

CAOS Student Personal Information Sheet

Child's Name: _____ Birth Date: _____

Grown Up 1: _____ Grown Up 2: _____

In the event that the school needs to communicate with you during the day, please rank your preferred method of communication in the spaces provided below:

Please put an asterisk beside the address and phone number you would like your child to practice (beginning in Pre-K).

Name: _____ Name: _____

Address: _____ Address: _____

City/Zip: _____ City/Zip: _____

_____ Home Phone: _____ Home Phone: _____

_____ Cell Phone: _____ Cell Phone: _____

_____ Text OK? Y/N List Carrier: _____ Text OK? Y/N List Carrier: _____

_____ Work Phone: _____ Work Phone: _____

Employer: _____ Employer: _____

_____ E-mail: _____ E-mail: _____

Family: Please list all persons living in the household(s) with the student. Please provide ages of other children in the home:

Name	Nickname	Relationship	Sex	Age

EMERGENCY INFORMATION

Pediatrician's Name: _____ Pediatrician's Phone Number: _____

Preferred Hospital: _____

In-area emergency contacts when parents cannot be reached:

Name: _____ Relationship to Child: _____ Can pick up child? Y N

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Relationship to Child: _____ Can pick up child? Y N

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name: _____ Relationship to Child: _____ Can pick up child? Y N

Home Phone: _____ Cell Phone: _____ Work Phone: _____

It is your responsibility to inform us in writing if you need to add or remove authorized persons to pick up your child. Please indicate below other persons authorized to pick up your child.

Name: _____ Relationship to Child: _____ Contact #: _____

Name: _____ Relationship to Child: _____ Contact #: _____

Known Allergies (Food Allergies will be reported separately): _____

Medical/physical factors that may impact participation in school activities: _____

Please sign below if you are interested in participating in the CAOS PTO organization:

Sponsor 1 Signature

Sponsor 2 Signature

The CAOS PTO publishes a family directory that is useful for planning events and activities with other CAOS families and is not distributed for any other purpose. If you would like to be included in this directory, please provide consent to provide the following information to the CAOS PTO:

Patent name(s), e-mail addresses, cell phone numbers, home phone number, CAOS student's name, birth date, grade level, teacher and any siblings not at CAOS. Please mark through any items you do not wish to publish.

Sponsor 1 Signature (consent for PTO directory)

Sponsor 2 Signature (consent for PTO directory)

Please confirm receipt of the tuition policy. I/We plan to:

_____ Use Tuition Express (debit or credit cards) _____ Carle payroll deduction _____ Apply for exeption

I/We have read and understand the following information.

_____ Illness policy

_____ Attendance policy

_____ Tuition policy

_____ Weather closure process

_____ Understanding of HIPAA regulations regarding communications

_____ Parent handbook

_____ University student placements

_____ Offsite walks

Please confirm you have read and understand the above:

Grown Up 1 Signature

Grown Up 2 Signature

CAOS Child Fact Sheet

805 W. Park St., Urbana, IL 61801

Child's Full Name (including middle) _____ / _____
Nickname

Form Completed By: _____

Family interests and hobbies: _____

Facts about your child:

What are some of your child's likes? _____

What are some of your child's dislikes? _____

Are there some things that can generally make your child mad or sad? _____

What helps calm your child when he/she is upset? _____

Are there any situations that may be difficult for your child? _____

Please list any additional concerns/behaviors specific to your child that the teacher/therapist should know about: _____

Please list any special goals or areas of focus for your child this year: _____

Food Information Form (FIF)

Child's Name: _____ Date Completed: _____

Person Completing the Form/Relationship: _____ / _____

Please complete the sections below to provide guidance on your child's interactions with food while enrolled at our school. Please mark in each box to indicate your child's dietary restrictions in each category. Please mark 'none', rather than leaving a box blank, if you do not have dietary restrictions to report in any of the listed areas.

Children may be exposed to a variety of foods during learning activities at the school. Under the family preferences section, please let us know how you would like us to support your child in trying new foods.

<p>Potentially Life-Threatening Food Allergy: ingestion and/ or contact with the food trigger causes an immune system reaction resulting in respiratory distress that is treated using epinephrine. A Food Allergy Emergency Action Plan must be completed by a physician for each life-threatening food allergy. Family will complete the Food Allergy History. Additionally, the staff and family will work together to develop an Individual Health Care Plan.</p>	<p>Food Sensitivity/ Intolerance: ingestion of the food triggers undesirable gastrointestinal, skin or behavioural symptoms. A Physician Statement for Food Substitution form is required for each food sensitivity/ intolerance. Family will complete the Food Sensitivity History as well.</p>
<p>Religious Belief: the family's faith dictates avoidance of certain foods or food combinations; examples include avoiding meat on Fridays during Lent for a Catholic family or avoiding pork for a Jewish family. A Family Statement for Food Restriction/ Substitution form is required.</p>	<p>Family Preference: any dietary restriction determined by the family; examples include a family's choice to follow a vegetarian diet, avoid food dyes, or choking hazards or limit sugar intake. A Family Statement for Food Restriction/ Substitution form is required.</p> <p>How would you like us to support your child in trying new foods? Please indicate your choice below:</p> <p><input type="checkbox"/> Encourage child to taste food before saying 'no thank you'.</p> <p><input type="checkbox"/> Child can say 'no thank you' without first tasting.</p>

