YELLOW BRICK ROAD Preschool

YELLOW BRICK ROAD

PRESCHOOL REGISTRATION

YELLOW BRICK ROAD PRESCHOOL REGISTRATION FORM

PRESCHOOL PARTICIPANT EMERGENCY INFORMATION FORM

PERMISSION TO DISPENSE MEDICATION WAIVER

CHILD BACKGROUND INFORMATION

ILLINOIS HEALTH EXAMINATION FORM

COPY OF BIRTH CERTIFICATE

NEW FOR 2026

YBR paperwork is due by August 1st, 2026. It can be delivered 3 ways:

- The Paulus Park Barn at 200 S. Rand Road, Lake Zurich
- By fax at 847-380-5471
- By e-mail to: askparkrec@lakezurich.org

For YBR Preschool questions, please email Recreation Supervisor Jenna Stanonik at jenna.stanonik@lakezurich.org

Village of Lake Zurich Park and Recreation Department Registration Form

PLEASE FILL OUT THIS FORM COMPLETELY AND MAIL OR FAX IT TO: Village of Lake Zurich Park and Recreation Department, 200 South Rand Road, Lake Zurich, IL 60047, **FAX:** 847-380-5471

Registration Form

Family Information

☐ Resident ☐ Non-Resident

Please print. Fill out the information below for your entire family; then list each participant separately in the Registration Information section. Proof of residency may be required.

Family (or primary guardian) Last Name | Father or Guardian First Name | Mother or Guardian First Name

Address | City | State | Zip

Home Phone | Cell Phone (State Whose Number) | Work Phone (State Whose Number)

E-mail Address

Alternate Name | Phone | Relationship

■ *In case of an emergency, an attempt will be made to contact a parent at home, at work and via cell phone. If a parent cannot be reached, the Park Department will contact the alternate name listed above.*

Does a participant in your family require Americans with Disabilities (ADA) assistance or a one-on-one aid? ☐ **Yes** ☐ **No**
If yes, please request an additional form at the Park Department Office. (Good for this registration only.)

Family Member Registration Information

Please list your first and second choice options for each class (if more than one section, date, or time is available).

Program #	Program Name	Participant's First Name	Participant's Last Name	Birth Date mo/day/yr	Fall 2026 Grade	Gender	R/NR Fee
412940 - GG	Terrific Two's (Mon)						$50 nonrefundable registration fee
412940 - HH	Terrific Two's (Tue)						$50 nonrefundable registration fee
412940 - II	Terrific Two's (Wed)						$50 nonrefundable registration fee
412940 - JJ	Terrific Two's (Thur)						$50 nonrefundable registration fee
412940 - FF	Just for Me Almost Three						$50 nonrefundable registration fee

Payment Information

Total Fee Payment Method: ***Check One:***

☐ Visa ☐ MasterCard ☐ Cash ☐ Check (#:_____)

This section must be filled out if you are using Visa or MasterCard.

Account Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Cardholder Name _____

Expiration Date _____ Amount of Charge $_____

Authorized Signature_____

Village of Lake Zurich - WAIVER AND RELEASE OF ALL CLAIMS

Please read this form carefully and be aware that in registering yourself and/or your minor child for participation in the program(s), you will be waiving and releasing all claims for injuries you or your child/ward might sustain arising out of the program(s). I recognize and acknowledge that there are certain risks of physical injury to participants in the program(s) and I agree to assume the full risk of any such injuries, damages, or loss regardless of severity which I or my child/ward may sustain as a result of participating in any of the program(s). I hereby fully release and discharge the Village of Lake Zurich and its officers, agents, servants and employees from any and all claims resulting from injuries, damages and/or losses sustained by me or by my child/ward, arising out, connected with, or in any way associated with the activities of any of the program(s). **I HAVE READ, FULLY UNDERSTAND AND ACCEPT THE CONDITIONS AS DESCRIBED ABOVE.**

Signature of Parent/Guardian/Participant **Date**

■ ***This waiver must be signed by adults 18 years old and older.***

Photo Release Photos and videos are periodically taken of people participating in Village of Lake Zurich Park and Recreation Department programs and activities. All persons registering for Park Department programs/activities or using Park Department property thereby agree that any photograph or videotape taken by the Park Department may be used by the Park Department for promotional purposes including in its electronic media, videotapes, brochures, flyers and other publications without additional prior notice or permission and without compensation to the participant.

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Home Phone | Cell Phone (State Whose Number) | Work Phone (State Whose Number)

E-mail Address

Alternate Name | Phone | Relationship

■ *In case of an emergency, an attempt will be made to contact a parent at home, at work and via cell phone. If a parent cannot be reached, the Park Department will contact the alternate name listed above.*

Does a participant in your family require Americans with Disabilities (ADA) assistance or a one-on-one aid? ☐ **Yes** ☐ **No**
If yes, please request an additional form at the Park Department Office. (Good for this registration only.)

Family Member Registration Information

Please list your first and second choice options for each class (if more than one section, date, or time is available).

