Form (Enrollment)

South Suburban - CDC

15800 South State Street
South Holland, IL 60473
(708) 596-2000

3:28 PM

7/15/2008

Family Information

LAST	FIRST	MI	LAST	FIRST	MI

RELATION	SSN	RELATION	SSN

ADDRESS1

ADDRESS2

CITY	STATE	ZIP	CITY	STATE	ZIP

HOME PHONE	WORK	EXT	HOME PHONE	WORK	EXT

CELL	EMAIL	CELL	EMAIL

Child Information

LAST	FIRST	MI	LAST	FIRST	MI

SEX	ETHNICITY	BIRTHDAY	SEX	ETHNICITY	BIRTHDAY

EMG CONTACT	EMG PHONE	EMG CONTACT	EMG PHONE

EMG CONTACT	EMG PHONE	EMG CONTACT	EMG PHONE

DR'S NAME	DR'S PHONE	DR'S NAME	DR'S PHONE

INS PROVIDER	POLICY	INS PROVIDER	POLICY

BLOOD TYPE	LAST PHYSICAL	BLOOD TYPE	LAST PHYSICAL

ALLERGIES

ALLERGIES

EMERGENCY AUTHORIZATION

State law requires that we have written authorization from a child's legal guardian to seek medical help in the event of a medical emergency. Signing the statement at the bottom of this letter will provide us with that authorization.

Our policy, in the event of a medical emergency is to contact you first. If we can't contact you, we will try to contact any others you may designate. In the event that we are unable to contact you or your designated representative(s), or if the medical emergency warrants immediate response, we will act, on your behalf and in the best interests of the child.

Please sign here:_____,_____
Signature Date

OFFICE USE ONLY

Tuition: $_____ **Classroom:**_____ **Enrolled:**_____
Billing cycle:_____ **Program:**_____

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 5/2006

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name Last	First	Middle	**Birth Date**	**Sex**	**Grade Level**	**ID#**

Address Street City **ZIP code** | Parent/ Guardian | Telephone # Home Work

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

VACCINE/DOSE	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)				Comments		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23
Check specific type (PCV7, PPV23) Date						
Other (Specify hepatitis A, meningococcal, etc.)						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

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

Lab Results **Date** MO DA YR **(Attach copy of lab report, if available.)**

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

																							Code:
Date																							**P = Pass**
Age/Grade																							**F = Fail**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**U = Unable to test**
Vision																							**R = Referred**
Hearing																							**G/C = Glasses/ Contacts**

Printed by Authority of the State of Illinois
(Complete Both Sides)

IL444-4737 (R-01-05)

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

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

ALLERGIES (Food, drug, insect, other)				**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during the night coughing?	Yes No Yes No	Indicate Severity		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth complications/prematurity?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental 9 Braces 9 Bridge 9 Plate Other Other concerns?			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?							

Entire section below to be completed by MD/DO/APN/PA

PHYSICAL EXAMINATION REQUIREMENTS **HEAD CIRCUMFERENCE** **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (Not required for daycare.) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionairre Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** .
(If child resides in Chicago, blood test is required.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. ☐ No Test Needed ☐ Test performed **Date Read** / / **Result** **mm**

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

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** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)

Child and Adult Care Food Program

CACFP ANNUAL ENROLLMENT FORM

ENROLLMENT FORM FOR CHILDREN IN CHILD CARE CENTERS, PRE-K PROGRAMS, AND LICENSED OUTSIDE SCHOOL HOURS PROGRAMS

(This document does not have to be completed for children in At-Risk After-School Hour Programs, license-exempt Outside School Hours Programs, or emergency shelters.)
It is recommended to have new CACFP Annual Enrollment Forms completed each year during the Household Income Eligibility Application renewal period.

Parents: This institution participates in the Child and Adult Care Food Program (CACFP) and receives reimbursement to provide more nutritious meals for your child(ren). Federal CACFP regulations require all parents and guardians to complete a CACFP Annual Enrollment Form when enrolling their child(ren) and again every year there after. This information will help ensure all children receive appropriate meals during their care.

Please complete areas 1 through 6 below. Be sure to sign and date the document.