Carle Auditory Oral School/Carle Foundation Hospital Physician Authorization And Permission For Medication Administration

Student's Name: _____ Today's Date: _____
(Last) (First) Birth Date

Student attends the following days/times: _____

Medication is administered following these guidelines:

- Physician/Prescriber signed, dated authorization to administer the medication
- Parent signed, dated authorization to administer the medication
- Medication is in the original labeled contained as dispensed (or the manufacturer's labeled container)

PHYSICIAN AUTHORIZATION:

Medication:		Dosage:
Time to be administered:	Intended effect of this medication:	
Expected side effects, if any:	Administration instructions:	
Other medications student is taking:	Discontinue/Re-Evaluate/Follow-up Date (circle one):	
Physicians Signature:		Date Signed:
Physicians Name:		Physician's Emergency Phone #:

PARENT AUTHORIZATION AND PERMISSION FOR MEDICATION ADMINISTRATION

I herewith acknowledge that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorization Carle Auditory Oral School and its employees and agents, on my behalf, to administer or attempt to administer to my child lawfully prescribed medication or over-the-counter medications that I have provided. These medications must be labeled appropriately as follows:

- Prescription medication is administered in accordance with the pharmacy label directions as prescribed by the child's health care provider. Instructions from the child's parent/guardian shall not conflict with the label directions as prescribed by the child's health care provider.
- Over the Counter medications may be administered in accordance with the product label directions on the container with physician authorization. The instructions from the child's parent/guardian shall not conflict with the product label directions on the container.

I further acknowledge and agree that, when the lawfully prescribed medication is so administered, I waive any claims I might have against Carle Auditory Oral School or Carle Foundation Hospital or its agents and employees arising out of the administration of said medication.

Child's Name:	Date Signed:
Parent/Guardian Signature:	Contact Phone #:

CAOS Family Involvement Expectations

Child's Name: _____

Many private schools require parents to commit to a certain number of volunteer hours each year, helping in the classrooms, lunch room, school library or at after school events as part of their tuition agreement. Families who are unable to meet this requirement are often charged an additional fee. CAOS families are spared this requirement, largely due to the tremendous volunteer support that we receive from Carle's Volunteer Office and University of Illinois students. In lieu of this, we ask that families commit to each of the listed activities by initiating each expectation and signing below. Please see the handbook for additional information about each commitment statement.

ALL PARENTS:

- _____ Read with your children 5 - 7 days per week. Check and respond to information in your child's folder each night.
- _____ Review your child's journal each night, making entries as requested by your child's teacher.
- _____ Send morning snack for the school, approximately once every two months, for each enrolled student.
- _____ Share 3 traditions/ experiences with your child's class per school year.
- _____ Communicate with your child's teacher, school office or the program director if you have questions, suggestions or concerns about your child's educational program.
- _____ Participate in Parent Teacher Conferences two to three times per school year.

PARENTS OF CHILDREN WITH HEARING LOSS:

- _____ Ensure that your child arrives with functioning hearing device(s) on each day of attendance.
- _____ Ensure that you send extra batteries for your child's hearing device.
- _____ Ensure that you send troubleshooting equipment, such as earmold cleaning brushes, cochlear implant cables and headpieces, if applicable.
- _____ Observe or participate in 2 therapy session and 2 classroom lessons per year.
- _____ Participate in monthly Parent Professional Collaboration Meetings.

We greatly appreciate your support in these areas and realize that our school could not function successfully without you!

Signature Date Signature Date

FAMILY ENGAGEMENT

Please list three traditions you will share with your child's class this school year, the time of year most meaningful for sharing and whether you will be coming into class or providing materials to be shared at school. Please contact your child's teacher or the school office if you have any questions.

Tradition	When?	Provide materials only/provide materials & able to lead the activity

CAOS Nap Information

Child's Name: _____

CAOS staff knows that getting adequate rest is an important part of being ready to learn and play each day. Because of this, nap will be provided to **three year olds/PS students** enrolled in Carle Auditory Oral School. We will continually monitor the napping procedures and napping behaviors of the children. If requested, families can receive daily notification about sleeping behaviors.

Napping behaviors include whether or not the child fell asleep during the allotted naptime as well as a description of their behavior during the time they are awake in the nap room.

Some children fall asleep quickly, and others more slowly. Some children sleep every day; others only sleep one or two times per week. These normal variances are okay as long as behaviors and noise levels do not detract from other students' ability to fall asleep. As with all processes and procedures at CAOS, nap time management is continually adapted to ensure maximal benefit. Staff will track napping behaviors and if concerns arise, the napper's family will be consulted to develop a plan moving forward. This plan may include development of a behavior plan for individual children, requests for support from home, or exclusion from nap at CAOS, if warranted.

<p>Our four year-old Pre-K classroom schedule does not include a break for a nap. However some 4 year-olds have not yet transitioned out of a nap.</p> <p>Please indicate below if your four year old requires a nap during the school day. Please indicate your preferred nap duration:</p> <p style="text-align: center;">Circle one: 30 min 60 min 90 min</p>
--

I/We understand the napping procedures.

I/We understand that we may request a summary of my/our child's napping behavior.

I/We understand that CAOS staff will provide this summary if they have a concern about my/our child's napping behaviors.

Parent Signature

Date

Parent Signature

Date

Tuition Policy

- Participation in automatic payment plan is **required** for all enrolled students. Electronic Funds Transfers (Tuition Express) will be made according to the attached schedule.

