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 ensure 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.

Rev 10/2017
APPLICATION FOR FOSTER FAMILY HOME
LICENSE FOR RELATIVE CAREGIVERS

DO NOT WRITE IN THIS SPACE – AGENCY USE ONLY

Region/Site/Field
Responsible for License
County No.
Supervising Agency No.

Date Received
Date Entered
DCFS Regional Office
Field Office
Licensed Child Welfare Agency
Name
Street Address
City Zip
Telephone No.

PLEASE READ INSTRUCTIONS ON THE BACK BEFORE COMPLETING THIS APPLICATION

I. APPLICANT INFORMATION:

Name of Applicants:  
A. Last Name First Name Middle Social Security Number or ITIN Number

B. Last Name First Name Middle Social Security Number or ITIN Number

Address No. and Street City, State and Zip County

Mailing Address No. and Street City, State and Zip County

Home Telephone Area Code Number

Work or Cell Number Applicant A Area Code Number Applicant B Area Code Number

Email Address Applicant A Applicant B

Does Applicant A and/or B speak a language other than English? ☐ No ☐ Yes If yes indicate:

Applicant A’s Language:

Applicant A’s Proficiency: Bilingual Fluent Conversational

Applicant B’s Language:

Applicant B’s Proficiency: Bilingual Fluent Conversational
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)

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
<th>BIRTHDATE</th>
<th>SOCIAL SECURITY or ITIN NUMBER</th>
<th>RELIGION</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Applicant A:</td>
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<tr>
<td>Applicant B:</td>
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<td></td>
</tr>
</tbody>
</table>
### VI. CURRENT EMPLOYMENT

<table>
<thead>
<tr>
<th>Name of Firm</th>
<th>Address</th>
<th>Title or Position</th>
<th>Working Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant A</td>
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<tr>
<td>Applicant B</td>
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</tbody>
</table>

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: (Months) (Years)  
Applicant B: (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

IV. MEMBERS OF HOUSEHOLD  
(include Children, Relatives, Others)

<table>
<thead>
<tr>
<th>NAME</th>
<th>RELATIONSHIP</th>
<th>BIRTHDATE</th>
<th>SOCIAL SECURITY OR ITIN NUMBER</th>
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<tr>
<td>Applicant A:</td>
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<td>Applicant B:</td>
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<td>Other Adult/Child:</td>
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<td>Other Adult/Child:</td>
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Language(s) Spoken ____________________________

V. CURRENT EMPLOYMENT

<table>
<thead>
<tr>
<th>CURRENT EMPLOYMENT</th>
<th>NAME OF FIRM</th>
<th>ADDRESS</th>
<th>TITLE OR POSITION</th>
<th>WORKING HOURS</th>
<th>YEARS EMPLOYED</th>
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<tbody>
<tr>
<td>Applicant A</td>
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<td>Applicant B</td>
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</table>

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 _________________________________
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:

☐ Heart Problems ☐ Arthritis ☐ Depression ☐ Tremors
☐ Lung Problems ☐ Obesity ☐ Sleep Disorder ☐ Hepatitis
☐ Diabetes ☐ Poor Ambulation ☐ Confusion ☐ Allergies
☐ High Blood Pressure ☐ Weak/Frail ☐ Dementia ☐ Strokes/Paralysis
☐ Asthma ☐ Vision ☐ Epilepsy/Seizures
☐ Kidney Disease ☐ Hearing

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:

<table>
<thead>
<tr>
<th>Illness/Injury</th>
<th>Operation</th>
<th>Hospitalization</th>
<th>Date</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
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?

<table>
<thead>
<tr>
<th>Substance</th>
<th>Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
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<tr>
<td>Tobacco</td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

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:

   - Lift from a bed to chair, etc.: Yes □ No □ Don’t Know □
   - Frequent Feedings: Yes □ No □ Don’t Know □
   - Frequent Suctions: Yes □ No □ Don’t Know □
   - Frequent Monitoring: Yes □ No □ Don’t Know □
   - Frequent Medication: Yes □ No □ Don’t Know □
   - Frequent Nebulizations: Yes □ No □ Don’t Know □
   - Frequent Treatments: Yes □ No □ Don’t Know □

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: ____________________________
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