Program #	Program Name	Participant's First Name	Participant's Last Name	Birth Date mo/day/yr	Fall 2026 Grade	Gender	R/NR Fee
412940 - AA	3 Year Old Buffalo Creek						$50 nonrefundable registration fee
412940 - BB	3 Year Old Barn						$50 nonrefundable registration fee
412940 - CC	4 Year Old Buffalo Creek						$50 nonrefundable registration fee
412940 - DD	4 Year Old Barn						$50 nonrefundable registration fee

Payment Information

Total Fee Payment Method: ***Check One:***

☐ Visa ☐ MasterCard ☐ Cash ☐ Check (#:_____)

This section must be filled out if you are using Visa or MasterCard.

Account Number: __ __ __ __ - __ __ __ __ - __ __ __ __ - __ __ __ __

Cardholder Name _____

Expiration Date _____ Amount of Charge $_____

Authorized Signature_____

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Signature of Parent/Guardian/Participant **Date**

■ ***This waiver must be signed by adults 18 years old and older.***

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At the Heart of Community

PRESCHOOL PARTICIPANT EMERGENCY INFORMATION

This form must be completed and returned with the registration form. One form per child. The following questions are being asked so that our preschool staff can better serve your child and all other children. Your answers are strictly confidential. Please be as specific as possible. Please print clearly. Thank you.

☐ Terrific Two's ☐ Almost Three ☐ Barn 3's ☐ Barn 4's
☐ Buffalo Creek 3's ☐ Buffalo Creek 4's

Childs Name: _____ Birthdate: _____ Age: _____ Gender: _____

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

Family E-Mail : _____

Parent/Guardian: _____ Relationship: _____ Primary Phone: _____

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

Employer: _____ Title: _____ Work Hours: _____ Work Phone: _____

Parent/Guardian: _____ Relationship: _____ Primary Phone: _____

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

Employer: _____ Title: _____ Work Hours: _____ Work Phone: _____

Child lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other

Adults AUTHORIZED to Pick-Up my Child/Emergency Contacts other than Parent/Guardian (minimum of 2 are required)

	Name	Relationships	Primary Phone	Alternate Phone
1				
2				
3				
4				

UNAUTHORIZED PICK-UP: People who CANNOT pick up your child from preschool:

1. Name: _____ Relationship: _____

2. Name: _____ Relationship: _____

INSURANCE INFORMATION: Is the participant covered by family medical/hospital insurance? ☐ Yes ☐ No

If yes, indicate carrier or plan name: _____ Group # _____

Carrier address: _____ City/State/Zip: _____

Name of insured: _____ Relationship to participant: _____

HEALTH HISTORY: Describe any of your child's current health conditions requiring medical attention, treatment or special restrictions or considerations while at preschool: _____

Does your child take any medications? _____

Does your child have any allergies, including food? _____ If so, please list: _____

Reaction to allergy/management of allergy: _____

Are there any activities that your child should be exempted from for health reasons? _____

Please list any past medical treatments: _____

AUTHORIZED PICK-UP/EMERGENCY PICK-UP:

I, _____ authorize the people listed to pick up my child and be contacted in the event of an emergency from the Village of Lake Zurich. In doing so, I relieve the Village of Lake Zurich, its centers and employees of all responsibility for my child after he/she has been released from the program. Attempts will be made to reach the parent/legal guardian first.

Initials _____

PHOTOGRAPHS:

By registering for any Lake Zurich Park and Recreation Department program, you agree to allow use of any photos taken at any programs, events or facilities for illustration or publicity.

Signature of Parent/Legal Guardian: _____ Date: _____

MEDICAL RELEASE:

I do hereby give permission for the Village of Lake Zurich to transfer child named above off property for the purpose of medical care as deemed appropriate by the Supervisor and in the event that I cannot be reached in an EMERGENCY, I hereby give my permission to the physician selected by the Supervisor, to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above.

Initials _____

WAIVER AND RELEASE OF ALL CLAIMS:

Please read this form carefully and be aware that in registering your minor child for participation in the above program, you will be waiving and releasing all claims for injuries you or your child/ward might sustain arising out of the above program. I recognize and acknowledge there are risks of physical injury to participants in the above program and I agree to assume the full risk of any such injuries, damages, or loss regardless of severity which I or my child/ward may sustain as a result of claims resulting from injuries, damages and losses sustained by my child/ward, and I HAVE READ, FULLY UNDERSTAND AND ACCEPT THE CONDITIONS AS DESCRIBED ABOVE.

Signature of Parent/Legal Guardian: _____ Date: _____
This waiver must be signed by adults 18 years old and older

VIDEO RELEASE FORM

I, _____, hereby grant permission to the Village of Lake Zurich, the rights of my child's image, in video or still, and of the likeness and sound of my child's voice as recorded on audio or video tape without payment or any other consideration. I understand that my child's image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my child's likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my child's image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for ANY USE which may include, but is not limited to:

- Presentations;
- Courses;
- Online/Internet Videos;
- Media;
- News (Press);

By signing this release, I understand this permission signifies that photographic or video recordings of my child may be electronically displayed via the Internet or in the public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed.