With this method of tuition billing, all accounts should remain current. In the event that tuition is not paid in full (due to change in banking institution or other unforeseen circumstance), families have one week to reconcile accounts and return to a zero balance. Failure to keep the tuition bill current will result in a temporary suspension for the student.

Students can be re-enrolled when tuition balance is paid in full within one week. The student's spot may be given to another family if tuition balance is not paid in full within two weeks.

We apologize for any inconvenience this policy may cause. It is essential that revenue from tuition be kept current in order to maintain our program and educational offerings. Please contact the director with any questions or concerns.

- It may be possible to obtain an exception by completing the Exception Request Form. Any approved exception will come with an expectation to pre-pay tuition, one month at a time. That is, August school tuition would be paid by August 1st, September Tuition in addition to unforeseen childcare fees from August, would be paid by September 1st, etc. Failure to comply with this pre-payment plan would result in your child's suspension from school/child care.
- Please indicate on the Student Personal Information form which method of payment you will be utilizing - Tuition Express or Tuition Exception.

CAOS Tuition Policy Exception Request Form

Child's Name: _____ Child's Date of Birth: _____

Projected Classroom Placement: _____

Reason for Tuition Policy Exception Request: _____

Details of Exception Request (I.E. Alternate Date Of EFT Withdrawal, Date/Method of Prepayment, Etc): _____

Course of Action if Exception is Not Granted: _____

I/We understand that if this exception is granted, that:

_____ Failure to comply with this payment plan will result in my/our child's suspension from the school and child-care programs until tuition is paid in full.

_____ If back tuition is not caught up within one week of suspension, my/our child's spot may be taken by another family.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

OFFICE USE

Tuition Policy Exception Request:

Approved

Approved with Modifications

Approved

Modifications, if Applicable: _____

OUTLINE OF APPROVED EXCEPTION PAYMENT PLAN

Due Date: _____

Invoice to be Sent? Yes No

Receipt Provided? Yes No

Receipt Provided? Check Money Order Cash

I/We Agree to the Terms Outlined Above:

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Biweekly Payment Timetable for 2021-2022

Payment Dates:	
Aug 6	
Aug 20	
Sep 3	
Sep 17	
Oct 1	
Oct 15	
Nov 12	
Nov 26	
Dec 10	
Dec 24	
Jan 7	
Jan 21	
Feb 4	
Feb 18	
Mar 4	
Mar 18	
Apr 1	
Apr 15	
Apr 29	
May 13	
May 27*	
*May 27 will be FINAL payment date for any remaining balances for the 2021-22 school year.	

Tuition Express deductions will occur on the dates listed. Tuition payments will be processed across 20 billing periods for the 2021-2022 school year, with two payments being processed monthly* from August 2021 to May 2022.
*April is the exception

Regarding child care, families will need to anticipate child care needs for the month ahead. You will receive a child care form each month for the next month. Please complete and return these forms by the 15th of the month. Once your child care needs have been determined, you will then be notified of the payment amounts for the following month. Please understand that biweekly deduction amounts will vary based on the amount of child care services utilized.

Summer camp charges will be processed during June 2022 (on June 10th and 24th).



**Hop aboard the Tuition Express
and never write a check again!**

ProCare Software

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check or remember your checkbook when you're picking up your child at the end of a hectic day. Your payment will be safely and securely processed by Tuition Express, giving you peace of mind that your tuition has been paid on time! It's easy to enroll and even easier to participate. You'll be joining tens of thousands of parents nationwide who enjoy the ease and convenience of Tuition Express.

To learn more about Tuition Express, automatic payment notifications or reviewing your payment history, please visit www.tuitionexpress.com.

For Bank Account Authorization, complete and return to center management.

ELECTRONIC FUNDS TRANSFER AUTHORIZATION

I (we) authorize _____, (called "CENTER" in this Authorization) to initiate debit entries to my (our) Checking or Savings Account indicated below at the depository financial institution indicated below (called "DEPOSITORY" in this Authorization). I (we) authorize CENTER to withdraw sufficient funds to pay my (our) regular childcare tuition and/or other childcare related fees that are due and payable. I (we) authorize CENTER to use the third party sender, Tuition Express* to process all payments. I (we) acknowledge that the origination of Automated Clearing House (ACH) transactions to my (our) account must comply with the provisions of United States Law.

Credit Union Members: Please contact your Credit Union to verify account and routing numbers for automatic payments.

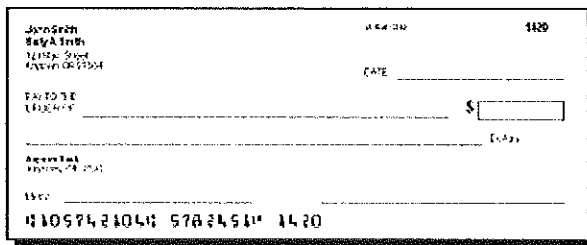
Your Name _____		Phone # _____	DEPOSITORY - Bank or Credit Union Name _____		
Address _____		Bank or Credit Union Address _____			
City _____	State _____	Zip _____	City _____	State _____	Zip _____
			Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		
Routing Transit Number (see sample below) _____			Account Number (see sample below) _____		

This authorization will remain in full force and effect until I (we) notify the CENTER in writing of its termination in such time and in such manner as to afford Tuition Express and DEPOSITORY a reasonable opportunity to act upon it. Notices must be received at a minimum of 5 business days in advance of the termination date.

