State of Illinois
Department of Human Services

IDHS CHILD CARE ASSISTANCE PROGRAM
SIGN-IN / SIGN-OUT LOG

Provider Name:

Provider Location:

Service Period: Month: Year: Date:

Parent Please Read: By signing this log, I attest that this is an accurate record of the hours and day of attendance. Each individual child must be signed in and out.

Child Name	Parent/Guardian Name	Signature	Time In	Signature:	Time Out

I attest that this is an accurate reflection of the hours and day of attendance for the above listed children.

Provider Name: Provider Signature:

* I no longer care for: as of (enter date):