



REGISTRATION INFORMATION

School Year 2023-24

Welcome to the Gorton Children's Learning Center. We are licensed by the State of Illinois and meet or exceed all of their standards. A qualified staff provides a warm, nurturing, and educational environment that meets each child where they are on their developmental journey.

Enrollment payments can be made online at <http://www.gortoncenter.org>, just click on Children's Learning Center and click "enroll." State law requires actual signatures and paper copies of these forms and birth certificate copies to remain on file at the Center.

Please complete items 1-4 below and bring these documents to the Children's Learning Center.

1. Registration Form - Please complete the entire Registration Form, sign, and date. Sign and date the Verification of Receipt section.

2. DHS Certificate of Child Health Examination signed and dated by the child's physician in two places. THIS FORM MUST BE DATED NO EARLIER THAN SIX MONTHS BEFORE THE BEGINNING DATE OF THE PROGRAM.

Childhood Lead Risk Assessment Questionnaire signed and dated by the 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 DOCTOR'S NOTE ON FILE.

3. Birth Certificate - A photocopy of each child's birth certificate – is required by DCFS.

4. Standard Registration fee – Early enrollment is from 5/1/23 to 8/11/23. Early enrollment is \$175.00 for one child and \$230.00 for two or more children. After 11:59PM on August 11th, it is \$205 for a family enrolling one child and \$275 for families enrolling two or more children. Pay the enrollment fee online, then download and print the enrollment forms. Your registration is complete once the director has received all the forms and the fee has been paid. If you pay by check, make it payable to: Gorton Children's Learning Center. **Registration fees are non-refundable.**

5. Reservations - We are a flexible schedule center that operates on a standing reservation-only platform. Standing reservations are defined as a 2.5-hour minimum commitment, the same time and day of the week for the entire semester. ***The fall semester is from 9/5/23 to 12/22/23 and Spring begins 1/8/24 until 5/31/24.*** The hourly rates as of 9/5/23 are: for one child attending \$17 per hour for 0-24 months, \$14.50 per hour for 2-year-olds, and \$13.50 per hour for 3-5 years; half-hourly price for each additional child. Standing reservations are accepted on a first-come, first-serve basis.

6. Lunch – Lunch is \$5 for children ages 15 months and up. You may bring food in if your child has food allergies (or sensitivities), or is under 15 months. Children with food allergies and sensitivities must have a note from a doctor. Please do not bring bottles after the age of 2.

We are a nut-free environment. Menus follow DCFS guidelines and are posted behind the reception desk.

Thank you for your cooperation in completing the necessary information. Please read the Parent Handbook to become familiar with our Center.

REGISTRATION FOR 2023-2024

I, _____ confirm all below information is the same as 2022-23 school year registration forms____(check if applicable). *Please do not complete if information has not changed.*

Child's Name _____ Parents/Guardians Name _____

Address _____ ZIP _____

Home Phone _____ Parent/Guardian Mobile _____

Parent/Guardian Employer _____ Work Phone _____

Children: Name _____ DOB _____ Gender: M/F

Name _____ DOB _____ Gender: M/F

Name _____ DOB _____ Gender: M/F

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 will help us better care for your child (ex; what provides comfort: fears or behaviors we should be aware of: circumstances such as adoption or child custody agreements.)

Allergies/ Medical issues:

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 the need for stitches or x-rays), I understand that 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. If 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. The CLC staff will make reasonable accommodations to the best of their ability. (initial____)

7. All children enrolled at the Gorton Children's Learning Center must be up to date on the state-recommended immunizations. See the parent handbook for the schedule. (initial____)

PAYMENT - Two Payment options only:

1. Families may keep a credit card on file that will run twice per month. You will be sent a statement via email for charges accrued from the 1st-15th and then the 16th-31st for your review. The credit card will run 2 business days after the statement is sent unless otherwise communicated. To utilize this option, please complete the credit card authorization form included in this packet. Credit card information will be kept in a secure location.

2. Drop off payment via check or cash in the payment drop box. I understand that I will be charged \$25.00 plus bank fees for any checks that are returned.

*There is a \$25.00 late fee charge for all unpaid balances after 72 business hours.

PHOTO/VIDEO PERMISSION: (circle one)

YES I give my permission for my child(ren) to be photo/video graphed at the Center for display at the Center or on the Gorton Center website. I understand that I would be contacted for my permission before a photograph would be released for publicity outside the Center or Gorton Center website.