Signature _____ Date _____

Record Retention Notice: The child care provider shall retain all parent (client) authorization forms in a secure location for a period of two years from the date of client withdrawal from the Tuition Express™ program.

*Tuition Express is an assumed business name of Blum Investment Group, Inc.



Routing Transit Account Check
Number Number Number

Please attach a copy of a voided check here. Deposit slips not accepted.

TUITION

Express

ProCare Software

Hop aboard the Tuition Express and never write a check again!

As your childcare provider, we are excited to offer you the convenience of automatic tuition payments through Tuition Express. You'll no longer need to write a check, or remember your checkbook, as you're picking up your child at the end of a hectic day. Your account will be safely and securely debited by Tuition Express, giving you peace of mind, knowing your tuition is being paid when it's due. It's easy to enroll and even easier to participate. You'll join millions who already pay mortgages, car payments, and childcare tuition automatically. Tuition Express is convenient and safe for you, and it helps us do a better job caring for your child.

Frequently Asked Questions

When I pay my tuition automatically, how secure is my account information?

Very secure – more secure than when you write checks. The checks you write every day have your name, address, phone number, and sometimes your driver's license number on them. With this information, criminals have all they need to access your account or worse, *steal your identity*. Automatic payments greatly reduce this potential problem by limiting the amount of information available and who has access to it. Tuition Express also incorporates additional security procedures, utilizing 128 bit encryption.

What if the childcare center makes a mistake and takes out too much money?

Report the error to your childcare center immediately – it was most likely an honest mistake. The childcare center will then adjust your account accordingly.

What if my childcare center and I disagree about a payment?

If you feel that the payment should not have been made, you have the right to dispute the charge. Contact your bank or credit card company. Tuition Express and your childcare provider will work closely to resolve the issue in a timely manner.

Does this form of payment give the childcare center access to my account?

Nobody at the childcare center has access to your account. When you sign up for Tuition Express, you only authorize *your* bank or credit card company to release the exact amount owed to your provider when it is due and payable.

How will I know when a payment was taken out of my account?

Your childcare expenses will be taken out of your account on a schedule that you and the childcare center agree upon. Your childcare center has the ability to print statements for your records prior to the withdrawal of any money. Additionally, the charges will show up on your monthly statement as "Tuition Express".

When I sign up for Tuition Express, how will this help my childcare provider?

Your childcare provider has chosen to offer Automatic Payments for several reasons. First, it will give you the convenience of not having to write a check every time tuition and fees are due. Second, it allows regular scheduling of your payments. Most importantly, Automatic Payments reduce the amount of time your childcare center spends on management activities, giving staff more time to spend with the children.

How do I get started?

Simply complete the "Payment Authorization" form and return it to your childcare provider. They will do the rest! For more information on automatic payments, visit www.directpayment.org. This is an excellent resource explaining the system and its benefits.

Where can I learn more?

For more information on the benefits of Tuition Express, please visit us at www.tuitionexpress.com.



Your provider will issue you a unique Tuition Express account number: ➔ 6288-6773-032

What is Tuition Express?

Tuition Express™ is the premier payment processing service in the childcare industry. As one of the many benefits offered by Tuition Express, parents have the ability to receive their payment receipts via email. TuitionExpress.com keeps parents in-touch with their childcare center and their personal finances. Here are some of the features of TuitionExpress.com:

- Receive all your Payment Receipts via email.
- Email notification of all Non Sufficient Fund (NSF) items or Declined Credit Card transactions.
- View and print Transaction History reports.
- Re-generate past email payment notifications.
- All receipts are Flexible Spending Account qualified (provided center has submitted required data).
- Easy access to change email addresses notifications are sent to.

How to Register at TuitionExpress.com

- Your childcare provider will issue you a unique Tuition Express ID number.
- Go to <http://www.tuitionexpress.com> and click on "My Account".
- Click the "Click here to Register" link to begin the account set up.
- Enter the Tuition Express ID number and the Last 4 digits of your bank or credit card account number.
- Create a User Name and Password
- Type in your email address and check the box "Receive Notification"
- Click "Submit". When you receive an email from Tuition Express click on the link to confirm your email address.

Facts about Automatic Payments

- Automatic Payments have been around for more than 30 years and uses the same network as Automatic Deposits. More than 2 billion transactions a year are made via Automatic Payment.
- Each Automatic Payment is deducted from your account on the due date of each payment cycle so it is easy to track..
- Automatic Payments are confidential transactions. Just one or two people see them. In contrast, checks pass through three to nine hands as they are processed. PLUS, they have all the information available for a criminal to steal your identity.
- Automatic Payments help you maintain a good credit rating because bills are paid on time, every time.
- Record keeping is easy. Each bill paid automatically from your checking account or credit card is listed on your monthly statement.
- Consumers who use Automatic Payment are protected by the Electronic Funds Transfer Act of 1978, known as Federal Regulation E. www.bankersonline.com/regs/205/205.html
- Automatic Payment saves you money. It costs consumers close to \$100 a year in time and Automatic costs, such as postage, to pay bills by check instead of using Automatic Payment.
- Automatic Payments is great for travelers — since bills are paid automatically, you do not have to worry about them when you are out of town.