1 FULL NAME OF ENROLLED CHILD (Include Birth Date/Age)	2 DAYS OF WEEK IN ATTENDANCE	3 TIMES CHILD NORMALLY ATTENDS DURING WEEK								4 MEALS RECEIVED
		TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		
		AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	
First Child	☐ Monday									☐ Early Morning Snack
	☐ Tuesday	☐ Yes ☐ No I work multiple shifts and child(ren) may be in care different days/hours.								☐ Breakfast
Name	☐ Wednesday									☐ A.M. Snack
	☐ Thursday									☐ Lunch
Birth Date	☐ Friday									☐ P.M. Snack
	☐ Saturday									☐ Supper
Age	☐ Sunday									☐ Evening Snack
Second Child	☐ ***Same Days as Above***	☐ ***Same Times as Child Above***								☐ ***Same Meals as Above***
	☐ Monday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		☐ Early Morning Snack
	☐ Tuesday	AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	☐ Breakfast
Name	☐ Wednesday									☐ A.M. Snack
	☐ Thursday									☐ Lunch
Birth Date	☐ Friday									☐ P.M. Snack
	☐ Saturday									☐ Supper
Age	☐ Sunday									☐ Evening Snack
Third Child	☐ ***Same Days as Above***	☐ ***Same Times as Child Above***								☐ ***Same Meals as Above***
	☐ Monday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		☐ Early Morning Snack
	☐ Tuesday	AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	☐ Breakfast
Name	☐ Wednesday									☐ A.M. Snack
	☐ Thursday									☐ Lunch
Birth Date	☐ Friday									☐ P.M. Snack
	☐ Saturday									☐ Supper
Age	☐ Sunday									☐ Evening Snack
Fourth Child	☐ ***Same Days as Above***	☐ ***Same Times as Child Above***								☐ ***Same Meals as Above***
	☐ Monday	TIME IN			TIME OUT			TIMES CHILD ATTENDS SCHOOL		☐ Early Morning Snack
	☐ Tuesday	AM	PM	TIME	AM	PM	TIME	LEAVES CENTER	RETURNS TO CENTER	☐ Breakfast
Name	☐ Wednesday									☐ A.M. Snack
	☐ Thursday									☐ Lunch
Birth Date	☐ Friday									☐ P.M. Snack
	☐ Saturday									☐ Supper
Age	☐ Sunday									☐ Evening Snack

5 ETHNIC/RACIAL CATEGORIES—Answer Both Questions

A. Ethnic data of child(ren)—Mark only one ☐ Hispanic or Latino ☐ Not Hispanic or Latino

B. Racial data of child(ren)—Mark one or more that apply. ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ American Indian or Alaska Native

6 SIGNATURE

Signature of Parent or Guardian _____ *Date* _____ *Telephone Number of Parent or Guardian* _____

In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.

FOR OFFICE USE ONLY

Effective Date of This Enrollment Form _____

The effective date can be made retroactive back to the first day the child participates in CACFP as long as it occurs in the same month this form is received.

CHILD AND ADULT CARE FOOD PROGRAM

HOUSEHOLD ELIGIBILITY APPLICATION FOR CHILD CARE CENTERS

Parents: Complete this application by following the instructions provided in the parent letter.

1 CHILDREN ENROLLED IN CHILD CARE CENTER AND THEIR AGE

NAME (First and Last) | AGE

2 FOOD STAMP OR TANF CASE NUMBER

LIST EACH CHILD'S FOOD STAMP OR TANF CASE NUMBER, IF ANY. Do not use LINK card or subsidized child care case number.

After completing, skip to **Number 5**.

3 FOSTER CHILD

☐ Check here if applying for a foster child.

Complete a separate application for each foster child. A foster child is the legal responsibility of the welfare agency or court and resides in your home. List only the child's monthly personal use income. Write "0" if child has no personal use income. After completing, skip to **Number 5.**

$ _____

4 HOUSEHOLD MEMBERS AND GROSS INCOME—List the names of everyone living in household, related or non-related. If a person has a second job, list that income in the last column. After completing, go to **Number 5.**

NAMES (List Everyone in Household)	GROSS INCOME AND HOW OFTEN IT WAS RECEIVED (Example: $100/month; $100 /twice a month; $100/every other week; $100/week)							
	Gross Income (Before Deductions)		Welfare, Child Support, Alimony		Pensions, Retirement, Social Security		All Other Income and Benefits for Worker's Compensation, Strikes, and Unemployment	
	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?	How Much?	How Often?
1.	$	/	$	/	$	/	$	/
2.	$	/	$	/	$	/	$	/
3.	$	/	$	/	$	/	$	/
4.	$	/	$	/	$	/	$	/
5.	$	/	$	/	$	/	$	/
6.	$	/	$	/	$	/	$	/

5 SOCIAL SECURITY NUMBER AND SIGNATURE—An adult household member must sign the application. If Number 4 is completed above, the adult signing the form must also list his or her social security number or mark the *I do not have a social security number* box.

