WILLOW WEEKLY

www.willowspringsschool.org October 22, 2021

NEXT WEEK AT A GLANCE/PLEASE MARK YOUR CALENDAR!

IVY LEAGUE KIDS Before & Afterschool Care 630AM-6:00PM * ivyleaguekids.org

Monday, October 25 – Concert Band (All Members) 7:30am
Access Club 3:13-4:13pm
Boys Basketball practice 3:30-5:00pm
Jr High Cheer Practice 3:30-5:00pm
Tuesday, October 26- Beginning Band (Woodwinds) 7:30am
Board Meeting rescheduled (new date 10/28)
Access Club 3:13-4:13pm
Boys Basketball practice 3:30-5:00pm
Jr High Cheer Practice 3:30-5:00pm
2nd Grade Cheer Practice 3:13-4:13pm
Wednesday, October 27- Concert Band (All Members) 7:30am
Access Club 3:13-4:13pm
Boys Basketball practice 3:30-5:00pm
Jr High Cheer Practice 3:30-5:00pm
4th Grade Art Club 3:13-4:13pm
Thursday, October 28- Beginning Band (Brass/Percussion) 7:30am
Board Meeting 6:30pm
Access Club 3:13-4:13pm
Boys Basketball practice 3:30-5:00pm
Jr High Cheer Practice 3:30-5:00pm
2nd Grade Cheer Practice 3:13-4:13pm
5th Grade Art Club 3:13-4:13pm
Spooky season-wear **Orange** and **Black**
8th Grade PSAT testing
1st Quarter Report Cards go home
1st Grade Fieldtrip Siegel's Cottonwood Farm
Friday, October 29- Teacher Institute Day –No School

Coming up:
Tuesday, November 2- *Bus Evacuation Drill*
Thursday, Nov 11- *Veteran's Day- No School*
Friday, Nov 12- *Parent Teacher Conferences 12:00-7:30pm*
Friday, November 19- *8th Grade Cap and Gown Pictures*
Wednesday, Nov 24 to Friday, November 26- *Thanksgiving break- No School*

Monday- Chicken Luncheon Meat
Tuesday- Beef Hot Dog
Wednesday-Mini Taco
Thursday- Ribette
Friday- No Lunch –No School

Come cheer your student(s) on at the 3rd Annual

Wolverine Powder Run

3:20-4:10pm

Parent/Guardians:

- Parking in the front parking lot: Limited space available. Do not park in the bus lane.
- Parking on the side streets: Please obey all posted signs. You can walk over to the school
- Meet us on the black top in the back of the school.
- No one will be allowed to enter the building
- Do CHEER on your student!!

GO WOLVERINES!!!

Early Childhood

Ms.L.Baricovich's classroom made a scarecrow today. They stuffed him and then dressed him for the weather. Great job working as a team!

WILLOW SPRINGS PUBLIC SCHOOL

DISTRICT 108 • COOK COUNTY

SUPERINTENDENT • STEVE BAHN
PRINCIPAL • ALEXANDRA ORELUK

8345 ARCHER AVENUE
WILLOW SPRINGS, ILLINOIS 60480-1499
PHONE (708) 839-6828 • FAX (708) 839-8399
www.willowspringsschool.org

Ageless Eye Care will be offering **FREE** eye exams and eye glasses to those that qualify.

Please return the attached form to secure your spot ASAP

Date to be Determined!

Questions??? Contact the school nurse!

Lisa Perea BSN, RN, IL PEL-SN, NCSN
lperea@willowspringsschool.org
708-467-3511

LUNCHROOM/ RECESS MONITOR NEEDED

Position Summary: The Lunchroom/Recess Attendant will monitor and assist classrooms during lunch periods. This is a part-time, benefits-ineligible position. The work schedule will be: Monday - Friday, from 10:30am to 1:30pm.

Principal Duties And Responsibilities

- Provide supervision of students during lunch periods in the cafeteria and recess
- Monitors student behavior in assigned areas to ensure compliance with school rules and procedures.
- Manages misconduct by students in tactful and diplomatic manner.
- Must be able to lift 30lbs plus Other duties as assigned

How to apply: Call Mrs. Wacker to schedule an appointment to fill out an application 708-839-6828

SPECIAL EDUCATION INSTRUCTIONAL ASSISTANT

Position Summary: Duties include, but not limited to: assist with the delivery of instructional program planned by teacher; perform routine tasks and duties as assigned by teacher to allow teacher to spend vast majority of day instructing students; perform lunchroom and playground duties as assigned by administration.

