------	-----------	-------	------

3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella  
Lab Results Date MO DA YR (Attach copy of lab result)

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

Date											<b>Code:</b>		
Age/Grade												P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
	R	L	R	L	R	L	R	L	R	L	R		L
Vision													
Hearing													

<b>Student's Name</b> Last First Middle	<b>Birth Date</b> Month/Day/ Year	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
--	--------------------------------------	------------	---------------	--------------------------

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

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

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

<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ (Blood test required if resides in Chicago.)				
<b>TB SKIN OR BLOOD TEST</b> 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. <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/>				
<b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____				

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist ) <input type="checkbox"/> Controllor medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> Needs/Restrictions
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**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

**MENTAL HEALTH/OTHER** Is there anything else the school should know about this student?  
If you would like to discuss this student's health with school or school health personnel, check title:  Nurse  Teacher  Counselor  Principal

**EMERGENCY ACTION** needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?  
Yes  No  If yes, please describe.  
On the basis of the examination on this day, I approve this child's participation in \_\_\_\_\_ (If No or Modified,please attach explanation.)

**PHYSICAL EDUCATION** Yes  No  Modified  **INTERSCHOLASTIC SPORTS** (for one year) Yes  No  Limited

Print Name \_\_\_\_\_ (MD,DO, APN, PA) Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

(Complete both sides)

Illinois Department of Children and Family Services  
**AUTHORIZATION FOR BACKGROUND CHECK**  
**For UNLICENSED HOME OF RELATIVE**

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

<b>1</b>	<input type="checkbox"/> <b>PRIVATE AGENCY</b> or <input type="checkbox"/> <b>DCFS</b>	Name of Agency _____ Case ID # _____ Provider# _____ Interstate Office (ICPC) # _____		
	<input type="checkbox"/> Unlicensed Relative Placement	<input type="checkbox"/> Unlicensed Relative Adoption		

**PERSONAL INFORMATION**

<b>2</b>	Last Name/First Name/Middle Initial _____				Social Security Number or ITIN Number _____						
	Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____				I am or will be a foster family household member. <input type="checkbox"/> Yes <input type="checkbox"/> No I am or will be transporting foster children. <input type="checkbox"/> Yes <input type="checkbox"/> No If both statements are yes, list your Drivers License number here: _____						
	CURRENT ADDRESS Street/Apt.#: _____ City: _____ State: _____ Zip Code: _____ County: _____ Telephone (Including Area Code) ( _____ ) _____ - _____				Have you lived outside of Illinois in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No List all previous addresses for the past five (5) years including Illinois. (Street/Apt.#/City/County/State/Zip Code) _____ Dates From/To _____ _____ _____ _____						
	Date of Birth (Month/Date/Year) _____-_____-____	Age _____	Place of Birth (City and State) _____	Citizenship (Country) <input type="checkbox"/> USA <input type="checkbox"/> Other Specify _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height Ft. In.	Weight (lbs.)	Hair (color)	Eyes (color)	Skin Tone	Race

**AUTHORIZATION /CERTIFICATION**

<b>3</b>	Have you ever been indicated as perpetrator in a child abuse/neglect investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been convicted of a criminal offense, other than a minor traffic violation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	I certify that I have read and understood the Authorization/Certification box on the back page of this form.	
	SIGNATURE _____	DATE _____
	Parent/Guardian Signature (if applicable) _____	DATE _____

<b>4</b>	<b>BACKGROUND RESULTS</b>	<b>FOR CENTRAL OFFICE OF LICENSING USE</b>
	Sex Offender Result : _____	SID# _____
	CANTS Result : _____ / Out of State: ISP Fingerprint: _____ FBI Fingerprint: _____	

<b>5</b>	<b>TO BE COMPLETED BY WORKER</b>	
	This authorization form will not be processed without completion of this section.	
	Date Fingerprinted: _____	
	Provider's Full Name and ID # _____	
	Worker's Name and ID # _____	
	Worker's Phone Number ( ) _____ - _____	
Worker's Office Address: _____		
Supervisor's Name and ID # _____		

**INSTRUCTIONS FOR COMPLETION OF  
CFS 718-RL - AUTHORIZATION FOR BACKGROUND CHECK**

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*Do not send a request for a Child Abuse/Neglect Tracking System (CANTS) check to Central Licensing until the person has been fingerprinted.*

**SECTION 1** – Please indicate if the relative applying for foster home license will be under the supervision of a private agency (CWA) or under direct supervision of DCFS.