1. HISTORY

1. Check any health problems:

☐ Heart Problems ☐ Arthritis ☐ Depression ☐ Tremors
☐ Lung Problems ☐ Obesity ☐ Sleep Disorder ☐ Hepatitis
☐ Diabetes ☐ Poor Ambulation ☐ Confusion ☐ Allergies
☐ High Blood Pressure ☐ Weak/Frail ☐ Dementia ☐ Strokes/Paralysis
☐ Asthma ☐ Vision ☐ Epilepsy/Seizures ☐ Kidney Disease ☐ Hearing
☐ Kidney Disease

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):

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Are there any physical limitations as a result of medication(s)? Yes ☐ No ☐
If yes, explain:

________________________________________________________________________

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<table>
<thead>
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<th>Illness/Injury</th>
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<th>Date</th>
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<tr>
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- Tobacco
- Drugs
- Other

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

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   - 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:
   - Lift from a bed to chair, etc.: Yes □ No □ Don’t Know □
   - Frequent Feedings: Yes □ No □ Don’t Know □
   - Frequent Suctions: Yes □ No □ Don’t Know □
   - Frequent Monitoring: Yes □ No □ Don’t Know □
   - Frequent Medication: Yes □ No □ Don’t Know □
   - Frequent Nebulizations: Yes □ No □ Don’t Know □
   - Frequent Treatments: Yes □ No □ Don’t Know □

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**

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>School /Grade Level/ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>Middle</td>
<td>Month/Day/Year</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>Zip Code</th>
<th>Parent/Guardian</th>
<th>Telephone #</th>
<th>Home</th>
<th>Work</th>
</tr>
</thead>
</table>

**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.**

<table>
<thead>
<tr>
<th>Vaccine / Dose</th>
<th>1 MO DA YR</th>
<th>2 MO DA YR</th>
<th>3 MO DA YR</th>
<th>4 MO DA YR</th>
<th>5 MO DA YR</th>
<th>6 MO DA YR</th>
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</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
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<td>Tdap; Td or Pediatric DT</td>
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<td>Polio (Check specific type)</td>
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<td>Hib Haemophilus influenza type b</td>
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<td>Hepatitis B (HB)</td>
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<td>Varicella (Chickenpox)</td>
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<tr>
<td>MMR Combined Measles Mumps. Rubella</td>
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<tr>
<td>Single Antigen Vaccines</td>
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<tr>
<td>Measles</td>
<td>Rubella</td>
<td>Mumps</td>
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<tr>
<td>Pneumococcal Conjugate</td>
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**ALTERNATIVE PROOF OF IMMUNITY**

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<table>
<thead>
<tr>
<th>Date of Disease</th>
<th>Signature</th>
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</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

3. Laboratory confirmation (check one) *(Attach copy of lab result)*

<table>
<thead>
<tr>
<th>Measles</th>
<th>Mumps</th>
<th>Rubella</th>
<th>Hepatitis B</th>
<th>Varicella</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Date</th>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Age/ Grade</th>
<th>Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>R L R L R L R L R L R L R L R L R L</td>
<td>P = Pass</td>
</tr>
<tr>
<td>P = Pass</td>
<td></td>
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<td>R = Referred</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

IL.444-4737 (R-01-12)  
(COMPLETE BOTH SIDES)  
Printed by Authority of the State of Illinois
### Health History

To be completed and signed by parent/guardian and verified by health care provider.

#### Allergies
(Food, drug, insect, other)

- **Diagnosis of asthma?** Yes No
- **Child wakes during the night** Yes No
- **Birth defects?** Yes No
- **Developmental delay?** Yes No
- **Blood disorders? Hemophilia, Sickie Cell, Other? Explain.** Yes No
- **Diabetes?** Yes No
- **Head injury/Concussion/Passed out?** Yes No
- **Seizures?** Yes No
- **Heart problem/Shortness of breath?** Yes No
- **Heart murmur/High blood pressure?** Yes No
- **Dizziness or chest pain with exercise?** Yes No
- **Eye/Vision problems?** Yes No
- **Bone/Joint problem/Injury/Scoliosis?** Yes No

#### Medication
(List all prescribed or taken on a regular basis.)

- **Currently prescribed Asthma Medication:**
  - Quick-relief medication (e.g., Short Acting Beta Antagonist)
  - Controller medication (e.g., inhaled corticosteroid)

#### 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. See CDC guidelines.

- **Blood Test Indicated?** Yes No
- **Blood Test Date**
- **Blood Test Required if resides in Chicago.**
- **Blood Test performed**
- **Family History of Sudden Death before age 50?**
- **TB skin test positive (past/present)?** Yes* No

#### Lab Tests (Recommended)

- **Hemoglobin or Hematocrit**
- **Sickle Cell (when indicated)**
- **Urinalysis**
- **Developmental Screening Tool**

### 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**
- **Ethnic Minority**
- **Signs of Insulin Resistance**
- **Family History**
- **At Risk**

#### Lead Risk Questionnaire

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.

