CAMP GORTON 2024

This year's summer camp theme is all about Outer Space! Campers will be going on an adventure that is out of this world – exploring the stars, planets and getting to know about astronauts. This galactic adventure will unfold through stories, songs, games, crafts, and dramatic play!

Ages: 6 weeks - 5 years

Session I: June 10 - June 28 (holiday 6/19/24)

8:30 am-12:30 pm	Full Day Option
M-F: $1022	M-F: $1855
MWF: $585	MWF: $1060
T/Th: $438	T/Th: $795

Session II: July 1 - July 19

8:30 am-12:30 pm	Full Day Option
M-F: $949	M-F: $1722.50
MWF: $584	MWF: $1060
T/Th: $365	T/Th: $662.50

Session III: July 22 - August 9

8:30 am-12:30 pm	Full Day Option
M-F: $1095	M-F: $1987.50
MWF: $657	MWF: $1192.50
T/Th: $438	T/Th: $795

Our 2% Convenience Fee has been lowered to $10 per camp selection

Options available: MWF, TTh or M-F. AM Only or Full Day. No exceptions.

Lunch will be served at noon – cost is included in tuition.

CURRENT 2023-2024 PARENTS

If your child was enrolled in the 2023-2024 school year at the GCLC and your child's information is still valid (medical, birth certificate, contact info) your Camp Gorton registration is complete when you answer the first question on page 3.

If your information has changed or you are new, please complete the entire packet.

☐ 1. REGISTRATION FORMS:
Please complete pages 3-7 of this Registration Packet and return.

☐ 2. MEDICAL: Please take your DHS medical form and lead questionnaire to your child's doctor to complete and return.

Childhood Lead Risk Assessment Questionnaire signed and dated by child's physician. LEAD SCREENING IS REQUIRED FOR ALL CHILDREN SIX MONTHS AND OLDER WITH A PHYSICIAN'S SIGNATURE. A TB TEST IS ALSO REQUIRED FOR ALL CHILDREN ONE YEAR OLD AND OVER. IF YOUR CHILD'S PHYSICIAN ELECTS NOT TO ADMINISTER A LEAD TEST OR A TB TEST, WE MUST HAVE A NOTE ON FILE.

☐ 3. Photocopy of child's birth certificate – as required by DCFS. Please make a copy of your child's birth certificate and return.

CANCELLATION POLICY: You may cancel your child's Camp Gorton registration up to four weeks before the first day of camp. We are not able to give refunds for cancellations with less than four weeks notice. A 10 percent handling fee will be assessed for all cancellations. To cancel, please call 847-810-4115. If your child is unable to attend camp due to medical reasons, you may receive a refund (less the 10% processing fee) at any time prior to the start of camp by providing a doctor's note. We are unable to refund for any missed days of camp.

I, _____ confirm all below information is the same as 2023-2024 school year registration forms___ (check if applicable).

Last Name_____

Mother_____ Father_____

Address:_____ZIP_____

Home Phone:_____

Mother Cell:_____

Father Cell:_____

Mother's or Father's Employer: _____

Work Phone: _____

Children:

Name: _____

DOB_____ Gender: ☐ Male ☐ Female

Name: _____

DOB_____ Gender: ☐ Male ☐ Female

Name: _____

DOB_____ Gender: ☐ Male ☐ Female

EMERGENCY CONTACTS:

Name: _____

Address:_____

Phone #:_____

Relationship:_____

Name: _____

Address:_____

Phone #:_____

Relationship:_____

Name: _____

Address: _____

Phone #:_____

Relationship: _____

MEDICAL INFORMATION:

Physician:_____ Address:_____

Phone#:_____

Dentist:_____ Address:_____

Phone#:_____

Please provide any additional information that you believe your child's caregivers should be aware of regarding your child (i.e. allergies, extreme separation anxiety, health issues, custody arrangements, etc).

_____

_____

EMERGENCY AND MEDICAL PROCEDURES:
I have been informed of and agree to the following emergency and medical procedures:
1. In cases of illness, I will be called and required to pick up my child as soon as possible. If I cannot be reached, the Center will contact the emergency contacts I provided. I agree to provide at least 2 contacts. (initial_____)
2. In cases of simple injury (such as abrasion, skinned knee, splinters etc.), I understand the Center staff will perform routine hygienic procedures, such as washing wounds and applying bandages. I understand further, the Center staff will perform basic first aid procedures if the situation warrants such action. (initial____)
3. In cases requiring the attention of a physician (such as need for stitches or x-rays), I understand I will be called. If I, or the emergency contacts, cannot be reached, I request and give my permission for my child's doctor to be called and for that doctor to render any necessary treatment. I agree to assume financial responsibility for the doctor's care. (initial____)
4. In case of a medical emergency, I will be called immediately. If circumstances require, the paramedics will be called. The Center's staff will respond as necessary until the paramedics arrive. In the event that hospitalization is required, I give my consent for my child to be taken to Northwestern Lake Forest Hospital. I give my

consent for treatment by a qualified physician at Northwestern Lake Forest Hospital. I agree to assume all financial responsibility for such treatment. (initial____)
5. I agree to leave a telephone number where I or an emergency contact can be reached upon each visit to the Center. (initial____)
6. To the best of my knowledge, my child has no condition, which restricts his/her full participation in the Center program. If, in the future, such restrictions should become necessary, I will inform the Center staff in writing of those restrictions. (initial____)
7. I understand that if the Center deems it appropriate for my child to have an aide, I the parent will provide the aide. I agree to assume all financial responsibility for said aide. (initial_____)

