

Application Packet

Initial Foster Family Home License:

Relative Caregivers

Revised: October 2017

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.illinois.gov/dcfs/aboutus/notices/Pages/pr_policy_rules.aspx, 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 for Foster Care and Adoption (CFS 718-A) - - - Everyone living in the home who is age 13 or older must complete and sign a CFS 718-A 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-A 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-A (Authorization for Background Check for Foster Care and Adoption) 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-A 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.

DCFS is an equal opportunity employer, and prohibits unlawful discrimination in all of its programs and/or services.

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:				
Other Adult/Child:				
Other Adult/Child:				
Other Adult/Child:				
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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| <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:

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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



Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
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		
	DTP or DTaP																	
Tdap; Td or Pediatric DT (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		
Polio (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		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										COMMENTS:								
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps											
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

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

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

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

*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 (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

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

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

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night	Yes	No		Yes	No
Birth defects?	Yes	No	Hospitalizations? When? What for?	Yes	No
Developmental delay?	Yes	No		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
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 <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____		
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	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	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ (Blood test required if resides in Chicago.)				
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____				
Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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			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	

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** (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



Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
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		
	DTP or DTaP																	
Tdap; Td or Pediatric DT (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		
Polio (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		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										COMMENTS:								
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps											
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

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ALTERNATIVE PROOF OF IMMUNITY

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*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 (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date											Code:		
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													

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

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night	Yes	No	Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other		
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
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)					
Ear/Hearing problems?	Yes	No	Parent/Guardian Signature		
Bone/Joint problem/injury/scoliosis?	Yes	No	Date		

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

HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date (Blood test required if resides in Chicago.)				
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____				
Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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			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	

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** (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



Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
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		
	DTP or DTaP																	
Tdap; Td or Pediatric DT (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		
Polio (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		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										COMMENTS:								
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps											
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

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

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

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

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

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Date											Code:		
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													

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

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night	Yes	No	Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
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)					
Ear/Hearing problems?	Yes	No	Parent/Guardian Signature		
Bone/Joint problem/injury/scoliosis?	Yes	No	Date		

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

HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ (Blood test required if resides in Chicago.)				
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____				
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Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
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Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
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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	

NEEDS/MODIFICATIONS required in the school setting	DIETARY 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?

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Yes No If yes, please describe.

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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



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

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Polio (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		
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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)

AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:			
	Category of Facility	Specific Type of Application	Person in the Home
1	A Foster Care	<input type="checkbox"/> Initial <input type="checkbox"/> Renewal <input type="checkbox"/> Relative <input type="checkbox"/> Traditional <input type="checkbox"/> ICPC	<input type="checkbox"/> Applicant <input type="checkbox"/> Member of Household (ages 13 to 17)* *Parent/Guardian signature required <input type="checkbox"/> Member of Household (age 18 and over) <input type="checkbox"/> Ward
	B Adoption	<input type="checkbox"/> Adopt Only Home <input type="checkbox"/> Unlicensed Relative in Illinois <input type="checkbox"/> Unlicensed Relative Out of State	<input type="checkbox"/> For Placement Purposes <input type="checkbox"/> For Adoption Purposes

PERSONAL INFORMATION (Please see additions instructions on the back page)

Last Name/First Name/Middle Initial _____		Social Security or ITIN Number _____ - _____ - _____							
Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____		I am or will be transporting foster children <input type="checkbox"/> Yes <input type="checkbox"/> No If this statement is yes, list your Drivers License number here: _____ - _____ - _____							
CURRENT ADDRESS, TELEPHONE (when applicable): Street/Apt.#: _____ City: _____ State: _____ Zip Code: _____ County: _____ Home Telephone (_____) _____ - _____ Cell Phone (_____) _____ - _____		Is this an Illinois Drivers License Number? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		List all previous addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/County/State/Zip Code)						Dates From/To	
		_____						_____	
		_____						_____	
		_____						_____	
		_____						_____	
		Have you lived outside of Illinois in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Date of Birth (Month/Date/Year) ____-____-____	Age	Place of Birth (City and State)	Citizenship (Country) <input type="checkbox"/> USA <input type="checkbox"/> Other Specify	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height Ft. In.	Weight (lbs.)	Hair (color)	Eye (color)	
Race (Check all that apply) <input type="checkbox"/> Native American/Alaskan (Indian or Eskimo) <input type="checkbox"/> Asian		<input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander		<input type="checkbox"/> White <input type="checkbox"/> Unknown		<input type="checkbox"/> Declined to Identify <input type="checkbox"/> Could not be Verified		Ethnicity (see codes on Page 2)	