Childcare Needs – August 2021

Childcare needs for:		MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
		2	3	4	5	6
Before Care		No School/ Daycare Closed	No School/ Daycare Closed	No School/ Daycare Closed		
After Care						
Choose Your Own Hours Care	Drop-off Time:	No School/ Daycare Closed	No School/ Daycare Closed	No School/ Daycare Closed		
	Pick-up Time:					
		9	10	11	12	13
Before Care						
After Care						
Choose Your Own Hours Care	Drop-off Time:					
	Pick-up Time:					
		16	17	18	19	20
Before Care						
After Care						
Choose Your Own Hours Care	Drop-off Time:					
	Pick-up Time:					
		23	24	25	26	27
Before Care						
After Care						
Choose Your Own Hours Care	Drop-off Time:					
	Pick-up Time:					
		30	31			
Before Care						
After Care						
Choose Your Own Hours Care	Drop-off Time:					
	Pick-up Time:					

Please return no later than July 15, 2021 to ensure the early bird rate.

Drop off begins at 7:00 AM. Parents are encouraged to arrive by 5:25* PM. Late pickup charges of \$1.00/minute will apply for every minute past 5:30 PM.

*5:25 pick-up allows our staff to gather their belongings, close up the building, and clock out on schedule.



CARLE AUDITORY
ORAL SCHOOL



Media Authorization Consent to Release Information

Name: _____ MRN/Badge#: _____ Date of Birth: ____/____/____

Phone: _____ E-mail Address: _____

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

Throughout this document the reference to "Carle" collectively refers to Carle Health including Carle Foundation Hospital, Carle Physician Group, Carle Hoopeson Regional Health Center, Carle Richland Memorial Hospital, Carle BroMenn Medical Center and Carle Eureka. I authorize **Carle** to **release information** about me as follows:

1. **Carle** may use and/or disclose the information described below to the general public, through media, Carle publications or in other public venues including, but not limited to, print materials, social media, radio, television, and the internet.
2. I understand that the **purpose** of the disclosure(s) is for Carle's own marketing activities and/or general public information, awareness, education, and/or fundraising.
3. **Specific Records and/or Information** to be disclosed verbally, in writing or electronically, as the case may be: _____

4. **Revocation, Re-disclosure, & Expiration.** I understand that I may revoke this authorization at any time by submitting a written request to the Marketing & Communications department at 611 W. Park Street, Urbana, IL 61801, unless Carle has already acted upon my authorization. I understand that my revocation only applies to uses and disclosures of my personal information by Carle. I further understand that any information already disclosed pursuant to this authorization is no longer protected by the laws and regulations applicable to Carle, and may be subject to re-disclosure. Unless specified otherwise by me, this Authorization will have no expiration date.
(Optional expiration date/event: _____).
5. I understand that my authorization to disclose the above information is **voluntary**, and Carle will not condition the provision of treatment or payment on this authorization.
6. I **waive any right to inspect or approve** the material prior to its use. All reproductions of my medical or personal information shall remain the property of Carle and may be edited prior to use. Furthermore, I release Carle, their licenses, agents, successors and assigns from any and all claims for damages for libel, slander, invasion of privacy or any other claim based upon the use and/or disclosure of my information.

COPY OF THIS AUTHORIZATION: I have been offered a copy of this authorization for my records.

Signature (Parent/Guardian/Authorized Signature where applicable)

Date

Authority to Sign, if not the Patient/Employee

Date

Facebook Permission Form

Dear CAOS Parents,

As you know, CAOS has a public Facebook page and a private Facebook group.

The **public page** is designed to communicate externally. First, it allows us to maintain our connection with former CAOS families by sharing events and experiences that current students are having at school. Only group photos will be shared on the public page. It also shares the mission and important elements of our program with prospective parents, professionals and donors who together ensure the future of our school.

The **private group** is intended for internal communication with families of current students. Both individual and group photos will be shared in the private group. This allows us to share more photos from different events and provide you with specific information and reminders, such as time and location of events like field trips and performances.

Based on some discussion with members of the PTO, we wanted to give families the opportunity to opt in or out of including their children's photos in Facebook posts. Please fill out the form to communicate your preference.

CAOS Staff

Child's Name:

I understand that Carle Auditory Oral School staff members take photographs during class, therapy, field trips and special events. I understand that these pictures may be posted on the public and/or private CAOS Facebook page following special events. I understand that child/ family member names are never included in the Facebook posts. Please initial to indicate your agreement with these statements. _____

Please carefully read the statements below and initial to indicate your agreement with each statement.

Yes, I grant permission for my child/family member's photos to be posted in:

_____ Group photos on the **public** CAOS Facebook page.

_____ Individual and group photos on the **private** CAOS Facebook group.

No, please do **not** post my child/family member's photos on the **public** CAOS Facebook page and the **private** CAOS Facebook group.

_____ No, I do not authorize

Parent/Guardian Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

Notice of Non-Secure Text Messaging

If you requested that CAOS staff contact you via text message on the Student Information Sheet, please complete the authorization below. If you do not want CAOS staff to contact you via text, please disregard this form.