Qualifications
Must have or qualify for the Illinois Paraprofessional
license through the Illinois State Board of Education

Salary/Benefits
Commensurate with experience and education.

How to Apply
Email resume and letter of interest to: mlitko@willowspringsschool.org

Meghan Litko,
Director of Special Education

PFC NEWS

We are looking for parents/guardians to join our PFC (Parents for children) group. Becoming a member of the PFC shows that you want to help support the programs and events that help enhance students' experiences at school. It does not obligate you to attend all meetings or volunteer for all events. While we would love for everyone to attend, we understand families are busy during the school year and have other important commitments.

Attending meetings and volunteering at any of the several PFC sponsored events provide opportunities to meet other parents and students. As well as funding activities and events for our students. Always feel free to join us if you have any ideas, suggestions, or comments.

If you're interested please email Ms. Oreluk : aoreluk@willowspringsschool.org

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Dear Parent/Guardian,

10/22/21

We would like to inform you that we have recently received information about at least one confirmed case of COVID-19 in a student or staff person at Willow Springs School. Cleaning and disinfecting of the exposed location have been completed. Please know that any students or staff members that may be deemed a close contact have been informed by Willow Springs Staff.

No further action is necessary if you did not receive a phone call notification.

How You Can Help:

Be proactive about reducing the number of interactions that students and staff have with one another by practicing physical (or social) distancing (staying at least 3 feet apart) as well as practicing good hygiene to limit the spread of the coronavirus. This includes:

- **Stay home when you are sick.** Anyone with symptoms consistent with COVID-19 should remain at home in isolation and notify the school immediately for isolation guidance. Isolation will be determined on a case-by-case basis and in accordance with IDPH guidelines.
- **Wash your hands often with soap and water for at least 20 seconds.** If soap and water are not available, use alcohol-based hand sanitizers that contain at least 60% alcohol.
- **Cover your coughs and sneezes with a tissue, and then dispose of the tissue and clean your hands immediately.** If you do not have a tissue, use their sleeve, not your hands, to cover their coughs and sneezes.
- **Limit close contact with people who are sick, and avoid sharing food, drinks, or utensils.**
- **Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipes.**
- All students and staff should **wear a mask or face covering while in the Educational Setting.**

Home Self certification of students (by guardians) and staff for COVID-19 will help keep our educational setting safe.

Please note that all information, including the name(s) of ill persons, is confidential and protected under the laws of HIPAA in order to protect patient privacy.

Please contact me with any questions,

Lisa Perea BSN, RN, IL PEL-SN, NCSN

lperea@willowspringsschool

WICKED WILLOW HALLOWEEN PARTY

FRIDAY
OCTOBER 29, 2021

6PM - 8PM

LIONS PARK
201 PARK STREET

HAYRIDES - FOOD - GAMES - BONFIRE - HAUNTED BUSES!

WEAR YOUR COSTUME!

