Dear Parents, February 2, 2026

Welcome to Zion Preschool! We consider it a privilege to enroll your child in our preschool program. Enclosed is your child's registration package. Please read everything carefully. **Please fill out the forms and return them as soon as possible with your registration and snack fee check to guarantee your child's spot**. Classes are filled on a *first come, first served basis*. **When you return your child's registration packet, please bring along a certified copy of your child's birth certificate, which I will copy and return to you.** You may also mail the forms back to us at 101 S. Railway, Mascoutah, IL 62258.

New students need to have a physical dated no earlier than six months before the first day of school. Physical forms need to be turned in by August 27th. **Please read all instructions on the letter accompanying the required physical forms so repeated trips to the doctor's office will not be necessary. Your child will not be able to start school until ALL items on the physical form are met.** Physical forms may be dropped off at the preschool any time during the summer. If I am not in my office, they may be left with Zion's secretary who is in her office from 8:00-12:00, Monday - Thursday.

If you have any questions please feel free to call the preschool office or email me at zionpreschooldirector2020@gmail.com. Thank you for choosing Zion Preschool to begin your child's education. We look forward to another wonderful year educating children of Mascoutah and the surrounding communities.

God Bless,

Vikki Harms

Vikki Harms
Zion Preschool Director

For Office Use Only

Date:________________

Check #:______________

Amount:______________

Registration Information

2026-2027

Student's Name:____

Name Child goes by:____________________________________ Gender M / F

Birth date___/_____/_____Age on September 1, 2026_______ Phone #:____________________

Children must be three or four years old by September 1 and toilet-trained.

Student's Home Address:____

Parent/Guardian #1 Name:________________________________Phone:________________

Parent/Guardian #1 Address:____

Parent/Guardian #1 Occupation and Place of Employment:____________________________

Working Hours:_______________Parent/Guardian Email Address:_______________________

Parent/Guardian #2 Name:________________________________Phone:________________

Parent/Guardian #2 Address:____

Parent/Guardian #2 Occupation and Place of Employment:____________________________

Working Hours:_______________Parent/Guardian Email Address:_______________________

Parent's Marital Status:____

Emergency Contacts Other Than Parents:

Name:____

Phone:____

Relationship to child:____

Name:____

Phone:____

Relationship to child:____

Class Selection

-

Please mark your class preference

Three Year Old Class

_______Monday/Wednesday**	9-11:30 AM	$135.00/monthly
_______Tuesday/Thursday	9-11:30 AM	$135.00/monthly
_______Tuesday/Wednesday/Thursday	9-11:30 AM	$165.00/monthly
_______Monday/Tuesday/Wednesday/Thursday**	9-11:30 AM	$215.00/monthly

Four Year Old Class

_______Tuesday/Wednesday/Thursday	9-11:30 AM	$165.00/monthly
_______Monday/Tuesday/Wednesday/Thursday**	9-11:30 AM	$215.00/monthly

**Class availability is subject to enrollment #'s.

A non-refundable registration fee of $80.00 is required at the time of registration.

A one-time snack fee is also due at the time of registration:

2-day program: $60.00

3-day program: $75.00

4-day program: $90.00

Emergency Information

Physician's Name:____

Phone:____

Address:____

Hospital:____

Family Information

Brothers and/or sisters (please indicate ages and whether they live with the child):

Name: ______________________________ Age: ____________

Name: ______________________________ Age: ____________

Name: ______________________________ Age: ____________

Church you attend:

Personal Information

Has your child had any experience in preschool or group interaction?

If so, where and when?

Does your child have any allergies? What are they? Are there symptoms we should note?

Are there any past or current medical problems that we need to be aware of? Past surgeries?

List any special food or eating instructions:

Health Information

Medical Problems______________________________ Physical Handicaps____________________________

Restrictions for play__________________________ Allergies______________________________________

Fears____ Medications taken by child_____________________

Date of last tetanus shot_____________________ Other Information____________________________

This authorizes a representative of ZION PRESCHOOL to secure EMERGENCY medical care for my child when I cannot be immediately reached at the time of the emergency. I will be responsible for the emergency medical charges upon receipt of the statement.

____ *is the preferred doctor/clinic/hospital.*

____ ____________________

Signature of parent or guardian Date

Administer Prescription Medicine

I authorize____to administer prescribed medicine to my child as specified in the prescription's directions for administration.

