CFS 508-1
Rev. 12/2013

State of Illinois
Department of Children and Family Services

Date Submitted

INFORMATION ON PERSON EMPLOYED IN A CHILD CARE FACILITY*

I. Employing Facility_____

Facility Provider ID#_____

Address_____ _____ _____
(Street and Number) (City) (Zip Code)

II. Person Employed_____ _____
(Date of Birth)

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Phone _____

Home Address_____ _____ _____
(Street and Number) (City) (Zip Code)

III. **Employment** Date Employed:_____

Position for which employed (Check appropriate item):

- ☐ Executive, Superintendent, or Director
- ☐ Child Care Supervisor (child care institution)
- ☐ Child Care Worker (child care institution)
- ☐ Child Care Staff (group home)
- ☐ Child Welfare Supervisor (child welfare agency)
- ☐ Child Welfare/Licensing Worker (child welfare agency)
- ☐ Registered Nurse
- ☐ Teacher (residential facility)
- ☐ Housekeeping
- ☐ Licensed Practical Nurse (day care center only)
- ☐ Early Childhood Teacher (day care center)
- ☐ School-age Worker (day care center)
- ☐ Early Childhood Assistant (day care center)
- ☐ School-age Assistant (day care center)
- ☐ Substitute
- ☐ Cook
- ☐ Clerical
- ☐ Other: _____

IV. **Previous Employment** (Last ten years of employment)

From	To	Name and address of Employer	Type of Work and Title

☐ The employer, or authorized official of the employing facility has contacted the human resources personnel, management or knowledgeable supervisor for each listed previous employer to inquire about the employee's work performance and whether the employee would be eligible for rehire.

NOTE: ATTACH THIS FORM TO THE CFS 508 AND SUBMIT IT TO YOUR DCFS LICENSING REPRESENTATIVE

V. **Other Direct, Unpaid Experience with Children** (Such as scout work, Sunday School teacher)

_____

_____

_____

Report of Reference on File (At least three character and/or business, from persons not related to the employee)

Name of Reference	Address	Relationship

VI. **Educational Background** (Circle the one item indicating highest grade completed)

Elementary Grade: High School: GED:

0 1 2 3 4 5 6 7 8 1 2 3 4 ☐ Yes ☐ No

Years of College (Undergraduate): Years of Graduate Work:

1 2 3 4 1 2 3 4

College Degree:_____ Graduate Degree:_____

Name of School, College, or University last attended:_____

Other Special Training or Professional License (Specify):_____

Professional License Number:_____

Evidence of Educational Achievement on File: ☐ Yes ☐ No_____ (Explain)

VII. **Physical Examination**

Last Examination (Date):_____

Name and Address of Examining Physician:_____

Health Clearance Report on File? ☐ Yes ☐ No _____ (Explain)

VIII. **Certification of Employment**

I, the employer, or authorized official of the employing facility, do hereby certify that the above-named person is employed in the position indicated and that, to the best of my knowledge is qualified for the position indicated, and employment is in accordance with minimum standards prescribed by the Department of Children and Family Services.

Signed: _____

Executive Director/Director: _____

CFS 602
Rev. 03/2016

STATE OF ILLINOIS
Department of Children and Family Services

MEDICAL REPORT ON AN ADULT IN A CHILD CARE FACILITY

(Includes employees and volunteers in DCFS licensed child care facilities, operators of day care/group day care homes and other adult members of their households)

_____ _____
(Name of Person Examined) (Birth Date)

Position (check one)

- ☐ Day Care/Group Day Care Home Caregiver
- ☐ Child Care Staff
- ☐ Other Staff in a Child Care Facility
- ☐ Member of Household
- ☐ Food Handler (See Section B)
- ☐ Child Care Facility Driver (See Section B)
- ☐ Volunteer in a Child Care Facility

Name of Licensee/applicant for License or Licensed Facility where individual is employed/volunteers _____

Address _____
Street City Zip Code County

I. TESTS

	Date	Results
Tuberculin test (by the Mantoux method or chest X-ray in a positive reactor)*		
Other (specify):		

II. IMMUNIZATIONS

☐ Yes ☐ No I have discussed the importance of immunizations for adult child care providers with this individual and recommend the following immunizations: _____

If this individual is employed in a child care facility that cares for children age 6 and under, please check two of the following:

This individual has received: ☐ 1 dose of the Tdap vaccine ☐ 2 doses of the MMR vaccine **or** is immune to MMR.

This individual is not medically indicated for: ☐ 1 dose of the Tdap vaccine ☐ 2 doses of the MMR vaccinations.

III. FINDINGS AND RECOMMENDATIONS

A. Findings

Summary of medical or emotional problems or conditions, if any, which may affect the individual's ability to work, volunteer or reside in a facility caring for children.

_____
_____
_____

B. Any conditions which contraindicate a person serving as a Food Handler or Child Care Facility Driver?
☐ Yes ☐ No If yes, please specify _____

C. Recommendations

The above individual was found free from symptoms of communicable disease and is otherwise medically and emotionally fit to work, volunteer or reside in a facility caring for children. ☐ Yes ☐ No

Explain "No": _____

In my opinion, the individual could meet the strength and mobility challenges required for caring for a child in one or more of the age groups checked below:

☐ 0-2 years of age ☐ 2-6 years of age ☐ 7-12 years of age ☐ 12-18 years of age

_____ _____
Date of Examination Physician's Name (Print) and State License Number

_____
Physician's Signature

_____
Street Address City State Zip Code

_____
Telephone Number

* Required in initial examination only. Physician to determine need for test in subsequent examinations.

REEXAMINATIONS

Date of Examination

Physician's Name (Print) and State License Number

Date of Examination

Physician's Name (Print) and State License Number

Date of Examination

Physician's Name (Print) and State License Number

Date of Examination

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