TO REGISTER CALL 708-467-3700

Willow Springs Residents ONLY

WILLOW SPRINGS SCHOOL DISTRICT 108

OCTOBER 2021

STUDENT LUNCH MENU

Mon	Tue	Wed	Thu	Fri
				1 CHEESE PIZZA LUNCHABLE VEGETABLE FRUIT MILK
4 SCHOOL IMPROVEMENT DAY EARLY STUDENT DISMISSAL	5 BEEF HOT DOG ON A BUN KETCHUP VEGETABLE FRUIT CHIPS MILK	6 HAMBURGER ON A BUN VEGETABLE KETCHUP FRUIT MILK	7 CORNED BEEF SANDWICH VEGETABLE FRUIT MILK	8 SOY PEANUT BUTTER AND JELLY SAND-WICH VEGETABLE FRUIT MILK
11 *HOLIDAY* *NO STUDENT ATTENDANCE*	12 HAMBURGER ON A BUN VEGETABLE FRUIT BAKED CHIPS MILK	13 BOSCO STICKS MARINARA SAUCE VEGETABLE FRUIT MILK	14 ROAST BEEF SANDWICH VEGETABLE FRUIT BAKED CHIPS MILK	15 TURKEY BREAST SANDWICH VEGETABLE FRUIT MILK
18 CHICKEN TENDERS BBQ SAUCE VEGETABLE FRUIT BREADSTICK MILK	19 TURKEY BOLOGNA SANDWICH BAKED CHIPS FRUIT MILK	20 REGULAR CORN DOG VEGETABLE FRUIT GOGURT MILK	21 ROAST BEEF SAND-WICH ON A BUN VEGETABLE FRUIT MILK	22 CHEESE HOT POCKET VEGETABLE FRUIT MILK
25 CHICKEN LUNCHEON MEAT SANDWICH VEGETABLE FRUIT MILK	26 BEEF HOT DOG ON A BUN KETCHUP VEGETABLE FRUIT BAKED CHIPS MILK	27 MINI TACO WITH SALSA BBQ SAUCE VEGETABLE FRUIT MILK	28 RIBETTE ON A BUN BBQ SAUCE VEGETABLE FRUIT MILK	29 TEACHER INSTITUTE NO STUDENT ATTENDANCE

Happy Halloween!

ALL LUNCHES ARE SUBJECT TO CHANGE....

ChooseMyPlate.gov

AGELESS
EYE CARE

Dear Parent/Guardian,

Good vision is important for success in school. We are pleased that Ageless Eye Care will be serving our School District this year!

Ageless Eye Care will provide eye exams and glasses (if needed) at **NO COST** to your child. If the student does not have insurance, the vision exam and eyeglasses are provided at no cost to the family. If available, health insurance will be billed.

Below are reasons why your child may need an eye exam:

- My child is entering kindergarten
- My child is entering Illinois schools for the first time at any grade level
- My child failed the vision screening
- My child has an IEP
- My child's teacher recommended they receive an eye exam
- My child experiences any of the following:
  - Squinting
  - Tilting the head
  - Sitting too close to the television
  - Losing place while reading
  - Rubbing eyes
  - Excessive tearing or headaches

A completed and signed consent form is required to give your child an eye exam. Please read the attached consent and ask about anything that you do not understand. We will be happy to explain it.

Please remember to:

- **Sign the signature line.**
- Complete the last page with your child's medical history.
- Return the form to your child's school **as soon as possible** – Your child must have a signed consent form to receive services.

After the eye exam, if your child requires glasses, an optician will help your child select frames. Glasses will be delivered within 4 weeks to the school. If further eye care is indicated, a referral will be provided.

If you have questions, please contact _____

Sincerely,

Ageless Eye Care
Vision Services Consent Form

Your child has failed a vision screening test performed at school or was recommended for a comprehensive eye exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional. Please fill out this consent for your child to receive the eye exam.

Patient Information

Child's FULL Legal Name _____
First Name Middle Name Last Name

Sex: ☐ Male ☐ Female Age _____ Birth Date _____

Parent/Guardian's Name _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Does your child have Medicaid?

[ ]Yes [ ]No

Does your child have any of the following insurance plans?

[ ]BlueCross [ ]County Care [ ]Harmony [ ]Illinicare [ ]Meridian [ ]Molina [ ]NextLevel [ ]Other

Medicaid ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ Member ID: _____

As part of your child's eye exam, eye drops will be used for the purpose of dilating his/her eyes. These drops are an important part of an eye exam because they widen the pupil so the doctor can check the health of the eye. Temporary effects of these eye drops may include blurred vision and sensitivity to light, both of which could restrict your child's mobility, making it unsafe for him/her to travel unassisted or to operate a vehicle for the rest of the day.

I hereby give my consent for my child to be examined by the doctors of Ageless Eye Care for an eye exam and prescription eyeglasses. This consent does not authorize any treatments or service beyond what is stated. I understand that the Provider will bill the Illinois Medicaid or any other currently applicable insurance (including Managed Care Organizations) for any reimbursable services and/or materials. I understand my consent will be valid for one year from the date of signature. I have read the above information and have had the opportunity to have my questions answered.

Parent/Guardian Signature: _____ **Date:** _____

If you do NOT want your child to receive the following services, please check the appropriate box. Please note services will be performed unless indicated otherwise.