Even though you should be aware that text messages are not encrypted and therefore unsecure, you have requested that CAOS communicate with you regarding your child/ children via text messaging. Please keep in mind that text messages containing information about your child can be read by anyone, forwarded to anyone, remain unencrypted on computer network servers, and permanently remain on both the sender's and receiver's phones. CAOS will honor your request to receive information via text messaging regarding your child/ children, but please be aware of the following:

- Text messages are not encrypted and therefore the information is not secured when sent via text.
- Unauthorized access to, or interception of, your medical information by others is possible.
- If you share your phone with family members, others may access your confidential information.
- If you use your employer's phone, you should determine the security/ ownership/privacy policy at your workplace. Your employer may have a legal right to your text messages.
- Do not use text messages for discussion of sensitive or highly confidential issues; for example, mental health issues, etc.
- Do not use text messages for emergencies.
- Please notify CAOS in writing if you wish to discontinue text messaging of your child's information.
- We highly recommend that you delete your messages after you have read them and no later than the end of each day.
- We prefer not to text/reply with any protected health information; therefore, our text messages will not identify your child by name.

Please confirm that you have read and understand the above information.

Child's Name

Date

Sponsor 1 Signature

Date

Sponsor 2 Signature

Date

CAOS Child Illness Policy

Should your child develop one or more of the following symptoms or conditions while at Carle Auditory Oral School, we will contact the parent/guardian to arrange for your child to be picked up. Your child must be picked up as soon as possible. If we are not able to reach a parent/guardian within 15 minutes, we will begin contacting emergency pick – up persons. Please be sure to inform us who will be picking up your child, even if you have listed them as authorized to pick up your child.

COVID-19 ILLNESS POLICY

The following symptoms are associated with COVID-19 infection.

List of Symptoms currently associated with COVID-19 (subject to change)

- Fever 100.4 or greater
- Chills
- Cough
- Shortness of breath
- Difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste
- New loss of smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Due to the ongoing pandemic, children presenting with symptoms from the list above will not be admitted to school. Children will be excluded from school until one of the following conditions are met:

- 10 days have passed since the onset of COVID related symptoms, child is fever free for 72 hours, COVID related symptoms have been resolved for 24 hours OR
- Letter from medical provider indicating that symptoms are related to another (named) diagnosis and that the child is cleared to return to school.

STANDARD ILLNESS POLICY (for symptoms not related to COVID-19)

Conjunctivitis (pink eye): Unusual tearing, redness of eyelid lining, irritation followed by swelling and/or discharge
May return when: Note from physician stating the child does not have conjunctivitis or 24 hours after antibiotic treatment has been initiated.

Skin rashes: Yellowish, unusual or persistent rash, severe itching of body or scalp, potentially infectious skin patches that are crusty, dry, scabbed, weepy or gummy
May return when: Note from physician that child is not contagious or condition has been resolved.

Impetigo: Blistering rash that when blisters are open, produce a thick, golden yellow discharge that dries, crusts and adheres to the skin.
May return: 24 hours after treatment has begun and there is no longer discharge.

Head lice: Tiny insects that live primarily on the head and scalp that appear as tiny white or dark ovals and are especially noticeable on the back of the neck and around the ears.
May return when: Lice and nit free. Student must report to school office for head check before returning to class.

Chicken Pox: Low grade fever, vesicular rash (blister-like rash or bumps)
May return when: Child's blisters must be completely scabbed.

Sometimes children are not experiencing the symptoms described above, but are clearly not themselves/ are not able to engage in learning and play at school. If the staff notices that your child is not themselves/ is unable to engage in learning and play at school, staff will call to let you know. Then you can help to determine the best treatment for your child.

Exhibits unusual behavior such as cranky, less active, cries more, loss of appetite, generally uncomfortable, or stomach ache, watery eyes, trouble swallowing, etc.

Date: _____ Time: _____

_____ is being sent home for symptoms marked above. Child may return when conditions marked above are met.

Parent Signature: _____ Staff Signature: _____

CAOS Weather-Related School Closure Information*

Weather related school closure information will be reported to WCIA-TV by 6:30 a.m. The website is <http://www.illinoishomepage.net/closings>

If you have chosen to receive communications from us via e-mail, an e-mail communication will also be sent before 6:30 a.m. by Danielle.

If you have chosen to be updated about school closures via text messages, a text will be sent before 6:30 a.m. by Danielle.

Additionally, we will also have an announcement indicating that school has been closed on our main phone line. Please dial 217-326-2824 and choose option "1".

Another method would be to check our Facebook page (Carle Auditory Oral School) which will also be updated by 6:30 a.m.

*If you are a student volunteer and the school has been closed, please do NOT report for volunteer duty. A school closure due to weather will be considered an excused absence.