**Questionnaire Administered?** Yes No
- **Blood Test Indicated?** Yes No
- **Blood Test Date**
- **Blood Test performed**

#### Lab Tests (Recommended)

- **Date**
- **Results**
- **Date**
- **Results**

#### System Review

- **Skin**
- **Ears**
- **Eyes**
- **Nose**
- **Throat**
- **Mouth/Dental**
- **Cardiovascular/HTN**
- **Respiratory**

- **Currently prescribed Asthma Medication:**
  - Quick-relief medication (e.g., Short Acting Beta Antagonist)
  - Controller medication (e.g., inhaled corticosteroid)

#### Needs/MODIFICATIONS

- **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

**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**

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>School /Grade Level/ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>Middle</td>
<td>Month/Day/Year</td>
<td></td>
</tr>
</tbody>
</table>

**Address**

<table>
<thead>
<tr>
<th>Parent/Guardian</th>
<th>Telephone #</th>
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</thead>
<tbody>
<tr>
<td>Home</td>
<td>Work</td>
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**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.

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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tr>
<td>DTP or DTaP</td>
<td></td>
<td></td>
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<tr>
<td>Polio (Check specific type)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Hib Haemophilus influenza type b</td>
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<td></td>
</tr>
<tr>
<td>MMR Combined</td>
<td></td>
<td></td>
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<td>Measles Mumps. Rubella</td>
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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

**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.)*

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.

3. Laboratory confirmation (check one)

- Measles
- Mumps
- Rubella
- Hepatitis B
- Varicella

Lab Results

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Age/Grade</th>
<th>Vision</th>
<th>Hearing</th>
<th>Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>R L</td>
<td>R L</td>
<td>P = Pass</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>R L</td>
<td>R L</td>
<td>R = Referred</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R L</td>
<td>R L</td>
<td>G/C = Glasses/Contacts</td>
</tr>
</tbody>
</table>

(COMPLETE BOTH SIDES)
HEALTH HISTORY
TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>School</th>
<th>Grade Level/ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
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<td></td>
</tr>
</tbody>
</table>

HEALTH HISTORY

MEDICATION (List all prescribed or taken on a regular basis.)

- **Diagnosis of asthma?** Yes No
- **Child wakes during the night** Yes No
- **Birth defects?** Yes No
- **Developmental delay?** Yes No
- **Blood disorders? Hemophilia, Sickie Cell, Other?** Yes No
- **Diabetes?** Yes No
- **Head injury/Concussion/Passed out?** Yes No
- **Seizures? What are they like?** Yes No
- **Heart problem/Shortness of breath?** Yes No
- **Heart murmur/High blood pressure?** Yes No
- **Dizziness or chest pain with exercise?** Yes No
- **Eye/Vision problems?** Yes No
- **Bone/Joint problem/injury/scoliosis?** Yes No

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

**HEAD CIRCUMFERENCES**

- **DIABETES SCREENING (NOT REQUIRED FOR DAY CARE)**
  - BMI≥85% age/sex: Yes No
  - Ethnic Minority: Yes No
- **Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans):** Yes No
- **LEAD RISK QUESTIONNAIRE:** Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
- **Questionnaire Administered?** Yes No
- **Blood Test Indicated?** Yes No
- **Blood Test Date**
- **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.
- **Test performed**
- **Skin Test: Date Read**
- **Result: Positive □ Negative □ mm ______________
- **Blood Test: Date Reported**
- **Result: Positive □ Negative □ Value ______________

**LAB TESTS (Recommended)**

- **Hemoglobin or Hematocrit**
- **Urinalysis**
- **System Review**
  - Skin
  - Ears
  - Eyes
  - Nose
  - Throat
  - Mouth/Dental
  - Cardiovascular/HTN
  - Respiratory
  - Developmental Screening Tool
- **Dietary Needs/Restrictions**
  - **Dietary**
- **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**
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:

**Physical Education**

- **Yes □ No □ Modified □**
- **InterScholastic Sports** (for one year)
  - Yes □ No □ Limited □