NO I do not give my permission for my child(ren) to be photo/video graphed at the Center.

EMAIL CONSENT:

I understand that by providing the email address below, I am giving consent to receive billing statements, notices, and important reminders and announcements sent by the Center Director.

Email address: _____

Email address: _____

Gorton Children's Learning Center (CLC) Drop-Off and Pick-Up Policy

I agree to drop off and pick up my child at the time I designated on my child's standing reservation at the Gorton Children's Learning Center.

If I drop my child off before the reserved time, I agree to pay for the time my child arrived.

If I pick up my child late, I agree to pay \$4.00 for every 5 minutes I am late.

If I have not contacted the CLC to notify them I am late within 10 minutes of the time I have reserved, the CLC will call the emergency number I provided on the sign-in sheet. If I cannot be reached immediately, the CLC 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 CLC is required by DCFS regulations to notify the local law enforcement officials and DCFS.

Signed _____ 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

Signature of Parent

Date

Note: the summary of licensing standards printed by the Illinois Department of Children and Family Services can be found at: <https://gortoncenter.org/learning-center/enroll/>

I AGREE TO COOPERATE WITH THE RULES AND REGULATIONS OF THE GORTON CHILDREN'S LEARNING CENTER REGARDING FEES, ABSENT DAY POLICY, ILLNESS, IMMUNIZATION UPDATES, CLOTHING AND OTHER ITEMS SPECIFIED IN THE PARENT HANDBOOK.

Parent/Guardian Signature

Date

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.

Signature of Parent

Date

Parent Handbook - I have received and read a copy of the Gorton Children's Learning Center parent handbook:

Signature of Parent

Date

Printed Parent/Guardian Name

Attach Photocopy(ies) of Child(ren)'s Birth Certificate(s) Here (As Required by DCFS)

Gorton Children's Learning Center
Credit Card Authorization Form Repeat Payments

CARDHOLDER INFORMATION

Name _____

Street Address _____

Billing Address (if different) _____

City _____ State _____ Zip Code: _____

Country _____ Email (for receipts) _____

Direct Telephone _____

CREDIT CARD INFORMATION

Credit Card Type: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover Card

Number _____

Expiration Month/Expiration Year _____ Security Code _____

I authorize Gorton Children's Learning Center to charge my credit card for the amounts due.

Signature of Card Holder

Date



State of Illinois Certificate of Child Health Examination

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



Student's Name				Birth Date		Sex	Race/Ethnicity		School /Grade Level/ID#									
Last		First		Middle		Month/Day/Year												
Address				Street		City		Zip Code		Parent/Guardian		Telephone # Home						
												Work						
IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for <i>every</i> dose administered. The day and month is required if you cannot determine if the vaccine was given <i>after</i> the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.																		
Vaccine / Dose	1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA YR		
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)													COMMENTS:					
Varicella (Chickenpox)																		
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) ** <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> 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
Vision																		
Hearing																		
																		Code: P = Pass F = Fail U = Unable to test 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					
Birth defects?	Yes	No		Hospitalizations?	Yes	No	
Developmental delay?	Yes	No		When? What for?			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.)	Yes	No	
				When? What for?			
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 of 10 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 |