This release applies to photographic, audio or video recordings collected as part of the **Yellow Brick Road Preschool Program.**

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

Full Name_____Child's Name_____

Street Address/P.O. Box_____

City _____ State _____ Zip Code _____

Phone _____ Fax _____

Email Address_____

Signature _____ Date_____

If this release is obtained from a participant under the age of 19, then the signature of that participant's parent or legal guardian is also required.

Parent's Signature_____Date_____

I do not consent, Parent's Signature _____Date_____

PERMISSION TO DISPENSE MEDICATION WAIVER AND RELEASE OF ALL CLAIMS

☐ **If not applicable, please check here** **Initial here:**_____

At the Heart of Community

The Village of Lake Zurich will not dispense medication to a minor child or any other participant until this waiver has been fully completed by a parent or guardian

Participants Name: _____ ***Age:*** _____

Address: _____

Parent's/Guardian's Name(s): _____

Daytime Phone: _____ ***Other Phone:*** _____

Program Name: _____

Family Doctor's Name: _____ ***Phone:*** _____

MEDICATION NAME	DOSAGE	TIME TAKEN	DOCTOR'S NAME

Please list any possible side effect of medication and which medication they apply to.

_____

Please list special dispensing or storage instructions that may apply to the medications and which medications they apply to.

_____

_____

I _____ the parent/guardian of _____

give permission to the staff of the Village of Lake Zurich to administer to my child the medications listed above.

I understand it is my responsibility to give medication (including Inhalers) directly to the program staff in individual dosage containers, original prescription containers, or envelopes clearly labeled with participants name and dosage. I also understand, that over the counter medicine such as cough medicine, Tylenol etc. will not be administered.

In all cases the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to the Village of Lake Zurich to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medications to my minor child. In consideration of the Village of Lake Zurich administering medication to my minor child, I do hereby fully release or discharge the Village of Lake Zurich, and its officers, agents, volunteers and employees from any and all claims from injuries, damages and losses I or my minor child may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless and defend the Village of Lake Zurich and its officers, agents, volunteers and employees from any and all claims resulting from injuries, damages and losses sustained by me or my minor child and arising out of, connected with, incidental to or in any way associated with the administering of medication.

Signature of Parent of Guardian: _____ ***Date:*** _____

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication changes. I will do so by completing another Permission to Dispense Medication Form.

Signature of Parent of Guardian: _____ ***Date:*** _____

YELLOW BRICK ROAD BACKGROUND INFORMATION

At the Heart of Community

Dear Parents:

One of the first things we work on with the children is learning to recognize and write their name. We would like for you to let us know what name you would like your child to recognize and write at school.

Please print your child's correct name on the lines below.

Your child's registered name:

_____

(i.e. Michael Brown)

Name you would like your child to be called and write:

_____

(i.e. Mike)

List Siblings & Ages:

_____ _____

_____ _____

_____ _____

_____ _____

Are there any special custody arrangements:

_____

Normal Naptime: ___:___

Normal Bedtime: ___:___ ***Normal Wake-Up Time:*** ___:___

Please check mark your child's hand preference?

☐ Left ☐ Right ☐ Undetermined

What methods of behavior management have you found work best for your child?

_____

_____

_____

Please check mark what best describes your child:

☐ Happy	☐ Good-Natured
☐ Moody	☐ Aggressive
☐ Sympathetic	☐ Fearful
☐ Dependent	☐ Quiet
☐ Outgoing	☐ Stubborn
☐ Impulsive	☐ Attentive
☐ Clumsy	☐ Shy

Other:

_____

_____

Does your child prefer to play alone?

_____

Does your child play well with others?

_____

How does your child handle group situations?

_____

_____

What age group does your child play with most often?

_____

Please list your child's favorite activities:

_____

_____

Are there any fears we should be aware of?

_____

Are there any hearing or vision problems?

_____

Are there any allergy or health needs? If yes, please complete the Permission to dispense medication waiver

☐ Yes ☐ No

Are there any regular medications your child will be taking during class?

_____

Are there any serious accidents or operations?

_____

Has your child had any group play experience or attended another preschool?

_____

Any day care with someone other than family?

_____

Were these experience positive ones, if not please explain:

_____

What would you like your child to gain from this program:

_____

_____

Does your child accept correction easily?

_____

Please list what holidays you celebrate throughout the year:

_____

Other comments:

_____

_____

_____

_____

_____

_____

_____

Please return this packet by August 1st, 2026 to the Paulus Park Barn 200 South Rand Road, Lake Zurich, 60047. You may also fax it to 847-380-5471 or e-mail it to askparkrec@lakezurich.org

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

DCFS

State of Illinois
Certificate of Child Health Examination

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

IMMUNIZATIONS: To be completed by health care provider. 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)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
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 **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																				
Age/ Grade																				
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																				
Hearing																				

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

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

ALLERGIES (Food, drug, insect, other)

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

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

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐

Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _____

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value**

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

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

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Limited** ☐

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

Address **Phone**

(Complete Both Sides)

COPY OF
BIRTH CERTIFICATE