**SECTIONS 2 AND 3 - COMPLETION OF IDENTIFICATION INFORMATION**

All identifying information must be accurate and complete.

**PRINT ALL INFORMATION**

- Name Current and all former names used by the individual must be included. If no other names, write "none."
- Social Security or ITN No. **THIS FORM WILL NOT BE PROCESSED WITHOUT A COMPLETE SOCIAL SECURITY NUMBER OR INDIVIDUAL TAXPAYER IDENTIFICATION (ITIN) NUMBER**
- Address Current and all addresses, including county, where the person has lived in the past **five** years (If outside of Illinois, check appropriate box)
- Race : Enter all codes that apply
- |          |   |
|----------|---|
| BL/AA    | Black or African American                             |
| WHITE    | White   |
| AI/AN    | American Indian or Alaskan Native                     |
| ASIAN    | Asian   |
| NH/PI    | Native Hawaiian or Other Pacific Islander             |
| UNDET    | Undetermined  |
| HISP ORG | Indicate whether the individual is of Hispanic origin |

The person completing the identification information must sign and date page 1 of the authorization form.

**AUTHORIZATION/CERTIFICATION**

I authorize the Illinois Department of Children and Family Services to conduct an investigation to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I authorize the Department to request information and assistance from the U.S. Justice Department and the Illinois Department of Law Enforcement in the conduct of this investigation. I authorize the Department to periodically search the Child Abuse and Neglect Tracking System to determine whether I have been a perpetrator of an "indicated" incident of child abuse or neglect pursuant to the Abused and Neglected Child Reporting Act. If I am applying for a foster home license, I authorize the Department of Children and Family Services to obtain information from those entities to which I had applied for license or supervision of license, regarding licensing violations or removal of children from my home. If I am or will be a member of a foster family household and will be transporting foster children, I authorize the Department to conduct periodic checks of my driver's license and driving record through the Secretary of State. The child abuse and neglect background check and the criminal history investigation may be used for considering an application for license, current or prospective employment, or service as a volunteer in a child care facility. Persons 13-17 years of age signing this form authorize a search of CANTS and LEADS only and are not subject to fingerprinting.

I understand that information obtained as a result of my authorizing this investigation is confidential and may be shared with my placement worker or with licensing staff only in accordance with applicable state and federal law and DCFS Regulations. I further certify that the information provided on this form is true and correct. I acknowledge that falsification of any information provided above and/or the results of the background check may be full and sufficient grounds to deny my application for licensure or may result in the termination of my employment.

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Illinois Department of Children and Family Services  
**AUTHORIZATION FOR BACKGROUND CHECK**  
**For UNLICENSED HOME OF RELATIVE**

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

<b>1</b>	<input type="checkbox"/> <b>PRIVATE AGENCY</b>		Name of Agency _____		Case ID # _____	
	or		<input type="checkbox"/> <b>DCFS</b>		Provider# _____ Interstate Office (ICPC) # _____	
	<input type="checkbox"/> Unlicensed Relative Placement		<input type="checkbox"/> Unlicensed Relative Adoption			

**PERSONAL INFORMATION**

<b>2</b>	Last Name/First Name/Middle Initial _____				Social Security Number or ITIN Number _____						
	Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____				I am or will be a foster family household member. <input type="checkbox"/> Yes <input type="checkbox"/> No I am or will be transporting foster children. <input type="checkbox"/> Yes <input type="checkbox"/> No If both statements are yes, list your Drivers License number here: _____						
	<b>CURRENT ADDRESS</b>				Have you lived outside of Illinois in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No						
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	City: _____				(Street/Apt.#/City/County/State/Zip Code) _____ Dates From/To _____						
State: _____				_____							
Zip Code: _____				_____							
County: _____				_____							
Telephone (Including Area Code)				_____							
( _____ ) _____ - _____				_____							
Date of Birth (Month/Date/Year) _____ - _____ - _____		Age _____	Place of Birth (City and State) _____	Citizenship (Country) <input type="checkbox"/> USA <input type="checkbox"/> Other Specify _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height Ft. In. _____	Weight (lbs.) _____	Hair (color) _____	Eyes (color) _____	Skin Tone _____	Race _____

**AUTHORIZATION /CERTIFICATION**

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	SIGNATURE _____						DATE _____				
Parent/Guardian Signature (if applicable) _____						DATE _____					

<b>4</b>	<b>BACKGROUND RESULTS</b>						<b>FOR CENTRAL OFFICE OF LICENSING USE</b>				
	Sex Offender Result : _____						SID# _____				
	CANTS Result : _____ / Out of State: _____										
ISP Fingerprint: _____ FBI Fingerprint: _____											