__ __ __ – __ __ – __ __ __ __
Social Security Number

☐ I **do not** have a social security number.

I certify all information is true and correct and that all income is reported. I understand this information is being given for the receipt of federal funds. I understand the institution, Illinois State Board of Education, or Office of Inspector General, may verify this information on the application. Deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Date | Printed Name of Adult Household Member | Signature of Adult Household Member

Home Phone # | Work Phone # | Home Address (Number, Street, City, Zip Code)

6 ALL KIDS HEALTH INSURANCE PROGRAM—All Kids offers affordable health insurance for children, and your child(ren) may qualify. We may share your application information with All Kids unless you do not want us to. If you DO NOT want us to share this information, sign here.

Signature of Parent of Legal Guardian

CHILD CARE REPRESENTATIVE USE ONLY—ELIGIBILITY DETERMINATION—COMPLETE ALL FOUR SECTIONS

Follow the instructions provided in the Household Eligibility Information booklet to process this application. The instructions are called—*Instructions for Sponsors to Process Household Eligibility Applications.*

SECTION 1

Mark one of the boxes below to show how you are going to determine eligibility.

☐ **Food Stamp/TANF Household—**the food stamp or TANF number meets the criteria for an acceptable case number. Complete Sections 2, 3, and 4.

OR

☐ **Income Household—**Complete the information below and Sections 2, 3, and 4.

CONVERSION TABLE

To convert all income to monthly income use conversion calculations.

Weekly Income x	4.33
Every 2 Weeks x	2.15
Twice a Month x	2
Annual Income ÷	12

Total Household Size ..... _____

Total Household Income ..... $ _____ / _____

Example: $100/week, or $100/every 2 weeks

Compare total income to *Household Income Eligibility Guidelines*. When household incomes are listed for different pay periods, you must convert all income to monthly income by using the conversion table above.

SECTION 2

Based on the information provided this application will be:

☐ Approved Free

☐ Approved Reduced

☐ Denied—the meals will be claimed in the paid category.

TEMPORARY APPLICATION

This application reported zero income or a temporary reduction income.

☐ Approved Free on Temporary Basis

☐ Approved Reduced on Temporary Basis

Temporary applications must be reevaluated every 45 days until income changes.

until _____ *Date* | until _____ *Date* | until _____ *Date*

SECTION 3

Signature of Representative _____ ***Date*** _____

SECTION 4

Effective Date _____

ISBE 69-88 (4/08)

NON-DISCRIMINATION: In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call 800/795-3272 or 202/720-6382 (TTY). USDA is an equal opportunity provider and employer.

PRIVACY ACT STATEMENT: The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Food Stamp, Temporary Assistance for Needy Families (TANF) Program or Food Distribution Program on Indian Reservations (FDPIR) case number for your child or other (FDPIR) identifier or when you indicate that the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced price meals, and for administration and enforcement of the Program.

We may share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs; auditors for program reviews; and law enforcement officials to help them look into violations of program rules.

South Suburban College Child Development Center

Guidance and Discipline Policy

Here at the SSC Child Development Center, our philosophy is for each child to be nurtured in a non-threatening environment, which does not incorporate the use of corporal punishment. Staff shall help ensure children develop self-control and assume responsibility for their own actions. Limits and consequences shall be clear and understandable to children, consistently enforced and explained to the child before and as part of any disciplinary action.

Firm positive statements about behaviors or redirection of behaviors shall be our goal. In circumstances where a child may need to be removed from the group to help a child gain control it shall not exceed one minute per year of age.

Children shall not be disciplined for toilet accidents. Corporal punishment, including hitting, spanking, swatting, beating, shaking, pinching and other measures intended to induce physical pain or fear, any threatening or actual withdrawal of food, rest or use of the bathroom; abusive or profane language, public or private humiliation, including threats of physical punishment or any form of emotional abuse, including shaming, rejecting, terrorizing or isolating a child is not acceptable or tolerable.