____ __________________________________

Signature of parent or guardian Date

____

Relationship to Child

Pick Up Authorization

The people listed below are authorized to pick up_______________________________

from Zion Preschool. (Child's Name)

1. Name ______________________________Relationship to child_________________

2. Name ______________________________Relationship to child_________________

3. Name ______________________________Relationship to child_________________

________________________________ ______________________

Signature of Parent/Guardian Date

____

Relationship to Child

-

Zion Preschool – Discipline Policy

I have read and understand the discipline procedures as stated in the Student Handbook and listed below.

Discipline procedures for children:

Discipline

The teacher will verbally reprimand your child individually. Firm positive statements about behaviors or redirection of behavior will also be used. If this is not effective, your child will be removed from the group setting. Removal from the group will not exceed one minute per year of the child's age. If there is still a problem, the teacher will confer with the parents.

Discharge

In the event that your child is not adjusting to the preschool environment, a parent/teacher conference will be held. If the situation cannot be resolved, a meeting will be held with the parents, the teacher, the director and the Board of Christian Education at which time the board will make the final determination. Suggestions of more appropriate centers will be given to the parents at this time.

____

Name of Preschool Student

____ ________________

Signature of Parent or Guardian Date

Maple Park and Field Trip Permission

When the weather is cooperative, we will take nature walks around the neighborhood. We might also take your child on mini-field trips to Maple Park, across the street from our school. Children will be supervised by the classroom teacher and aide while at the park.

____ has permission to go to Maple Park with his/her class for the current school year.

____has permission to leave the premises of Zion Preschool under supervised care for field trips. I understand my child will be returned to Zion Preschool at the conclusion of the field trip in order to go home at his/her regular time unless I am otherwise notified.

___________________________________ _____________________________

Signature of parent or guardian Date

Photo Print Permission

We periodically take pictures of our students participating in the fun activities we plan for them. They love to see themselves in print! We occasionally print pictures in the Preschool portion of Zion's monthly newsletter and/or the Mascoutah Herald and would like to make sure parents are agreeable to having their child included. Zion's newsletter is not published on social media. We will also post student's photos in private Facebook classroom pages.

Please fill out the bottom portion of this form to indicate your preference.

______Yes, you may include my child's photos in publications and social media platforms.

______I prefer you not include my child's photos in any publications or social media platforms.

___________________________________ ___________________________________

Signature Date

ZION PRESCHOOL – POLICY FOR LATE PICK-UP

If parents or caregivers are five minutes late in picking up their child, the parent will be sent a message through Brightwheel. If we do not receive a response through Brightwheel, we will contact the parents at the phone number(s) listed on their child's registration paperwork.

If we are unable to reach the parents, the child's emergency contact person will be contacted at the number indicated in the child's file. If your telephone number or that of your emergency pick up person changes, please let the preschool office know immediately so we will always be able to contact someone in case of an emergency.

If parents or caregivers are more than 10 minutes late in picking up their child, they will be charged $1.00 per minute as a late pickup fee.

We have not had a need to contact authorities due to children being left at our facility and do not foresee such circumstances. Every effort will be made to contact parents, caregivers, emergency contact people, and all others listed on the child's pick-up authorization form. Your child will remain with his/her teacher or the preschool director until someone from your child's pick-up authorization list can be located. The Mascoutah Police Department will only be contacted if we cannot reach anyone on your child's contact list within an hour of the end of the school day.

At no time will your child be made to feel uncomfortable if he/she needs to wait for a parent or caregiver to arrive. Your child will not be held responsible for the situation and discussion of the issue will only be with the parent or guardian, not the child. Any child waiting for a parent will be supervised by the classroom teacher or director until he/she is picked up. Every effort will be made to occupy the child and make sure the child is not concerned about the late pick up.

I understand that dismissal time is at 11:30 AM and agree to pick up or have my child picked up at that time. I have read and understand the policies listed above.

Child's Name (print)____

Parent's Signature___________________________Date_____________________

Zion Preschool

Student Info. Card

First Name ______ Last Name ______ Student's Birthdate ______

Address ______ City ______ State ______ Zip ______ Home Phone ______

Parent's/Guardian #1 Name ______ Parent/Guardian #1 Work or Cell # ______

Parent/Guardian #2 Name ______ Parent/Guardian #2 Work or Cell # ______

Parent/Guardian #1 E-mail Address ______ Parent/Guardian #2 E-mail Address ______

Medical Concerns/Allergies: ______________________________

____

____

Emergency Contact (Other than Parents):

Name: ______________________________ Phone # ______________

Name: ______________________________ Phone# ______________

Dear Parents,

Please read these instructions carefully and make sure your child's physician is aware of these requirements at the time of your child's physical.