☐ At this time I DO NOT consent for my child's eyes to be dilated

*****Please sign and date the signature line. Complete the medical history on reverse side of this form. ****

AGELESS EYE CARE

Student Medical History Form

Please Print:
Student's Name: _____ School Name: _____

Student's Date of last Eye Exam: _____ Does your child currently wear glasses or contacts? ☐ Yes ☐ No

Does your child have any of the following conditions: (Check all that apply)

☐ Asthma	☐ Behavioral problems	☐ Attention Deficit Disorder	☐ Glaucoma
☐ Neurological problems	☐ Endocrine problems	☐ High Blood Pressure	☐ Musculoskeletal problems
☐ Heart Disease	☐ Mental Health illness	☐ Gastrointestinal problems	☐ Genitourinary problems
☐ Hearing/Ear problems	☐ Diabetes	☐ Other Condition	_____

Is your child taking any medications? ☐No ☐Yes
List medications:

_____

_____

Does your child have allergies? ☐No ☐Yes
List allergies:

_____

_____

Does your child use eye drops? ☐No ☐Yes
List eye drops:

_____

_____

Has your child ever had eye surgery? ☐No ☐Yes
If yes, please explain:

_____

_____

Has s/he had any of the following?

Vision Therapy	☐ No	☐Yes	Eye Injury	☐ No	☐Yes	Trouble finishing work	☐ No	☐Yes
Eye patch	☐ No	☐Yes	Eye Infection	☐ No	☐Yes	Lack of confidence	☐ No	☐Yes
Eye Surgery	☐ No	☐Yes	Itching/Burning	☐ No	☐Yes	Difficulty sitting still	☐ No	☐Yes
Pain in eyes	☐ No	☐Yes	Eye Discharge	☐ No	☐Yes	Avoids reading/writing	☐ No	☐Yes
Difficulty Tracking	☐ No	☐Yes	Tearing/Watering	☐ No	☐Yes	Difficulty paying attention	☐ No	☐Yes
Lazy/Wandering Eye	☐ No	☐Yes	Light sensitivity	☐ No	☐Yes	Reads below grade level	☐ No	☐Yes
Blurred/Double Vision	☐ No	☐Yes	Redness	☐ No	☐Yes	Poor handwriting	☐ No	☐Yes
Loses place while reading	☐ No	☐Yes	Drooping Lid	☐ No	☐Yes	Frustrates easily	☐ No	☐Yes

Other _____

Does your child have an IEP (Individualized Education Plan)? ☐ No ☐ Yes

Is the child performing at: ☐ above grade level ☐ grade level ☐ below grade level

If below grade level, please select the class (Check all that apply)
☐ Reading ☐ Writing ☐ Math ☐ Social Studies ☐ Other _____

Is the child currently receiving any of the **services** below? (Check all that apply)
☐ Special Education ☐ Tutoring ☐ Speech Therapy ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)

List any of your child's Hobbies or Special Interests: _____

Is there anything else you would like us to know about your child? _____

_____

_____

Does your child's immediate family member have any of the following? (Check all that apply and list the relationship to child)

☐ Wears glasses	☐ Wandering Eye	☐ Diabetes	☐ Cardiovascular problems
☐ Glaucoma	☐ Blindness	☐ Musculoskeletal problems	☐ Neurological problems
☐ Lazy eye	☐ Macular Degeneration	☐ Heart Disease	☐ Mental Health illness
☐ High Blood Pressure			

AGELESS
EYE CARE

Estimados Padres/Tutores,

Una buena visión es importante para tener éxito en la escuela. Estamos muy contentos de que la óptica Ageless estara sirviendo a nuestro distrito durante todo el año!

La óptica Ageless ofrecerá exámenes de la vista y anteojos (si es necesario) SIN COSTO ALGUNO para su niño. Si el alumno no tiene seguro médico, el examen de visión y un par de lentes son proporcionados sin costo para la familia. Si tiene alguno, se le enviará la factura al seguro de salud.

Si un estudiante requiere un par de anteojos de reemplazo, es posible que estén disponibles a un costo mínimo. Pregunte al momento de realizar el pedido. Los anteojos de repuesto deberán recogerse en nuestra oficina, momento en el que se deberá realizar el pago si es que aplica una tarifa.