AUTHORIZATION /CERTIFICATION

3	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 _____	

TO BE COMPLETED BY SUPERVISING AGENCY

This authorization form will not be processed without completion of this section. The licensing representative must complete the following

4	Date Fingerprinted: _____	Supervising Agency Name: _____
	Full Name of Facility _____	Provider ID# _____
Provider ID # _____	Or DCFS Region/Site/Field _____	
Street Address: _____	Name of Worker _____	Worker ID#/Phone Number _____
City _____ IL ZIP: _____	Name of Supervisor _____	Supervisor ID#/Phone Number _____

BACKGROUND RESULTS AS APPLICABLE

FOR CENTRAL OFFICE OF LICENSING USE

5	Sex Offender Clearance: _____	SID# _____ Clear _____ Record _____
	CANTS Clearance: _____	BC-03 Registered: _____
	Illinois State Police Clearance: _____	FBI Sent Out: _____
	FBI Clearance: _____	Valid Driver's License: Yes _____ No _____
	Transfer Clearances: SO/CANTS: _____ ISP: _____	

WHO SHOULD USE THIS FORM: This form must be completed by every person age 13 or older as part of an application to operate or reside in a foster care home. Every person subject to a background check must complete the first three sections identifying the type of facility and what role they will have at the facility and all personal information. All identifying information must be accurate and complete. The Parent or Guardian's signature is required if background check is for a minor.

ADDITIONAL INSTRUCTIONS FOR SECTIONS 2 AND 3 OF THE FRONT PAGE

Name:	Current and all former names used by the individual must be included. If no other names, write "none."
Social Security, ITIN or Assigned #.	THIS FORM WILL NOT BE PROCESSED WITHOUT A COMPLETE SOCIAL SECURITY, INDIVIDUAL TAXPAYER IDENTIFICATION (ITIN) NUMBER OR DEPARTMENT ASSIGNED NUMBER
Address:	Current and all addresses, including county, where the person has lived in the past five years (Indicate if outside of Illinois)
Race:	Enter all race codes that apply. NA = Native American/Alaskan (Indian or Eskimo) WH = White AO = Asian UK = Unknown BL = Black/African American DI = Declined to Identify PI = Native Hawaiian/Pacific Islander CV = Could not be Verified
Ethnicity:	Enter the primary Ethnicity NH = Not Hispanic (NONE) HA = Hispanic Central American HS = Hispanic South American HN = Hispanic Dominican HM = Hispanic Mexican HO = Hispanic Other HP = Hispanic Puerto Rican UK = Unknown HD = Hispanic Spanish Descent DI = Declined to Identify HC = Hispanic Cuban CV = Could not be Verified

ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -		Instructions for Right Side -	
Name of Facility:	The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)	Supervising Agency:	Print the name and Provider ID# of Agency which will supervise the facility
Provider ID #:	The Provider ID. (The number which appears on the license certificate for the facility. Initial Applications will be assigned # by Background Check Unit.)	Provider ID #:	
Street/City/Zip:	The site of licensed facility where person is licensed or employed.	DCFS Region/Site/field:	The DCFS Region/Site/Field.
		Name of the Worker:	Name, ID and phone of the worker
		Name of the Supervisor:	Name, ID and phone of the supervisor

The Authorization for Background Check must be submitted to the worker for completion of Section 4 and for forwarding to the DCFS pertinent Background Check Unit. The worker must check the form for completeness and accuracy, confirm that the person (if age 18 or older) has been fingerprinted, and verify the correct spelling of names alongside a form of identification, such as a driver's license or photo ID.