CAOS 2021-2022 School Supply List*

Preschool (Label)**	Pre-K/ PK2 (Label)**	K/ Primary (Label)
1 package of 10 count BOLD washable classic Markers^	1 package of 10 count BOLD washable classic Markers^	1 package of 8-count washable classic color markers (bold)*
Nap mat & blanket**	Nap mat & blanket**	1 package of 8-count washable classic color markers (skinny)*
Fat Crayola® crayons	1 box of 24-count Crayola® crayons^	1 box of 24-count Crayola® crayons^
Backpack (large enough to hold a folder and journal and still zip)	Backpack (large enough to hold a folder and journal and still zip)	Backpack (large enough to hold a folder and journal and still zip)
Lunch box with ice pack included (labeled w/child's name)	Lunch box with ice pack included (labeled w/child's name)	Lunch box with ice pack included (labeled w/child's name)
2 composition journals (with stitched binding) 4 for children with hearing loss (2 are used for therapy)	2 composition journals (with stitched binding) 4 for children with hearing loss (2 are used for therapy)	2 composition journals (with stitched binding) 4 for children with hearing loss (2 are used for therapy)
10 glue sticks	10 glue sticks	10 glue sticks
2 bottles white school glue	2 bottles white school glue	2 bottles white school glue
Plastic pencil box	Plastic pencil box	Plastic pencil box
1 pair of child's rounded scissors	1 pair of child's scissors	1 pair of child's scissors
1 bottle sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies)	2 bottles sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies)	2 bottles sunscreen (suggested Coppertone® Kids Continuous Spray ^^due to skin allergies)
1 oversized t-shirt for art smock	1 oversized t-shirt for art smock	1 oversized t-shirt for art smock
1 tray of watercolor paints^	1 tray of watercolor paints^	1 tray of watercolor paints^
Play-Doh® - a pack of 3 large (4 oz) or more	Play-Doh® - a pack of 3 large (4 oz) or more	Play-Doh® - a pack of 3 large (4 oz) or more
4 boxes of Kleenex®	12 pack Ticonderoga pencils	12 pack Ticonderoga pencils
4 packages unscented baby wipes (classroom use)	4 boxes of Kleenex®	4 boxes of Kleenex®
1 box Ziploc baggies quart size	4 packages unscented baby wipes (classroom use)	4 packages unscented baby wipes
1 box Ziploc baggies gallon size	1 box Ziploc baggies quart size	1 box Ziploc baggies quart size
1 box Ziploc snack size baggies	1 box Ziploc baggies gallon size	1 box Ziploc baggies gallon size
1 box Ziploc baggies sandwich size	1 box Ziploc snack size baggies	1 box Ziploc snack size baggies
If potty training, send diapers and additional wipes	1 box Ziploc baggies sandwich size	1 box Ziploc baggies sandwich size
	If potty training, send diapers and additional wipes	If potty training, send diapers and additional wipes

^ Suggest Crayola® brand

^^Due to skin allergies

Suggested School Donations			
White paper lunch bags	Baking Soda	Brown paper lunch bags	Two-gallon Ziploc bags
Hand Sanitizer	Food Coloring	Vegetable Oil	Aluminum foil
Napkins	Cinnamon	Cream of Tartar	Wax paper
Yarn	Cornstarch	Salt	Sugar
Flour	Shaving Cream	Small thin white paper plates	Large thin white paper plates

**Nap mats (plastic and foldable that can be wiped down), pillows, blankets, and sleeping toy (if applicable) required for nappers.

Please see CAOS Parent Handbook for additional materials that your child will need while at school.



State of Illinois Certificate of Child Health Examination

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

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	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																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										Comments:								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

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 (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

***MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies 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
------------------------	------------------	--------------

3. Laboratory Evidence of Immunity (check one) Measles* Mumps Rubella Varicella Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.

**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes No	List:
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	Hospitalizations?		Yes No
Birth defects?		Yes No	When? What for?		
Developmental delay?		Yes No	Surgery? (List all.)		Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		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
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 <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Information may be shared with appropriate personnel for health and educational purposes.		
Ear/Hearing problems?		Yes No	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	BMI PERCENTILE	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. (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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

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		Screening Result:	Gastrointestinal	
Eyes		Screening Result:	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 Agonist) <input type="checkbox"/> 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 **Modified**

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

Address _____ Phone _____



Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: Normal or Positive for _____

Medical history: Normal or Positive for _____

Drug allergies: NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? Yes No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other _____



Recommendations

- 1. Corrective lenses: No Yes, glasses or contacts should be worn for:
 - Constant wear Near vision Far vision
 - May be removed for physical education

- 2. Preferential seating recommended: No Yes

Comments _____

- 3. Recommend re-examination: 3 months 6 months 12 months
- Other _____

4. _____

5. _____

Print name _____

License Number _____

Optometrist or physician (such as an ophthalmologist)
who provided the eye examination MD OD DO

Address _____

Phone _____

<p>Consent of Parent or Guardian</p> <p>I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p>_____</p> <p style="text-align: center;">(Parent or Guardian's Signature)</p> <p>_____</p> <p style="text-align: center;">(Date)</p>
--

Signature _____

Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

CAOS Permission for Emergency Treatment (Must be Notarized)

You have my permission to proceed with any treatment necessary to care for my child in case of illness or injury while attending Carle Auditory Oral School.

Signature of Parent/Guardian: _____ Date: _____

In the state of _____, and the county of _____, on this _____ day of _____, 20____, before me personally appeared, _____ known to be the person described in and who executed the foregoing instrument, and acknowledged that he/she executed that same as his/her free deed and act.

In testimony whereof, I hereunto subscribe my name and affix my official seal at my office in _____, the day and year first above written.

My commission expires: _____

Signature of Notary Public: _____

The information contained on this sheet is correct to the best of my/our knowledge and I/we agree to update the information on a regular basis.