Children shall have reasonable opportunity to resolve their own conflicts. Discipline shall be the responsibility of adults who have an ongoing relationship with the child.

In certain circumstances, where the center has been unsuccessful in resolving the child's behavior, we will request assistance of the child's parent(s). Any program developed with the assistance of the parent will include the Director, Staff and Parent(s) monitoring the progress of this plan of action.

When efforts by the center and parents have been unsuccessful the center reserves the right to begin the process of terminating services for the child. All efforts will be documented in the child's file, along with appropriate consents. All staff working with the child shall receive training on implementing the plan.

Discharge Policy

Unfortunately, at times, despite the best efforts of our staff, any child who, after attempts have been made to meet the child's individual needs, demonstrates inability to benefit from the type of care offered by our program, or whose presence is detrimental to the group shall be discharged from the program.

In all instances, when the center decides that it is in the best interest for the child to terminate enrollment, the child's and parents' needs shall be considered by planning with the parents to meet the needs when they leave the facility. We will make referrals to other agencies or programs to the best of our ability.

Parent or Guardian _____ **Date**_____

Signature

Class Attendance/ Drop-off and Pick-up Policy

To help serve both you and your children better, parents please be advised that children **ARE NOT** allowed to be dropped off **until 15 minutes before** your scheduled class time. Parents who have internships must fill out a form and have written permission from the Manager or Program Coordinator for an earlier drop off time. In addition, parents have a 15 minute grace period after class ends to pick up their child(ren) from the center. Children are ONLY allowed in the center during **class and work study times**. Schedules will be checked and if you are found in violation of this policy your child will be **IMMEDIATELY dropped** from our program and services terminated for the semester. For more information or questions please feel free to contact the Manager or Program Coordinator. Thank you.

I have read and understand the above policy. I fully understand that if I'm found in violation of this policy that my child(ren) will be dropped from the program and services terminated for the semester.

Child(ren) Name(s):_____

Parent Signature: _____ Date: _____

South Suburban College
Child Development Center

Authorization for Drop-off/Pick-up

The following people are authorized to pick-up and drop-off my

child(ren):_____

1.
2.
3.
4.
5.
6.
7.

Your child (ren) may only be at the Center while you are attending classes or working at the College. Failure to comply with this policy will result in termination of services. Any additions to this list must be done in writing. No exceptions will be made.

_____ _____
Parent's signature Date

South Suburban College Child Development Center

Child Care Initiative Policy

The Child Development Center of South Suburban College does participate in the Child Care Initiative Program. It is the parent's responsibility to obtain and fill out the application required with Action for Children. It is the parent's responsibility to maintain eligibility with Child Care Initiative. A child may begin our program before approval has been received from Child Care Initiative with the understanding that if you are determined to be ineligible for the program that you the parent are responsible for all fees incurred. Parents are responsible for registration and enrollment fees. In addition, parents who are assessed a co-payment with Child Care Initiative must make timely payments on their co-payments.

Child Care Initiative Policy

I have read and understand the policy stated by The Child Development Center regarding Child Care Initiative. I agree to abide by such policies stated herein.

_____ _____

Parent's Signature Date

_____ _____

Director's Signature Date

Child's Name_____ DOB_____ Age _____
Parent's Name_____ Term _____

Time	Monday	Tuesday	Wednesday	Thursday	Friday
7:30 a.m. – 9:00 a.m.					
9:00 a.m. – 10:00 a.m.					
10:00 a.m.– 11:00 a.m.					
11:00 a.m. – 12:00 p.m.					
12 p.m. – 1:00 p.m.					
1:00 p.m. – 2:00 p.m.					
2:00 p.m. – 3:00 p.m.					
3:00 p.m. – 4:00 p.m.					
4:00 p.m. – 5:00 p.m.					
5:00 p.m. – 6:00 p.m.					
6:00 p.m. – 7:00 p.m.					
7:00 p.m. – 8:00 p.m.					
8:00 p.m. – 9:00 p.m.					
9:00 p.m. – 10:00 p.m.					

Please list Course, Instructors names and room numbers. If you are or become a student worker, list local supervisor and supervisor' extension, as well as work hours.