PHOTO/VIDEO PERMISSION:
☐Yes, I give my permission for my child(ren) to be photo/video graphed for the Center's secret facebook page for the purpose of display at the Center or on the Gorton Community Center website. I understand that I would be contacted for my permission before a photograph would be released for the purpose of publicity outside the Center or Gorton Community Center website.
☐No, I do not give my permission for my child(ren) to be photo/video graphed at the Center.
EMAIL CONSENT:
Please confirm that you consent to receive communications from the Center's director.
I understand that by providing the email address below.

Email address: _____

Email address: _____

Gorton Children's Learning Center and Camp Gorton Drop-Off and Pick-Up Policy
I agree to drop-off my child no earlier than 8:25 am and pick by 12:30 pm for half day, and 4 pm for full day. Please come to your child's classroom to sign them in and sign out at pick-up.

If I pick up my child LATE, I agree to pay $10.00 for every 5 minutes I am late.
If I have not contacted the Gorton Children's Learning Center (GCLC) to notify them I am late within 15 minutes of the time I have reserved, the GCLC will call the emergency number I provided on the sign-in sheet. If I cannot be reached immediately, the GCLC will call the Emergency Contacts listed in my child's file.
If my child's emergency contacts cannot be reached or are unavailable to pick up my child, the GCLC is required by DCFS regulations to notify the local law enforcement officials and DCFS.

Signed:_____

Date:_____

Gorton Children's Learning Center Hearing and Vision

I, _____Parent of _____

understand that I am responsible for having my child's hearing and vision tested at age 3, as indicated by DCFS regulations. Date: _____

VERIFICATION OF RECEIPT:
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
Name(s) of Child(ren)

I/we have received a copy of a summary of licensing standards printed by the Illinois Department of Children and Family Services.

_____ _____
Signature of Parent Date

Note: the summary of licensing standards printed by the Illinois Department of Children and Family Services is found at the reception desk and on the Learning Center website.

*Registration forms must be turned into the Gorton Children's Learning Center no later than 1 week prior to the start of your child's camp start date.

State law requires actual signatures and paper copies of these forms and birth certificate copies to remain on file at the Center.

State of Illinois
Certificate of Child Health Examination

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

Illinois Department of DCFS Children & Family Services

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

Student's Name 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? Child wakes during the night	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
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 _____ Dental ☐ Braces ☐

Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING (410 ILCS 45/6.2)

Name _____ Today's Date_____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**R E S P O N S E**

1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? Yes No Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher? Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978? Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978? Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country? Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)? Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)? Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area? Yes No Don't Know

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A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _____ Test 2: Blood Lead Result_____mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_____ _____

Signature of Doctor/Nurse Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

Illinois Department of Public Health
Guidelines for Blood Lead Screening and Lead Risk Assessment

- **Blood lead screening** is defined as obtaining a blood lead test. **Lead risk assessment** is defined as evaluation of potential for exposures to lead based on questionnaire responses.

- **It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or potential exposure to lead has been identified, regardless of child's age.**

- Illinois has defined ZIP code areas at high risk and low risk for lead exposure based on housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.

- In Illinois, all children from **low-income families** (i.e., Medicaid-eligible children) should receive a blood lead test at ages 12 and 24 months, even if they live in a low-risk ZIP code area. If the child is 3 through 6 years old and has not been tested, a blood lead test is required.

Childhood Lead Risk Assessment Questionnaire

- Complete the Childhood Lead Risk Assessment Questionnaire during a health care visit at ages 12 and 24 months.
  - If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.
  - If any response is "YES" or "DON'T KNOW," obtain a blood lead test
- Consider evaluating children before 12 months of age, depending on the area.
- If the child is age 3-6 years ***and***
  1) there is any "YES" or "DON"T KNOW" ***and***
  2) has had two successive blood lead test results that were each less than < 10 mcg/dL with one of these tests at age 2 years or older ***and***
  3) risks of exposure to lead have not changed, **further blood lead tests are not necessary.**
- If the child is 1) 3-6 years, ***and*** 2) all answers to the Childhood Lead Risk Assessment Questionnaire are "NO," ***and*** 3) risks of exposure to lead have not changed, a blood lead test is not necessary.
- If the child is 3-6 years of age and risks of exposures to lead have increased, obtain a blood lead test.
- Continue to use the Childhood Lead Risk Assessment Questionnaire through age 6.