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

(Note both sides)
### 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.**

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**ALTERNATIVE PROOF OF IMMUNITY**

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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**

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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Laboratory confirmation (check one)  

- ✐ Measles
- ✐ Mumps
- ✐ Rubella
- ✐ Hepatitis B
- ✐ Varicella

**Lab Results**

<table>
<thead>
<tr>
<th>Date</th>
<th>MO DA YR</th>
<th>(Attach copy of lab result)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HEALTH HISTORY

<table>
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<th>Student's Name</th>
<th>Birth Date</th>
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<th>School</th>
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<td></td>
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</tbody>
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TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

MEDICATION (List all prescribed or taken on a regular basis.)

- **Diagnosis of asthma?**
  - Yes
  - No

- **Child wakes during the night?**
  - Yes
  - No

- **Birth defects?**
  - Yes
  - No

- **Developmental delay?**
  - Yes
  - No

- **Blood disorders? Hemophilia, Sickle Cell, Other? Explain.**
  - Yes
  - No

- **Diabetes?**
  - Yes
  - No

**EMERGENCY ACTION**

**MENTAL HEALTH/OTHER**

- **Is there anything else the school should know about this student?**
  - Yes
  - No

**PHYSICAL EDUCATION**

Yes

**INTERSCHOLASTIC SPORTS**

Yes

<table>
<thead>
<tr>
<th>Print Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(MD, DO, APN, PA)</td>
<td></td>
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</table>

(Complete both sides)
State of Illinois  
Certificate of Child Health Examination

<table>
<thead>
<tr>
<th>Student's Name</th>
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<th>Address</th>
<th>Street</th>
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<td>□ Tdap□Td□DT</td>
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<tr>
<td>Polio (Check specific type)</td>
<td>□ IPV □ OPV</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR Combined Measles Mumps. Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Single Antigen Vaccines**  
- Measles  
- Rubella  
- Mumps

<table>
<thead>
<tr>
<th>Pneumococcal Conjugate</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other/Specify Meningococcal, Hepatitis A, HPV, Influenza</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Signature</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

**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.)*

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.

<table>
<thead>
<tr>
<th>Date of Disease</th>
<th>Signature</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Lab Results</th>
<th>Date</th>
<th>MO DA YR</th>
<th>(Attach copy of lab result)</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>Date</th>
<th>Age/Grade</th>
<th>Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R L R L R L R L R L R L R L R L</td>
<td>P = Pass</td>
</tr>
<tr>
<td></td>
<td>R L R L R L R L R L R L R L R L</td>
<td>F = Fail</td>
</tr>
<tr>
<td></td>
<td>R L R L R L R L R L R L</td>
<td>U = Unable to test</td>
</tr>
<tr>
<td></td>
<td></td>
<td>R = Referred</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G/C = Glasses/Contacts</td>
</tr>
</tbody>
</table>

IL-444-4737 (R-01-12)  
(COMPLETE BOTH SIDES)  
Printed by Authority of the State of Illinois
# Health History

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

**ALLERGIES** (Food, drug, insect, other)

<table>
<thead>
<tr>
<th>Diagnosis of asthma?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child wakes during the night</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Birth defects?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Developmental delay?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood disorders? Hemophilia, Sickles Cell, Other? Explain.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**MEDICATION** (List all prescribed or taken on a regular basis.)

- Loss of function of one of paired organs? (eye/ear/kidney/testicle)
- Hospitalizations?
- Surgery? (List all)
- Serious injury or illness?
- TB skin test positive (past/present)?
- TB disease (past or present)?
- Tobacco use (type, frequency)?
- Alcohol/Drug use?
- Family history of sudden death before age 50? (Cause)?

**SYSTEM REVIEW** Normal Comments/Follow-up/Needs

<table>
<thead>
<tr>
<th>Eye/Vision problems?</th>
<th>Glasses</th>
<th>Contacts</th>
<th>Last exam by eye doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)</td>
<td>Dental</td>
<td>Braces</td>
<td>Bridge</td>
</tr>
<tr>
<td>Ear/Hearing problems?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Bone/Joint problem/injury/scoliosis?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**DIABETES SCREENING** (Blood test Indicated? Yes | No)

- BMI>85% age/sex Yes | No
- Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes | No
- At Risk Yes | No

**LEAD RISK QUESTIONNAIRE**

- Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

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

**HEAD CIRCUMFERENCE**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DIETARY NEEDS/MODIFICATIONS**

- 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 yes, please describe.