Le mostramos las razones por las cuales su hijo puede necesitar un examen de la vista:

- Mi hijo esta entrando a kindergarten
- Mi hijo esta entrando a las escuelas de Illinois por primera vez
- Mi hijo no paso el examen de la visión
- Mi hijo tiene un IEP
- El maestro de mi hijo recomendo que se le hiciera un examen de la vista
- Mi hijo experimenta cualquiera de los siguientes:
- Entrecierra los ojos
- Inclina la cabeza
- Se sienta demasiado cerca de la televisión
- Pierde el lugar al leer
- Se talla los ojos
- Lagrimeo excesivo o dolor de cabeza

La ley estatal requiere que la óptica Ageless obtenga su consentimiento con el fin de hacerle a su hijo un examen de la vista. Por favor lea el consentimiento adjunto y pregunte acerca de cualquier cosa que no entienda. Estaremos encantados de explicarle.

Por favor recuerde:

- Firmar en la línea.
- Contestar la ultima página del historial clínico de su hijo.
- Regresar el formulario a la escuela de su hijo **lo mas pronto posible** — Su hijo debe tener firmado el formulario de consentimiento para recibir los servicios.

Después del examen de la vista, si su hijo necesita lentes, un oftalmólogo le ayudará a su hijo a seleccionar los armazones. Los lentes seran entregados de 4-5 semanas en la escuela. Si ademas se requieren más exámenes, se le dará la información necesaria.

Si tiene preguntas, favor de contactar a _____

Ageless Eye Care
Forma de Consentimiento para Servisios de la Vista

Su hijo ha fallado una prueba de la vista realizada en la escuela o se le ha recomendado un examen de la vista completo para determinar si él/ella necesita anteojos o otro tratamiento por un profesional del cuidado de la vista (proveedor). Por favor llene este consentimiento para que su hijo reciba el examen de la vista.

Informacion del Paciente Escuela: _____

Nombre COMPLETO legal del niño _____
Nombre Segundo Nombre Apellido

Sexo: ☐ Masculino ☐ Femenino Edad _____ Fecha de Nacimiento _____

Nombre del Padre/Tutor _____

Dirección _____
Calle Ciudad Estado Código Postal

Teléfono de Casa _____ Teléfono Celular _____ Teléfono Trabajo _____

¿Su hijo tiene Medicaid/All Kids?

[ ]Sí [ ]No

¿Su hijo tiene alguno de estos planes de aseguranza?

[ ]BlueCross [ ]County Care [ ]Illinicare [ ]Meridian [ ]Molina
[ ]NextLevel [ ]Other

Numero ID: _ _ _ _ _ _ _ _ _ ID: _____

Como parte del examen de la vista, se usarán gotas para los ojos con el fin de dilatar la vista. Estas gotas son una parte importante de un examen de la vista porque amplia la pupila de modo que el proveedor puede verificar la salud de los ojos. Efectos temporales de estas gotas para los ojos pueden ocasionar visión borrosa y sensibilidad a la luz, ambos de los cuales podria restringir la movilidad de su hijo, que lo hace peligroso para que él/ella maneje un auto el resto del dia.

Doy mi consentimiento para que mi hijo sea examinado por un médico para un examen de los ojos y la prescripción de lentes, si se prescribe durante el examen de la vista. Este consentimiento no autoriza ningun tratamiento o servicio más allá de lo que se afirma.
Entiendo que el proveedor facturará al Departamento de Salud y Servicios a la familia de Illinois (HFS) o cualquier otro seguro actualmente aplicable (incluyendo organizaciones de atencion administrativa) por cualquier rembolso de servisios y/o materiales. Entiendo que mi consentimiento será válido por un año desde la fecha de la firma. He leído la información anterior y de haber tenido la oportunidad de que se contestaran mis preguntas.