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	62567	Effingham	62367	Knox	62526	61466	62976	60942
62301	62570	None	62373	61401	62537	61476	62992	60960
62320	Clark	Fayette	62379	61410	62551	61486	Putnam	60963
62324	62420	62458	62380	61414	Macoupin	Monroe	61336	61810
62339	62442	62880	Hardin	61436	62009	None	61340	61831
62346	62474	62885	62919	61439	62033	Montgomery	61363	61832
62348	62477	Ford	62982	61458	62069	62015	Randolph	61833
62349	62478	60919	Henderson	61467	62085	62019	62217	61844
62365	Clay	60933	61418	61474	62088	62032	62242	61848
Alexander	62824	60936	61425	61485	62093	62049	62272	61857
62914	62879	60946	61454	61489	62626	62051	Richland	61865
62988	Clinton	60952	61460	61572	62630	62056	62419	61870
Bond	62219	60957	61469	Lake	62640	62075	62425	61876
62273	Coles	60959	61471	60040	62649	62077	Rock Island	61883
Boone	61931	60962	61480	LaSalle	62672	62089	61201	Wabash
61038	61938	61773	Henry	60470	62674	62091	61236	62410
Brown	61943	Franklin	61234	60518	62685	62094	61239	62852
62353	62469	62812	61235	60531	62686	62538	61259	62863
62375	Cook	62819	61238	61301	62690	Morgan	61265	Warren
62378	All Chicago	62822	61274	61316	Madison	62601	61279	61412
Bureau	ZIP Codes	62825	61413	61321	62002	62628	St. Clair	61417
61312	60043	62874	61419	61325	62048	62631	62201	61423
61314	60104	62884	61434	61332	62058	62692	62203	61435
61315	60153	62891	61443	61334	62060	62695	62204	61447
61322	60201	62896	61468	61342	62084	Moultrie	62205	61453
61323	60202	62983	61490	61348	62090	61937	62220	61462
61328	60301	62999	Iroquois	61354	62095	Ogle	62289	61473
61329	60302	Fulton	60911	61358	Marion	61007	Saline	61478
61330	60304	61415	60912	61364	None	61030	62930	Washington
61337	60305	61427	60924	61370	Marshall	61047	62946	62214
61338	60402	61431	60926	61372	61369	61049	Sangamon	62803
61344	60406	61432	60930	Lawrence	61377	61054	62625	Wayne
61345	60456	61441	60931	62439	61424	61064	62689	62446
61346	60501	61477	60938	62460	61537	61091	62703	62823
61349	60513	61482	60945	62466	61541	Peoria	Schuyler	62843
61359	60534	61484	60951	Lee	Mason	61451	61452	62886
61361	60546	61501	60953	60553	62617	61529	62319	White
61362	60804	61519	60955	61006	62633	61539	62344	62820
61368	Crawford	61520	60966	61031	62644	61552	62624	62821
61374	62433	61524	60967	61042	62655	61602	62639	62835
61376	62449	61531	60968	61310	62664	61603	Scott	62844
61379	62451	61542	60973	61318	62682	61604	62621	62887
Calhoun	Cumberland	61543	Jackson	61324	Massac	61605	62663	Whiteside
62006	62428	61544	62927	61331	62953	61606	62694	61037
62013	DeWitt	61563	62940	61353	McDonough	Perry	Shelby	61243
62036	61727	Gallatin	62950	61378	61411	62832	62438	61251
62070	61735	62934	Jasper	Livingston	61416	62997	62534	61261
Carroll	61749	Greene	62432	60420	61420	Piatt	62553	61270
61014	61750	62016	62434	60460	61422	61813	Stark	61277
61051	61777	62027	62459	60920	61438	61830	61421	61283
61053	61778	62044	62475	60921	61440	61839	61426	Will
61074	61882	62050	62480	60929	61470	61855	61449	60432
61078	DeKalb	62054	Jefferson	60934	61475	61929	61479	60433
Cass	60111	62078	62883	61311	62374	61936	61483	60436
62611	60129	62081	Jersey	61313	McHenry	Pike	61491	Williamson
62618	60146	62082	62030	61333	60034	62312	Stephenson	62921
62627	60550	62092	62063	61740	McLean	62314	61018	62948
62691	Douglas	Grundy	Jo Daviess	61741	61701	62323	61032	62949
Champaign	61930	60437	61028	61743	61720	62340	61039	62951
61815	61941	60474	61075	61769	61722	62343	61044	Winnebago
61816	61942	Hamilton	61085	61775	61724	62345	61050	61077
61845	DuPage	62817	61087	Logan	61728	62352	61060	61101
61849	60519	62828	Johnson	62512	61730	62355	61062	61102
61851	Edgar	62829	62908	62518	61731	62356	61067	61103
61852	61917	62859	62923	62519	61737	62357	61089	61104
61862	61924	Hancock	Kane	62548	61770	62361	Tazewell	Woodford
61872	61932	61450	60120	62543	Menard	62362	61564	61516
Christian	61933	62311	60505	62635	62642	62363	61721	61545
62083	61940	62313	Kankakee	62643	62673	62366	61734	61570
62510	61944	62316	60901	62666	62688	62370	Union	61760
62517	61949	62318	60910	62671	Mercer	Pope	62905	61771
62540	Edwards	62321	60917	Macon	61231	None	62906	
62546	62476	62330	60954	62514	61260	Pulaski	62920	
62555	62806	62334	60969	62521	61263	62956	62926	
62556	62815	62336	Kendall	62522	61276	62963	Vermilion	
62557	62818	62354	None	62523	61465	62964	60932	