<b>5</b>	<b>TO BE COMPLETED BY WORKER</b>										
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	Date Fingerprinted: _____										
	Provider's Full Name and ID # _____										
	Worker's Name and ID # _____										
	Worker's Phone Number ( ) _____ - _____										
Worker's Office Address: _____											
Supervisor's Name and ID # _____											

**INSTRUCTIONS FOR COMPLETION OF  
CFS 718-RL - AUTHORIZATION FOR BACKGROUND CHECK**

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Illinois Department of Children and Family Services  
**AUTHORIZATION FOR BACKGROUND CHECK**  
**For UNLICENSED HOME OF RELATIVE**

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

<b>1</b>	<input type="checkbox"/> <b>PRIVATE AGENCY</b>		Name of Agency _____		Case ID # _____	
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**PERSONAL INFORMATION**

<b>2</b>	Last Name/First Name/Middle Initial _____				Social Security Number or ITIN Number _____						
	Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____				I am or will be a foster family household member. <input type="checkbox"/> Yes <input type="checkbox"/> No I am or will be transporting foster children. <input type="checkbox"/> Yes <input type="checkbox"/> No If both statements are yes, list your Drivers License number here: _____						
	<b>CURRENT ADDRESS</b>				Have you lived outside of Illinois in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No						
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State: _____				_____							
Zip Code: _____				_____							
County: _____				_____							
Telephone (Including Area Code) _____				_____							
( _____ ) _____ - _____				_____							
Date of Birth (Month/Date/Year) _____ - _____ - _____		Age _____	Place of Birth (City and State) _____	Citizenship (Country) <input type="checkbox"/> USA <input type="checkbox"/> Other Specify _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height Ft. In. _____	Weight (lbs.) _____	Hair (color) _____	Eyes (color) _____	Skin Tone _____	Race _____

**AUTHORIZATION /CERTIFICATION**

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	<b>I certify that I have read and understood the Authorization/Certification box on the back page of this form.</b>	
	SIGNATURE _____ DATE _____ Parent/Guardian Signature (if applicable) _____ DATE _____	

<b>4</b>	<b>BACKGROUND RESULTS</b>			<b>FOR CENTRAL OFFICE OF LICENSING USE</b>		
	Sex Offender Result : _____			SID# _____		
	CANTS Result : _____ / Out of State: _____			_____		
ISP Fingerprint: _____ FBI Fingerprint: _____			_____			

<b>5</b>	<b>TO BE COMPLETED BY WORKER</b>	
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Worker's Office Address: _____		
Supervisor's Name and ID # _____		

**INSTRUCTIONS FOR COMPLETION OF  
CFS 718-RL - AUTHORIZATION FOR BACKGROUND CHECK**

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The person completing the identification information must sign and date page 1 of the authorization form.

**AUTHORIZATION/CERTIFICATION**

I authorize the Illinois Department of Children and Family Services to conduct an investigation to determine whether I have ever been charged with a crime and, if so, the disposition of those charges. I authorize the Department to request information and assistance from the U.S. Justice Department and the Illinois Department of Law Enforcement in the conduct of this investigation. I authorize the Department to periodically search the Child Abuse and Neglect Tracking System to determine whether I have been a perpetrator of an "indicated" incident of child abuse or neglect pursuant to the Abused and Neglected Child Reporting Act. If I am applying for a foster home license, I authorize the Department of Children and Family Services to obtain information from those entities to which I had applied for license or supervision of license, regarding licensing violations or removal of children from my home. If I am or will be a member of a foster family household and will be transporting foster children, I authorize the Department to conduct periodic checks of my driver's license and driving record through the Secretary of State. The child abuse and neglect background check and the criminal history investigation may be used for considering an application for license, current or prospective employment, or service as a volunteer in a child care facility. Persons 13-17 years of age signing this form authorize a search of CANTS and LEADS only and are not subject to fingerprinting.

I understand that information obtained as a result of my authorizing this investigation is confidential and may be shared with my placement worker or with licensing staff only in accordance with applicable state and federal law and DCFS Regulations. I further certify that the information provided on this form is true and correct. I acknowledge that falsification of any information provided above and/or the results of the background check may be full and sufficient grounds to deny my application for licensure or may result in the termination of my employment.

Should you feel that the information on your Illinois State Police record or Federal Bureau of Investigation record is incorrect you may visit: <http://www.ilga.gov/commission/jcar/admincode/020/02001210sections.html> for the ISP and <http://www.fbi.gov> for FBI.