Firma del Padre/Tutor: _____ **Fecha:** _____

Si usted NO desea que su hijo reciba los siquientes servicios, por favor marque la caja correspondiente. Por favor tenga en cuenta que los servicios se realizarán a menos que se indique lo contrario

☐ Por ahora NO DOY MI permiso para que se le dilate la vista a mi hijo

*****Por favor firme en la línea. Conteste las preguntas del historial medico en la parte de atras de esta forma ****

AGELESS EYE CARE

Forma del Historial Medico del Estudiante

Por favos escriba:
Nombre del Estudiante:_____ Nombre de la Escuela: _____

Ultimo Examen de Vision del Estudiante: _____ ¿Su hijo usa actualmente lentes o contactos? □ No □ Sí

Su hijo tiene alguna de las siguientes condiciones: (Marque rodas las que sean aplicables)

□ Asthma
□ Problemas Neurologicos
□ Enfermedades del Corazon
□ Problemas de Augicion/oido
□ Problemas de Conducta
□ Problemas Endocrinos
□ Enfermedades Salud Mental
□ Diabetes
□ Trastorno deficit de Atención
□ Presion Arterial Alta
□ Problemas Gastrointestinales
□ Otra Condicion _____
□ Glaucoma
□ Problema Musculo-esquelético
□ Problemas Genitourinarios

¿Su hijo toma algun medicamento? □ No □ Sí
Enliste los medicamentos:

_____
_____

¿Tiene su hijo alergias? □ No □ Sí
Enliste las alergias:

_____
_____

¿Su hijo usa gotas en los ojos? □ No □ Sí
Enliste las gotas que usa

_____
_____

¿Su hijo a tenido cirugía en los ojos? □ No □ Sí
En caso afirmativo, por favor explique:

_____
_____

¿El/Ella ha tenido alguna de las siguientes?

Terapia de la Visión	□ No □ Sí	Lesión en el ojo	□ No □ Sí	Problemas para terminar el trabajo	□ No □ Sí
Parche en el ojo	□ No □ Sí	Infección	□ No □ Sí	Falta de confianza	□ No □ Sí
Cirugia del ojo	□ No □ Sí	Comezón/Ardor	□ No □ Sí	Dificultad para estar sentado	□ No □ Sí
Dolor en los ojos	□ No □ Sí	Secreción del ojo	□ No □ Sí	Evita la lectura/escritura	□ No □ Sí
Dificultad de Seguimiento	□ No □ Sí	Rasgado/Lagrimeo	□ No □ Sí	Dificultad para poner atención	□ No □ Sí
Ojo Peresozo/Vagando	□ No □ Sí	Sensibilidad a la luz	□ No □ Sí	Lee mas abajo de su nivel	□ No □ Sí
Visión Borrosa/Doble	□ No □ Sí	Enrojecimiento	□ No □ Sí	Escritura deficient	□ No □ Sí
Pierde el lugar al leer	□ No □ Sí	Parpado caido	□ No □ Sí	Frustración con facilidad	□ No □ Sí

Other_____

¿Su hijo tiene un IEP (Plan Individualizado de Education)?

El niño realiza: □ arriba de su nivel □a su nivel □ por debajo de su nivel

Si marco por debajo de su nivel, por favor seleccione la materia (Marque todas las que apliquen)

□ Lectura □ Matematicas □ Estudios Sociales □ Escritura □ Otra_____

¿El niño esta recibiendo actualmente alguno de los servicios de abajo? (Marque todos los que apliquen)

□ Educacion Especial □ Terapia de lenguaje □ Terapia Ocupacional (OT) □ Tutoria □ Terapia Fisica (PT)

Mencione algunos de los pasatiempos o intereses especiales de su hijo:_____
_____

¿Hay algo más que le gustaría que supiéramos sobre su hijo? _____
_____
_____

Los familiares inmediatos de su hijo tienen cualquiera de los siguientes? (Marque todos los que apliquen y la relacion con el niño)

□ Usa lentes
□ Glaucoma
□ Ojos cansados
□ Presión Arterial Alta
□ Ojos errantes
□ Ceguera
□ Degeración Macular
□ Diabetes
□ Problema Musculoesqueletico
□ Enfermedades del Corazon
□ Problemas Cardiovasculares
□ Problemas Neurologicos
□ Enfermedad Salud Mental

WALKER PARK REC CENTER

GIRLS BASKETBALL LEAGUE 2022

Pleasant Dale Park District

JANUARY 17-MARCH 12

1ST GRADE-8TH GRADE

$92R/$120NR

REGISTRATION DEADLINE NOVEMBER 24TH!!

FOR MORE INFORMATION VISIT PDPARKS.ORG
OR CALL (630) 662-6220

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