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 child abuse and neglect history reports 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 placement of a related child or an application for licensure. 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 but may be shared with the child placing worker or the licensing applicant for whom my background check is required or with authorized licensing staff 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 the application for licensure.

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.

AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:			
	Category of Facility	Specific Type of Application	Person in the Home
1	A	Foster Care	<input type="checkbox"/> Applicant <input type="checkbox"/> Member of Household (ages 13 to 17)* *Parent/Guardian signature required <input type="checkbox"/> Member of Household (age 18 and over) <input type="checkbox"/> Ward
	B	Adoption	<input type="checkbox"/> For Placement Purposes <input type="checkbox"/> For Adoption Purposes

PERSONAL INFORMATION (Please see additions instructions on the back page)

Last Name/First Name/Middle Initial _____		Social Security or ITIN Number _____ - _____ - _____							
Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____		I am or will be transporting foster children <input type="checkbox"/> Yes <input type="checkbox"/> No If this statement is yes, list your Drivers License number here: _____ - _____ - _____							
CURRENT ADDRESS, TELEPHONE (when applicable): Street/Apt.#: _____ City: _____ State: _____ Zip Code: _____ County: _____ Home Telephone (_____) _____ - _____ Cell Phone (_____) _____ - _____		Is this an Illinois Drivers License Number? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		List all previous addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/County/State/Zip Code) Dates From/To							

		Have you lived outside of Illinois in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Date of Birth (Month/Date/Year) ____-____-____	Age	Place of Birth (City and State)	Citizenship (Country) <input type="checkbox"/> USA <input type="checkbox"/> Other Specify	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height Ft. In.	Weight (lbs.)	Hair (color)	Eye (color)	
<input type="checkbox"/> Native American/Alaskan (Indian or Eskimo) <input type="checkbox"/> Asian		Race (Check all that apply) <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander		<input type="checkbox"/> White <input type="checkbox"/> Unknown		<input type="checkbox"/> Declined to Identify <input type="checkbox"/> Could not be Verified		Ethnicity (see codes on Page 2)	

AUTHORIZATION /CERTIFICATION

3	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 _____	

TO BE COMPLETED BY SUPERVISING AGENCY	
This authorization form will not be processed without completion of this section. The licensing representative must complete the following	
Date Fingerprinted: _____	Supervising Agency Name: _____
Full Name of Facility _____	Provider ID# _____
Provider ID # _____	Or DCFS Region/Site/Field _____
Street Address: _____	Name of Worker _____ Worker ID#/Phone Number _____
City _____ IL ZIP: _____	Name of Supervisor _____ Supervisor ID#/Phone Number _____

5	BACKGROUND RESULTS AS APPLICABLE	FOR CENTRAL OFFICE OF LICENSING USE
	Sex Offender Clearance: _____	SID# _____ Clear _____ Record _____
	CANTS Clearance: _____	BC-03 Registered: _____
	Illinois State Police Clearance: _____	FBI Sent Out: _____
	FBI Clearance: _____	Valid Driver's License: Yes _____ No _____
	Transfer Clearances: SO/CANTS: _____ ISP: _____	

WHO SHOULD USE THIS FORM: This form must be completed by every person age 13 or older as part of an application to operate or reside in a foster care home. Every person subject to a background check must complete the first three sections identifying the type of facility and what role they will have at the facility and all personal information. All identifying information must be accurate and complete. The Parent or Guardian's signature is required if background check is for a minor.