**PHYSICAL EDUCATION**

- INTERSCHOLASTIC SPORTS (for one year) Yes | No | Limited

**EMERGENCY ACTION**

- If No or Modified, please attach explanation.

**Print Name**

<table>
<thead>
<tr>
<th>(MD, DO, APN, PA)</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Address**

<table>
<thead>
<tr>
<th>Phone</th>
</tr>
</thead>
</table>
Illinois Department of Children and Family Services

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:

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<th>Category of Facility</th>
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<td></td>
<td>Applicant</td>
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<tr>
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<td></td>
</tr>
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<td></td>
</tr>
<tr>
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<td>Ward</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adopt Only Home</td>
<td></td>
</tr>
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<td></td>
<td>Unlicensed Relative in Illinois</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unlicensed Relative Out of State</td>
<td></td>
</tr>
<tr>
<td>B Adoption</td>
<td>For Placement Purposes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>For Adoption Purposes</td>
<td></td>
</tr>
</tbody>
</table>

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

Last Name/First Name/Middle Initial ____________________________ ______________

Maiden and/or Any Names Formerly Used (Last/First/Middle Initial) ____________________________ ______________

Social Security or ITIN Number ____________________________ ______________

I am or will be transporting foster children Yes No

If this statement is yes, list your Drivers License number here: ____________________________ ______________

Is this an Illinois Drivers License Number? Yes No

CURRENT ADDRESS, TELEPHONE (when applicable):

Street/Apt.#: ____________________________ ______________

City: ____________________________ State: __ __

Zip Code: __ __ __ __ County: ____________________________ ______________

Home Telephone ( __ __ __ ) __ __ __ - __ __ __ __

Cell Phone ( __ __ __ ) __ __ __ - __ __ __ __

List all previous addresses for the past five (5) years, including those outside of Illinois. Dates From/To ____________________________ ______________

Please list:

Have you lived outside of Illinois in the past 3 years? Yes No

Date of Birth (Month/Date/Year) ____________________________ ______________

Age ____________________________ ______________

Place of Birth (City and State) ____________________________ ______________

Citizenship (Country) USA Other Specify ____________________________ ______________

Gender M F ____________________________ ______________

Height Ft. In. ____________________________ ______________

Weight (lbs.) ____________________________ ______________

Hair (color) ____________________________ ______________

Eye (color) ____________________________ ______________

Race (Check all that apply) Native American/Alaskan (Indian or Eskimo) Yes No

Asian Black/African American White Declined to Identify

Native Hawaiian/Pacific Islander Unknown Could not be Verified

Ethnicity (see codes on Page 2) ____________________________ ______________

AUTHORIZATION /CERTIFICATION

Have you ever been indicated as perpetrator in a child abuse/neglect investigation? Yes No

Have you ever been convicted of a criminal offense, other than a minor traffic violation? Yes 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 # ____________________________ ______________

Or

DCFS Region/Site/Field ____________________________ ______________

Name of Worker ____________________________ ______________

Worker ID#/Phone Number ____________________________ ______________

Name of Supervisor ____________________________ ______________

Supervisor ID#/Phone Number ____________________________ ______________

BACKGROUND RESULTS AS APPLICABLE

Sex Offender Clearance: ____________________________ ______________

CANTS Clearance: ____________________________ ______________

Illinois State Police Clearance: ____________________________ ______________

FBI Clearance: ____________________________ ______________

Transfer Clearances: SO/CANTS: ____________________________ ______________

FOR CENTRAL OFFICE OF LICENSING USE

SID# Clear Record ____________________________ ______________

BC-03 Registered: ____________________________ ______________

FBI Sent Out: ____________________________ ______________

Valid Driver's License: Yes No
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)  
AO = Asian  
BL = Black/African American  
PI = Native Hawaiian/Pacific Islander  
WH = White  
UK = Unknown  
DI = Declined to Identify  
CV = Could not be Verified |
| Ethnicity: | Enter the primary Ethnicity  
NH = Not Hispanic (NONE)  
HS = Hispanic South American  
HM = Hispanic Mexican  
HP = Hispanic Puerto Rican  
HD = Hispanic Spanish Descent  
HC = Hispanic Cuban  
HA = Hispanic Central American  
HN = Hispanic Mexican  
HO = Hispanic Other  
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### ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

**Instruction for Left Side**  
Name of Facility: The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)  
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.)  
Street/City/Zip: The site of licensed facility where person is licensed or employed.  