Sponsor 1 Signature: _____ Date Signed: _____

Sponsor 2 Signature: _____ Date Signed: _____

CAOS Tuition and Child Care Costs

Tuition and Child Care Costs for First Child 2021-2022						
	Number of Days		Annual Cost	Biweekly Cost	Daily Cost	
School Program Preschool through Second Grade for the First Child	200		\$9,603.72	\$480.19	\$48.02	
Snack Fee	200		\$100.00	\$5.00	\$0.50	
Choose Your Own Hours Care (\$4.75/ hour) Families might consider this option if they need care for a short time before and after school. Family provides exact times care is needed, CAOS office staff will round up to the next hour and bill reserved care at an hourly rate. For example, a family needing care from 8 - 8:40 and 3 - 4:15 would be billed for 2 hours of hourly care, \$9, rather than paying for both before care (\$7.15) and after care (\$10.60), \$17.75	# of hours	# of days	Total Extended Care Hours	Annual Cost	Monthly Cost	Bi-Weekly Cost
	2	199	398	\$1,890.50	\$189.05	\$94.53
Before Care on School Days for the First Child Once reserved, care charges are non-refundable. (7 - 9 a.m. drop off any time in this range for this cost.)	# of Days	Annual Cost	Monthly Cost	Biweekly Cost	Daily Cost	
	200	\$1,430.00	\$143.00	\$71.50	\$7.15	
After Care on School Days for the First Child Once reserved, care charges are non-refundable. (3 - 5:30 p.m. pick up any time in this range for this cost.)	199	\$2,109.40	\$210.94	\$105.47	\$10.60	
Child Care on No School Days Once reserved, care charges are non-refundable.	9	\$472.50	N/A	N/A	\$52.50	
Summer Camp for the First Child (Care Provided Between Last Day of School in June through First Day of School in August - total number of days of care is dependent upon the school calendar, developed by April 15, 2021)	17	N/A	\$892.50	N/A	\$52.50	

Tuition and Child Care Costs for Additional Children 2021-2022						
	Number of Days		Annual Cost	Monthly Cost	Daily Cost	
School Program Preschool through Second Grade for any Additional Children	200		\$8,643.35	\$432.17	\$43.21	
Snack Fee	200		\$100.00	\$5.00	\$0.50	
Choose Your Own Hours Care (\$4.28/ hour) Families might consider this option if they need care for a short time before and after school. Family provides exact times care is needed, CAOS office staff will round up to the next hour and bill reserved care at an hourly rate. For example, a family needing care from 8 - 8:40 and 3 - 4:15 would be billed for 2 hours of hourly care, \$8.56, rather than paying for both before care (\$7.15) and after care (\$10.60), \$15.98	# of hours	# of days	Total Extended Care Hours	Annual Cost	Monthly Cost	Bi-Weekly Cost
	2	199	398	\$1,701.45	\$170.15	\$85.07
Before Care on School Days for the First Child Once reserved, care charges are non-refundable. (7 - 9 a.m. drop off any time in this range for this cost.)	# of Days	Annual Cost	Monthly Cost	Biweekly Cost	Daily Cost	
	200	\$1,287.00	\$128.70	\$64.35	\$6.44	
After Care on School Days for the First Child Once reserved, care charges are non-refundable. (3 - 5:30 p.m. pick up any time in this range for this cost.)	199	\$1,898.46	\$189.85	\$94.92	\$9.54	
Child Care No School Days for any Additional Children Once reserved, care charges are non-refundable.	9	\$425.25	N/A	N/A	\$47.25	
Summer Camp for any Additional Children (Care Provided Between Last Day of School in June through First Day of School in August - total number of days of care is dependent upon the school calendar, developed by April 15, 2021)	17	N/A	\$803.25	N/A	\$47.25	

Pricing listed above is for care reserved by the 15th of the previous month. Each unit of care reserved after this time falls under the drop in rate of +\$1. For example, for the first child, Drop In Before Care is \$8.15/ day, Drop In After Care is \$11.60/ day and Drop In Choose Your Own Hours Care is \$5.75/ hour.

INFORMATION ONLY - FORM TO BE COMPLETED DURING REGISTRATION



CARLE AUDITORY
ORAL SCHOOL



Google Drive Permission Form

Dear CAOS Parents,

During the COVID school closure, CAOS staff created the CAOS Google Drive to be an online location where parents and staff could collaborate, share materials and updates with one another. Each parent was asked to give permission for the creation of a folder for their child. Once permission was granted, access to that folder was shared with the child's team (i.e., parents, deaf educator, and therapists). Each member of the team could read information, add their own updates and provide input into goal selection. In the past, we have used a folder on Carle's shared drive which can be accessed by all staff members while logged into their Carle computer. The Google drive allows us to extend access to families as well.

We found that this worked really well for children who are deaf or hard of hearing last semester and we are interested in exploring how it might work for our typically hearing students this fall. Please read and sign below to grant permission for us to create a Google folder for your child. If you choose to opt out of the CAOS Google drive, you will still receive information via email/your child's folder as needed. If you have questions, please contact Danielle.

Thank you for your time and collaboration!

CAOS Staff

Child's Name:

I understand that a folder for my child will be created and added to the CAOS Google drive, that the CAOS Google drive will contain information about my child's academic test scores, month at a glance sheets, potentially journal assignments and that my child's team will be invited to read and edit the documents in my child's folder. Further, I understand that the Google drive is outside Carle's encrypted network, but is protected by Google's security measures and each user needs to be invited to collaborate by CAOS staff.

Please carefully read the statements below, mark that statement that represents your decision about the CAOS Google drive for the coming school year.

Yes , I grant permission for CAOS staff to create a folder for my child on the CAOS Google drive.	
Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	

No , I do <u>not</u> grant permission for CAOS staff to create a folder for my child on the CAOS Google drive.	
Signature:	Date Signed:
Relationship to Child/Authorization to Sign:	