ADDITIONAL INSTRUCTIONS FOR SECTIONS 2 AND 3 OF THE FRONT PAGE

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Ethnicity:	Enter the primary Ethnicity NH = Not Hispanic (NONE) HA = Hispanic Central American HS = Hispanic South American HN = Hispanic Dominican HM = Hispanic Mexican HO = Hispanic Other HP = Hispanic Puerto Rican UK = Unknown HD = Hispanic Spanish Descent DI = Declined to Identify HC = Hispanic Cuban CV = Could not be Verified

ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -		Instructions for Right Side -	
Name of Facility:	The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)	Supervising Agency:	Print the name and Provider ID# of Agency which will supervise the facility
Provider ID #:	The Provider ID. (The number which appears on the license certificate for the facility. Initial Applications will be assigned # by Background Check Unit.)	Provider ID #:	The DCFS Region/Site/Field.
Street/City/Zip:	The site of licensed facility where person is licensed or employed.	DCFS Region/Site/field:	The DCFS Region/Site/Field.
		Name of the Worker:	Name, ID and phone of the worker
		Name of the Supervisor:	Name, ID and phone of the supervisor

The Authorization for Background Check must be submitted to the worker for completion of Section 4 and for forwarding to the DCFS pertinent Background Check Unit. The worker must check the form for completeness and accuracy, confirm that the person (if age 18 or older) has been fingerprinted, and verify the correct spelling of names alongside a form of identification, such as a driver's license or photo ID.

AUTHORIZATION/CERTIFICATION

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AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:			
	Category of Facility	Specific Type of Application	Person in the Home
1	A	Foster Care	<input type="checkbox"/> Applicant <input type="checkbox"/> Member of Household (ages 13 to 17)* *Parent/Guardian signature required <input type="checkbox"/> Member of Household (age 18 and over) <input type="checkbox"/> Ward
	B	Adoption	<input type="checkbox"/> For Placement Purposes <input type="checkbox"/> For Adoption Purposes

PERSONAL INFORMATION (Please see additions instructions on the back page)

Last Name/First Name/Middle Initial _____		Social Security or ITIN Number _____ - _____ - _____							
Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____ _____		I am or will be transporting foster children <input type="checkbox"/> Yes <input type="checkbox"/> No If this statement is yes, list your Drivers License number here: _____ - _____ - _____							
CURRENT ADDRESS, TELEPHONE (when applicable): Street/Apt.#: _____ City: _____ State: _____ Zip Code: _____ County: _____ Home Telephone (_____) _____ - _____ Cell Phone (_____) _____ - _____		Is this an Illinois Drivers License Number? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		List all previous addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/County/State/Zip Code) Dates From/To _____ _____ _____ _____							
		Have you lived outside of Illinois in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Date of Birth (Month/Date/Year) ____ - ____ - ____	Age	Place of Birth (City and State)	Citizenship (Country) <input type="checkbox"/> USA <input type="checkbox"/> Other Specify	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height Ft. In.	Weight (lbs.)	Hair (color)	Eye (color)	
Race (Check all that apply) <input type="checkbox"/> Native American/Alaskan (Indian or Eskimo) <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Declined to Identify <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Could not be Verified							Ethnicity (see codes on Page 2)		

AUTHORIZATION /CERTIFICATION

3	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 _____

TO BE COMPLETED BY SUPERVISING AGENCY	
This authorization form will not be processed without completion of this section. The licensing representative must complete the following	
Date Fingerprinted: _____ Full Name of Facility _____ Provider ID # _____ Street Address: _____ City _____ IL ZIP: _____	Supervising Agency Name: _____ Provider ID# _____ Or DCFS Region/Site/Field _____ Name of Worker _____ Worker ID#/Phone Number _____ Name of Supervisor _____ Supervisor ID#/Phone Number _____

5	BACKGROUND RESULTS AS APPLICABLE	FOR CENTRAL OFFICE OF LICENSING USE
	Sex Offender Clearance: _____ CANTS Clearance: _____ Illinois State Police Clearance: _____ FBI Clearance: _____ Transfer Clearances: SO/CANTS: _____ ISP: _____	SID# _____ Clear _____ Record _____ BC-03 Registered: _____ FBI Sent Out: _____ Valid Driver's License: Yes _____ No _____

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Ethnicity:	Enter the primary Ethnicity NH = Not Hispanic (NONE) HA = Hispanic Central American HS = Hispanic South American HN = Hispanic Dominican HM = Hispanic Mexican HO = Hispanic Other HP = Hispanic Puerto Rican UK = Unknown HD = Hispanic Spanish Descent DI = Declined to Identify HC = Hispanic Cuban CV = Could not be Verified

ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -		Instructions for Right Side -	
Name of Facility:	The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)	Supervising Agency:	Print the name and Provider ID# of Agency which will supervise the facility
Provider ID #:	The Provider ID. (The number which appears on the license certificate for the facility. Initial Applications will be assigned # by Background Check Unit.)	Provider ID #:	
Street/City/Zip:	The site of licensed facility where person is licensed or employed.	DCFS Region/Site/field:	The DCFS Region/Site/Field.
		Name of the Worker:	Name, ID and phone of the worker
		Name of the Supervisor:	Name, ID and phone of the supervisor

The Authorization for Background Check must be submitted to the worker for completion of Section 4 and for forwarding to the DCFS pertinent Background Check Unit. The worker must check the form for completeness and accuracy, confirm that the person (if age 18 or older) has been fingerprinted, and verify the correct spelling of names alongside a form of identification, such as a driver's license or photo ID.

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AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION

CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:			
	Category of Facility	Specific Type of Application	Person in the Home
1	A Foster Care	<input type="checkbox"/> Initial <input type="checkbox"/> Renewal <input type="checkbox"/> Relative <input type="checkbox"/> Traditional <input type="checkbox"/> ICPC	<input type="checkbox"/> Applicant <input type="checkbox"/> Member of Household (ages 13 to 17)* *Parent/Guardian signature required <input type="checkbox"/> Member of Household (age 18 and over) <input type="checkbox"/> Ward
	B Adoption	<input type="checkbox"/> Adopt Only Home <input type="checkbox"/> Unlicensed Relative in Illinois <input type="checkbox"/> Unlicensed Relative Out of State	<input type="checkbox"/> For Placement Purposes <input type="checkbox"/> For Adoption Purposes

PERSONAL INFORMATION (Please see additions instructions on the back page)

Last Name/First Name/Middle Initial _____		Social Security or ITIN Number _____ - _____ - _____							
Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) _____ _____		I am or will be transporting foster children <input type="checkbox"/> Yes <input type="checkbox"/> No If this statement is yes, list your Drivers License number here: _____ - _____ - _____							
CURRENT ADDRESS, TELEPHONE (when applicable): Street/Apt.#: _____ City: _____ State: _____ Zip Code: _____ County: _____ Home Telephone (_____) _____ - _____ Cell Phone (_____) _____ - _____		Is this an Illinois Drivers License Number? <input type="checkbox"/> Yes <input type="checkbox"/> No							
		List all previous addresses for the past five (5) years, including those outside of Illinois. (Street/Apt.#/City/County/State/Zip Code) Dates From/To _____ _____ _____ _____							
		Have you lived outside of Illinois in the past 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Date of Birth (Month/Date/Year) ____ - ____ - ____	Age	Place of Birth (City and State)	Citizenship (Country) <input type="checkbox"/> USA <input type="checkbox"/> Other Specify	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height Ft. In.	Weight (lbs.)	Hair (color)	Eye (color)	
Race (Check all that apply) <input type="checkbox"/> Native American/Alaskan (Indian or Eskimo) <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Declined to Identify <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Could not be Verified							Ethnicity (see codes on Page 2)		

AUTHORIZATION /CERTIFICATION

3	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 _____	

TO BE COMPLETED BY SUPERVISING AGENCY	
This authorization form will not be processed without completion of this section. The licensing representative must complete the following	
Date Fingerprinted: _____ Full Name of Facility _____ Provider ID # _____ Street Address: _____ City _____ IL ZIP: _____	Supervising Agency Name: _____ Provider ID# _____ Or DCFS Region/Site/Field _____ Name of Worker _____ Worker ID#/Phone Number _____ Name of Supervisor _____ Supervisor ID#/Phone Number _____

5	BACKGROUND RESULTS AS APPLICABLE	FOR CENTRAL OFFICE OF LICENSING USE
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