**Instructions for Right Side**  
Supervising Agency: Print the name and Provider ID# of Agency which will supervise the facility  
Provider ID #:  
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](http://www.ilga.gov/commission/jcar/admincode/020/02001210sections.html) for the ISP and [http://www.fbi.gov](http://www.fbi.gov) for FBI.
# AUTHORIZATION FOR BACKGROUND CHECK for Foster Care & Adoption

**READ INSTRUCTIONS ON REVERSE SIDE AND PRINT ALL INFORMATION**

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<tr>
<td></td>
<td>ICPC</td>
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<tr>
<td></td>
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<td>For Placement Purposes</td>
</tr>
<tr>
<td></td>
<td>Unlicensed Relative in Illinois</td>
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</tr>
<tr>
<td></td>
<td>Unlicensed Relative Out of State</td>
<td></td>
</tr>
</tbody>
</table>

## 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**

**If this statement is yes, list your Drivers License number here:**

**Is this an Illinois Drivers License Number?**

**CURRENT ADDRESS, TELEPHONE (when applicable):**

**Street/Apt.#:**

**City:**

**State:**

**Zip Code:**

**Home Telephone**

**Cell Phone**

**Have you lived outside of Illinois in the past 3 years?**

**Date of Birth**

**Age**

**Place of Birth**

**Citizenship (Country)**

**Gender**

**Height**

**Weight**

**Hair**

**Eye**

**Race (Check all that apply)**

**Ethnicity**

(see codes on Page 2)

**AUTHORIZATION /CERTIFICATION**

**Have you ever been indicated as perpetrator in a child abuse/neglect investigation?**

**Have you ever been convicted of a criminal offense, other than a minor traffic violation?**

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 #**

**Provider ID#**

**Or**

**DCFS Region/Site/Field**

**Name of Worker**

**Worker ID#/Phone Number**

**Name of Supervisor**

**Supervisor ID#/Phone Number**

## BACKGROUND RESULTS AS APPLICABLE

**Sex Offender Clearance:**

**CANTS Clearance:**

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## CHECK ONE BOX IN EACH COLUMN IN THE APPLICABLE ROW A or B:

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<td></td>
</tr>
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## 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

#### Yes

#### No

### If this statement is yes, list your Drivers License number here:

#### __ __ __ __ - __ __ __ __ - __ __ __ __

#### Is this an Illinois Drivers License Number?

#### Yes

#### No

### CURRENT ADDRESS, TELEPHONE (when applicable):

#### Street/Apt.#:

#### City:   State:  __  __

#### Zip Code: __  __  __  __  __   County:

#### Home Telephone  ( __  __  __ )   __  __  __ - __  __  __  __

#### Cell Phone  ( __  __  __ )   __  __  __ - __  __  __  __

### List all previous addresses for the past five (5) years, including those outside of Illinois. Dates

#### From/To

### Have you lived outside of Illinois in the past 3 years?

#### Yes

#### No

### Date of Birth

<table>
<thead>
<tr>
<th>(Month/Date/Year)</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>-</strong>-__</td>
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</tbody>
</table>

### Place of Birth

(Old City and State)

### Citizenship (Country)

#### USA

#### Other Specify

### Gender

#### M

#### F

### Height

Ft.     In.

### Weight

(lbs.)

### Hair

(color)

### Eye

(color)

### Race (Check all that apply)

- Native American/Alaskan (Indian or Eskimo)
- Asian
- Black/African American
- Native Hawaiian/Pacific Islander
- White
- Declined to Identify
- Unknown
- Could not be Verified

### ETHNICITY

(see codes on Page 2)