All new students must have the following before their first day of school.

*A physical **dated no earlier than six months** prior to their first day of class. Please note that there is a section on the physical form for parents to fill out and sign, as well as the sections for the physician to complete, date and sign. **The doctor must use this physical form.**

***Immunizations** for poliomyelitis, measles, rubella, mumps, diphtheria, pertussis, tetanus, haemophilus influenza B, and hepatitis B must be documented. An attached immunization record is acceptable.

*A **tuberculin skin test by the Mantoux method** must be documented. **Test results must also be documented**. (This requires returning to the physician a few days after the test is administered, having the test read, and the results documented on the physical form.) If the examining physician makes a determination that he/she does not want your child to have the test done at this time, the physician can either note that on your child's health exam form or a note with signature and date can be attached to the physical form stating the physician's decision.

***Varicella vaccination against chicken pox** must be documented or a note with signature and date from the physician stating that he/she does not want your child to have the varicella vaccination at this time.

Parents must complete the attached **CHILDHOOD LEAD RISK ASSESSMENT QUESTIONNAIRE**. Please note, **any "yes" answer requires a lead test** by your child's physician, or a note with signature and date from the physician that he/she does not want your child to have the lead test done at this time.. Your provider can also note this on your child's health exam form.

Completion of all requirements will ensure that your child will be able to start school on time and will eliminate the need for you to make repeated trips to the physician's office. **All physical forms must be turned in no later than August 27th.** If you have questions, please call me at 618-566-7345 or you can email me at zionpreschooldirector2020@gmail.com.

God Bless,

Vikki Harms

Zion Preschool Director

State of Illinois
Certificate of Child Health Examination

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

IMMUNIZATIONS: To be completed by health care provider. 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 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
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

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? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor ______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
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?	Yes No				

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☐ 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 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		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ 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**

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

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

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area
- all Medicaid-eligible children should have a blood lead test prior to 12 months of age and 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If responses to all the questions are "No":

- re-evaluate at every well child visit or more often if deemed necessary

---

Child's name ______________________________ Today's date ______________

Age________ Birthdate________________ ZIP Code_________________

Respond to the following questions by circling the appropriate answer.		**RESPONSE**	
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes	No	Don't Know
2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	Yes	No	Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes	No	Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes	No	Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes	No	Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes	No	Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes	No	Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes	No	Don't Know
9. Does this child reside in a high-risk ZIP code area? (see reverse side of page for list)	Yes	No	Don't Know

---

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

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

Test 1: Blood Lead Result _____mcg/dL Date __________ Test 2: Blood Lead Result _____mcg/dL Date __________

______________________________________ ______________________

Signature of Doctor/Nurse *Date*

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

IOCI 15-678

Printed by Authority of the State of Illinois

State of Illinois
Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams
62301
62320
62324
62339
62346
62348
62349
62365

Alexander
62914
62988

Bond
62273

Boone
61038

Brown
62353
62375
62378

Bureau
61312
61314
61315
61322
61323
61328
61329
61330
61337
61338
61344
61345
61346
61349
61359
61361
61362
61368
61374
61376
61379

Calhoun
62006
62013
62036
62070

Carroll
61014
61051
61053
61074
61078

Cass
62611
62618
62627
62691

Champaign
61815
61816
61845
61849
61851
61852
61862
61872

Christian
62083
62510
62517
62540
62546
62555
62556
62557
62567
62570

Clark
62420
62442
62474
62477
62478

Clay
62824
62879

Clinton
62219

Coles
61931
61938
61943
62469

Cook
All Chicago
ZIP Codes
60043
60104
60153
60201
60202
60301
60302
60304
60305
60402
60406
60456
60501
60513
60534
60546
60804

Crawford
62433
62449
62451

Cumberland
62428

DeWitt
61727
61735
61749
61750
61777
61778
61882

DeKalb
60111
60129
60146
60550

Douglas
61930
61941
61942

DuPage
60519

Edgar
61917
61924
61932
61933
61940
61944
61949

Edwards
62476
62806
62815
62818

Effingham
None

Fayette
62458
62880
62885

Ford
60919
60933
60936
60946
60952
60957
60959
60962
61773

Franklin
62812
62819
62822
62825
62874
62884
62891
62896
62983
62999

Fulton
61415
61427
61431
61432
61441
61477
61482
61484
61501
61519
61520
61524
61531
61542
61543
61544
61563