For children living in Chicago:

- A blood lead test for children age 3 and younger should be obtained at 6, 12, 18, 24 and 36 months **OR** at 9, 15, 24 and 36 months.
- Children 4 through 6 years of age with prior blood lead levels <10 mcg/dL should have an annual risk assessment. A blood lead test should be performed if risk increases or if the child exhibits persistent oral behaviors.

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

High-Risk ZIP Codes for Pediatric Blood Lead Poisoning

Adams
62301
62320
62324
62339
62346
62348
62349
62365
Alexander
62914
62988
Bond
62273
Boone
61038
Brown
62353
62375
62378
Bureau
61312
61314
61315
61322
61323
61328
61329
61330
61337
61338
61344
61345
61346
61349
61359
61361
61362
61368
61374
61376
61379
Calhoun
62006
62013
62036
62070
Carroll
61014
61051
61053
61074
61078
Cass
62611
62618
62627
62691
Champaign
61815
61816
61845
61849
61851
61852
61862
61872
Christian
62083
62510
62517
62540
62546
62555
62556
62557
62567
62570
Clark
62420
62442
62474
62477
62478
Clay
62824
62879
Clinton
62219
Coles
61931
61938
61943
62469
Cook
All Chicago
ZIP Codes
60043
60104
60153
60201
60202
60301
60302
60304
60305
60402
60406
60456
60501
60513
60534
60546
60804
Crawford
62433
62449
62451
Cumberland
62428
DeWitt
61727
61735
61749
61750
61777
61778
61882
DeKalb
60111
60129
60146
60550
Douglas
61930
61941
61942
DuPage
60519
Edgar
61917
61924
61932
61933
61940
61944
61949
Edwards
62476
62806
62815
62818
Effingham
None
Fayette
62458
62880
62885
Ford
60919
60933
60936
60946
60952
60957
60959
60962
61773
Franklin
62812
62819
62822
62825
62874
62884
62891
62896
62983
62999
Fulton
61415
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61563
Gallatin
62934
Greene
62016
62027
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62050
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62078
62081
62082
62092
Grundy
60437
60474
Hamilton
62817
62828
62829
62859
Hancock
61450
62311
62313
62316
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62321
62330
62334
62336
62354
Effingham
62367
62373
62379
62380
Hardin
62919
62982
Henderson
61418
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61471
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Henry
61234
61235
61238
61274
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61434
61443
61468
61490
Iroquois
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60967
60968
60973
Jackson
62927
62940
62950
Jasper
62432
62434
62459
62475
62480
Jefferson
62883
Jersey
62030
62063
Jo Daviess
61028
61075
61085
61087
Johnson
62908
62923
Kane
60120
60505
Kankakee
60901
60910
60917
60954
60969
Kendall
None
Knox
61401
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61489
61572
Lake
60040
LaSalle
60470
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61301
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Lawrence
62439
62460
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Lee
60553
61006
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61378
Livingston
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61769
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Logan
62512
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62548
62543
62635
62643
62666
62671
Macon
62514
62521
62522
62523
Knox
62526
62537
62551
Macoupin
62009
62033
62069
62085
62088
62093
62626
62630
62640
62649
62672
62674
62685
62686
62690
Madison
62002
62048
62058
62060
62084
62090
62095
Marion
None
Marshall
61369
61377
61424
61537
61541
Mason
62617
62633
62644
62655
62664
62682
Massac
62953
McDonough
61411
61416
61420
61422
61438
61440
61470
61475
62374
McHenry
60034
McLean
61701
61720
61722
61724
61728
61730
61731
61737
61770
Menard
62642
62673
62688
Mercer
61231
61260
61263
61276
61465
61466
61476
61486
Monroe
None
Montgomery
62015
62019
62032
62049
62051
62056
62075
62077
62089
62091
62094
62538
Morgan
62601
62628
62631
62692
62695
Moultrie
61937
Ogle
61007
61030
61047
61049
61054
61064
61091
Peoria
61451
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61602
61603
61604
61605
61606
Perry
62832
62997
Piatt
61813
61830
61839
61855
61929
61936
Pike
62312
62314
62323
62340
62343
62345
62352
62355
62356
62357
62361
62362
62363
62366
62370
Pope
None
Pulaski
62956
62963
62964
62976
62992
Putnam
61336
61340
61363
Randolph
62217
62242
62272
Richland
62419
62425
62077
Rock Island
61201
61236
61239
61259
61265
61279
St. Clair
62201
62203
62204
62205
62220
62289
Saline
62930
62946
Sangamon
62625
62689
62703
Schuyler
62452
62319
62344
62624
62639
Scott
62621
62663
62694
Shelby
62438
62534
62553
Stark
61421
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61483
61491
Stephenson
61018
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61089
Tazewell
61564
61721
61734
Union
62905
62906
Vermilion
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61876
61883
Wabash
62410
62852
62863
Warren
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61473
61478
Washington
62214
62803
Wayne
62446
62823
62843
62886
White
62820
62821
62835
62844
62887
Whiteside
61037
61243
61251
61261
61270
61277
61283
Will
60432
60433
60436
Williamson
62921
62948
62949
62951
Winnebago
61077
61101
61102
61103
61104
Woodford
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