### AUTHORIZATION /CERTIFICATION

#### Have you ever been indicated as perpetrator in a child abuse/neglect investigation?

#### Yes

#### No

#### Have you ever been convicted of a criminal offense, other than a minor traffic violation?

#### Yes

#### 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, State, IL  ZIP:

### Supervising Agency Name:

### Provider ID# ________________

### DCFS Region/Site/Field:

### Name of Worker

### Worker ID#/Phone Number

### Name of Supervisor

### Supervisor ID#/Phone Number

### BACKGROUND RESULTS AS APPLICABLE

### FOR CENTRAL OFFICE OF LICENSING USE

### SID# ______ Clear ______ Record ______

### BC-03 Registered:

### FBI Sent Out:

### Valid Driver's License: Yes ______ No ______
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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NA</td>
<td>Native American/Alaskan (Indian or Eskimo)</td>
</tr>
<tr>
<td>AO</td>
<td>Asian</td>
</tr>
<tr>
<td>BL</td>
<td>Black/African American</td>
</tr>
<tr>
<td>PI</td>
<td>Native Hawaiian/Pacific Islander</td>
</tr>
<tr>
<td>WH</td>
<td>White</td>
</tr>
<tr>
<td>UK</td>
<td>Unknown</td>
</tr>
<tr>
<td>DI</td>
<td>Declined to Identify</td>
</tr>
<tr>
<td>CV</td>
<td>Could not be Verified</td>
</tr>
</tbody>
</table>

Ethnicity: Enter the primary Ethnicity

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NH</td>
<td>Not Hispanic (NONE)</td>
</tr>
<tr>
<td>HS</td>
<td>Hispanic South American</td>
</tr>
<tr>
<td>HM</td>
<td>Hispanic Mexican</td>
</tr>
<tr>
<td>HP</td>
<td>Hispanic Puerto Rican</td>
</tr>
<tr>
<td>HD</td>
<td>Hispanic Spanish Descent</td>
</tr>
<tr>
<td>HC</td>
<td>Hispanic Cuban</td>
</tr>
<tr>
<td>HA</td>
<td>Hispanic Central American</td>
</tr>
<tr>
<td>HI</td>
<td>Hispanic Mexico</td>
</tr>
<tr>
<td>HU</td>
<td>Hispanic Hispanic</td>
</tr>
<tr>
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</tr>
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ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

Instruction for Left Side -

Name of Facility: The full name which appears on the license application or the license. (DO NOT USE ACRONYMS)

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.)

Street/City/Zip: The site of licensed facility where person is licensed or employed.

Instructions for Right Side –

Supervising Agency: Print the name and Provider ID# of Agency which will supervise the facility

Provider ID #:

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** |
| A | Foster Care | A or B: | Application | Member of Household (ages 13 to 17)* | Member of Household (age 18 and over) |
| | | | | *Parent/Guardian signature required | Ward |
| B | Adoption | A or B: | For Placement Purposes | 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** Yes No

If this statement is yes, list your Drivers License number here:

__ __ __ __ - __ __ __ __ - __ __ __ __

**Is this an Illinois Drivers License Number?** Yes No

**CURRENT ADDRESS, TELEPHONE (when applicable):**

Street/Apt.#:

City: State: __ __

Zip Code: __ __ __ __ County: 

**Home Telephone** ( __ __ ___ ) __ __ __ - __ __ __ __

**Cell Phone** ( __ __ ___ ) __ __ __ - __ __ __ __

List all previous addresses for the past five (5) years, including those outside of Illinois. Dates From/To

**Date of Birth**

(Month/Date/Year) __ __ __

**Age**

Place of Birth (City and State) USA Other Specify

**Gender** M F

**Height** Ft. In.

**Weight** (lbs.)

**Hair** (color)

**Eye** (color)

**Race (Check all that apply)**

Native American/Alaskan (Indian or Eskimo) Black/African American White Declined to Identify

Asian Native Hawaiian/Pacific Islander Unknown Could not be Verified

Ethnicity (see codes on Page 2)

## AUTHORIZATION /CERTIFICATION

**Have you ever been indicated as perpetrator in a child abuse/neglect investigation?** Yes No

**Have you ever been convicted of a criminal offense, other than a minor traffic violation?** Yes 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) __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ ___
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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| Race:                      | Enter all race codes that apply.  
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  BL = Black/African American  
  PI = Native Hawaiian/Pacific Islander  
  WH = White  
  UK = Unknown  
  DI = Declined to Identify  
  CV = Could not be Verified |
| Ethnicity:                 | Enter the primary Ethnicity  
  NH = Not Hispanic (NONE)  
  HS = Hispanic South American  
  HM = Hispanic Mexican  
  HP = Hispanic Puerto Rican  
  HD = Hispanic Spanish Descent  
  HC = Hispanic Cuban  
  HA = Hispanic Central American  
  HN = Hispanic Mexican  
  HO = Hispanic Other  
  UK = Unknown  
  DI = Declined to Identify  
  CV = Could not be Verified |

ADDITIONAL INSTRUCTIONS FOR SECTIONS 4 OF THE FRONT PAGE

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