Gallatin
62934

Greene
62016
62027
62044
62050
62054
62078
62081
62082
62092

Grundy
60437
60474

Hamilton
62817
62828
62829
62859

Hancock
61450
62311
62313
62316
62318
62321
62330
62334
62336
62354
62367
62373
62379
62380
Hardin
62919
62982

Henderson
61418
61425
61454
61460
61469
61471
61480

Henry
61234
61235
61238
61274
61413
61419
61434
61443
61468
61490

Iroquois
60911
60912
60924
60926
60930
60931
60938
60945
60951
60953
60955
60966
60967
60968
60973

Jackson
62927
62940
62950

Jasper
62432
62434
62459
62475
62480

Jefferson
62883
Jersey
62030
62063

Jo Daviess
61028
61075
61085
61087

Johnson
62908
62923
Kane
60120
60505

Kankakee
60901
60910
60917
60954
60969

Kendall
None

Knox
61401
61410
61414
61436
61439
61458
61467
61474
61485
61489
61572

Lake
60040

LaSalle
60470
60518
60531
61301
61316
61321
61325
61332
61334
61342
61348
61354
61358
61364
61370
61372

Lawrence
62439
62460
62466

Lee
60553
61006
61031
61042
61310
61318
61324
61331
61353
61378

Livingston
60420
60460
60920
60921
60929
60934
61311
61313
61333
61740
61741
61743
61769
61775

Logan
62512
62518
62519
62548
62543
62635
62643
62666
62671

Macon
62514
62521
62522
62523
62526
62537
62551

Macoupin
62009
62033
62069
62085
62088
62093
62626
62630
62640
62649
62672
62674
62685
62686
62690

Madison
62002
62048
62058
62060
62084
62090
62095

Marion
None

Marshall
61369
61377
61424
61537
61541

Mason
62617
62633
62644
62655
62664
62682

Massac
62953

McDonough
61411
61416
61420
61422
61438
61440
61470
61475
62374

McHenry
60034

McLean
61701
61720
61722
61724
61728
61730
61731
61737
61770

Menard
62642
62673
62688

Mercer
61231
61260
61263
61276
61465
61466
61476
61486

Monroe
None

Montgomery
62015
62019
62032
62049
62051
62056
62075
62077
62089
62091
62094
62538

Morgan
62601
62628
62631
62692
62695

Moultrie
61937

Ogle
61007
61030
61047
61049
61054
61064
61091

Peoria
61451
61529
61539
61552
61602
61603
61604
61605
61606

Perry
62832
62997

Piatt
61813
61830
61839
61855
61929
61936

Pike
62312
62314
62323
62340
62343
62345
62352
62355
62356
62357
62361
62362
62363
62366
62370

Pope
None

Pulaski
62956
62963
62964
62976
62992

Putnam
61336
61340
61363

Randolph
62217
62242
62272

Richland
62419
62425

Rock Island
61201
61236
61239
61259
61265
61279

St. Clair
62201
62203
62204
62205
62220
62289

Saline
62930
62946

Sangamon
62625
62689
62703

Schuyler
61452
62319
62344
62624
62639

Scott
62621
62663
62694

Shelby
62438
62534
62553

Stark
61421
61426
61449
61479
61483
61491

Stephenson
61018
61032
61039
61044
61050
61060
61062
61067
61089

Tazewell
61564
61721
61734

Union
62905
62906
62920
62926

Vermilion
60932
60942
60960
60963
61810
61831
61832
61833
61844
61848
61857
61865
61870
61876
61883

Wabash
62410
62852
62863

Warren
61412
61417
61423
61435
61447
61453
61462
61473
61478

Washington
62214
62803

Wayne
62446
62823
62843
62886

White
62820
62821
62835
62844
62887

Whiteside
61037
61243
61251
61261
61270
61277
61283

Will
60432
60433
60436

Williamson
62921
62948
62949
62951

Winnebago
61077
61101
61102
61103
61104

Woodford
61516
61545
61570
61760
61771

IOCI 15-678

Printed by Authority of the State of Illinois

April 2015