



Summer Camp Registration

What you will need to turn in before starting camp:

1. Registration Form
2. Birth Certificate
3. Physical and Immunization Records
4. Tuition Contract
5. Signed DCFS Form
6. \$50 Registration Fee

Communication:

Remind App: Summer camp will use an app called REMIND to communicate with our parents and guardians. Once you have registered with us, we will add you to the app. This is a fast and easy way to communicate information to all families at once. You can also message us as well through this app. Any important information will come via text. Please download it.

S.O.T.H. Cell Phone: We have a phone that is with us at all times. Text or call at any time during camp hours
@ 815-276-6829

Facebook: Check us out during the day! See what fun we are up to.

Search: shepherdofhillsBandA

**2025
Shepherd of the Hills
Summer Camp**

Date Starting _____ Exit Date _____

Child's Name: _____ Age/Grade _____ D.O.B _____
Address _____ Home # _____
City _____ Zip _____ Male/Female (circle)

Parents/Guardians

Name: _____ Relationship _____
Address: _____ Cell # _____
Occupation _____ Work # _____
Email _____

Name: _____ Relationship _____
Address: _____ Cell # _____
Occupation _____ Work # _____
Email _____

Summer Drop off TIME _____ a.m. - **Pick up** TIME _____ p.m. DAYS (circle) **M T W TH F**

Registration Fee: _____ (\$50) **Weekly Tuition:** _____

Numbers For emergency Contact & Non-Emergency Release

In case of an emergency, and we are unable to contact a parent/guardian, please provide information on additional adults that we may contact. Also, please list people that you give permission to our staff to release your child to.

Name _____ Relationship _____ # _____
Name _____ Relationship _____ # _____
Name _____ Relationship _____ # _____

Signature of Understanding

After filling out this form and reading the "PARENT HANDBOOK", I understand all information given, that all forms are correct, and I agree to follow all terms of the B&A School Care and Summer Camp. **Initials** _____

Summer Camp

*Summer Camp includes a number of mandatory activities that will take place throughout the summer. Parents are responsible for the extra cost for these trips and activities when necessary. The summer activities may include, but are not limited to: Vacation Bible School, Knox Pool, Roller Rink, Bus Field Trips, and Walking Field Trips. We will walk to all local destinations. **Initials** _____

Medical Conditions

Please let the director or teacher know of any special allergies or medical conditions your child may have. This will assist us in being better prepared to handle any emergencies that might arise.

1. Are there any special family circumstances we should be aware of? i.e. Divorce, death, adoption, just moved etc..... _____

2. Are there any special characteristics we should be aware of? i.e. Physical disabilities, learning disabilities, difficulties in hearing or speech, special fears etc..... _____

3. Does your child have any allergies? If yes, what are they? _____

4. Does your child take medication on a regular basis? _____

5. Any other info that might be helpful to us? _____

Consent Forms

The consent forms listed below are to be filled out completely, signed, and dated. These are designed to assist us in giving your child the best care possible. If you have any questions, please contact Ms. Ashley.

Consent Form 1

I, _____, give my consent to the staff members of the Shepherd of the Hills B&A School Care and Summer Camp Programs to call for emergency medical treatment for my child, _____, if necessary. It is understood that a conscientious effort will be made to locate me and that I, the parent/guardian, will pay any expenses that may occur.

Signature of Parent/Guardian

Date

Consent Form 2

I, _____, give my consent to the staff members of the Shepherd of the Hills B&A School Care and Summer Camp Programs, who are trained in first-aid, CPR and AED to administer treatment to my child, _____, should such an emergency arise.

Signature of Parent/Guardian

Date

Child Doctor to be called in case of an emergency

Doctor's Name _____ # _____

Address _____ City _____ Zip _____

Comments _____

Photographs

I agree that my child's picture, not name, may be used in press releases and for promotion of the S.O.T.H. B&A School Care and Summer Camp Programs.

Signature of Parent/Guardian

Date

***Shepherd of the Hills reserves the right to dis-enroll any child for non-payment or behavioral issues.**

Initial. _____

5/2025

SHEPHERD OF THE HILLS
BEFORE AND AFTER-SCHOOL CARE
SUMMER CAMP PROGRAM

Welcome!! The purpose of the Shepherd of the Hills Before and After School Care and Summer Camp program is to provide a quality environment which displays intellectual, social, creative, spiritual, and physical skills which are necessary for the personal growth of the child.

SUMMER CAMP HOURS

6 a.m. – 6 p.m. – Summer hours,
Days off and Early Dismissals

REGISTRATION AND TUITION RATES

The registration fee to enroll is \$50.00. **This is an annual fee**

Summer Camp tuition:

6 a.m. – 6 p.m.....\$50 a day

***TUITION IS DUE EVERY MONDAY. WE DO NOT TAKE CREDIT CARDS. CHECK CAN BE MADE PAYABLE TO SHEPHERD OF THE HILLS (SOTH) AND/OR CASH ONLY.**

***FULL WEEKLY TUITION IS DUE REGARDLESS OF THE CHILD'S ATTENDANCE, SICK, VACATION OR HOLIDAYS.**

***VACATION WEEKS (MONDAY – FRIDAY) MAY BE TAKEN AT ONE HALF TUITION RATE WITH PRIOR NOTICE.**

***IF YOU ARE 2 WEEKS BEHIND ON TUITION PAYMENTS YOUR CHILD WILL NOT BE ABLE TO ATTEND THE PROGRAM UNTIL THE BALANCE IS PAID IN FULL.**

***IF LATE PAYMENTS CONTINUE YOU WILL HAVE TO START PAYING A WEEK IN ADVANCE.**

***THERE IS A DISCOUNT FOR FAMILIES WITH MULTIPLE CHILDREN. 2ND CHILD IS 10% OFF WEEKLY TUITION.**

Signature _____ Date: _____

Please sign the form below and turn in with your registration paper work.

You can print a copy of the DCFS summary of Licensing on S.O.T.H. web site or get a copy from the director.

Thank you

Ashley Metcalf

CFS 581
Rev. 12/2000

State of Illinois
Illinois Department of Children and Family Services

VERIFICATION OF RECEIPT

I/WE, _____
Please Print Name(s)

parent(s) of _____, hereby certify that I/we have
Name(s) of Child(ren)
received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

Signature of Parent

Date

Signature of Parent

Date

THIS COMPLETED FORM IS TO BE PLACED IN EACH CHILD'S FILE AT THE DAY CARE FACILITY.



State of Illinois
Certificate of Child Health Examination

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



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

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

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

COMMENTS:

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

Lab Results Date MO DA YR (Attach copy of lab result)

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

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

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night	Yes	No	Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other		
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor <input type="checkbox"/>			Parent/Guardian Signature	Date	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing 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 CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI > 85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ (Blood test required if resides in Chicago.)				
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____				

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

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

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

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: Nurse Teacher Counselor Principal

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

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

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

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

Address _____ Phone _____

(Complete both sides)