



9 Month Questionnaire

9 months 0 days through 9 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:



- Try each activity with your baby before marking a response.
- Make completing this questionnaire a game that is fun for you and your baby.
- Make sure your baby is rested and fed.
- Please return this questionnaire by _____.

Notes:



COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make sounds like "da," "ga," "ka," and "ba"?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
2. If you copy the sounds your baby makes, does your baby repeat the same sounds back to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
3. Does your baby make two similar sounds like "ba-ba," "da-da," or "ga-ga"? (The sounds do not need to mean anything.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
4. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peeka-boo," "clap your hands," "So Big")?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
5. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," without your using gestures?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
6. Does your baby say three words, such as "Mama," "Dada," and "Baba"? (A "word" is a sound or sounds your baby says consistently to mean someone or something.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
COMMUNICATION TOTAL				___

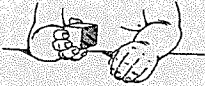
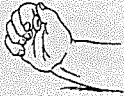



GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. If you hold both hands just to balance your baby, does she support her own weight while standing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				
2. When sitting on the floor, does your baby sit up straight for several minutes without using his hands for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
				

GROSS MOTOR (continued)

	YES	SOMETIMES	NOT YET	
3. When you stand your baby next to furniture or the crib rail, does she hold on without leaning her chest against the furniture for support?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. While holding onto furniture, does your baby lower himself with control (without falling or flopping down)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
6. Does your baby walk beside furniture while holding on with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				GROSS MOTOR TOTAL —

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. Does your baby pick up a small toy with only one hand?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
2. Does your baby <i>successfully</i> pick up a crumb or Cheerio by using her thumb and all of her fingers in a raking motion? (If she already picks up a crumb or Cheerio, mark "yes" for this item.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
3. Does your baby pick up a small toy with the tips of his thumb and fingers? (You should see a space between the toy and his palm.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
4. After one or two tries, does your baby pick up a piece of string with her first finger and thumb? (The string may be attached to a toy.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				
5. Does your baby pick up a crumb or Cheerio with the tips of his thumb and a finger? He may rest his arm or hand on the table while doing it.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—*
				
6. Does your baby put a small toy down, without dropping it, and then take her hand off the toy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	—
				FINE MOTOR TOTAL —

*If Fine Motor Item 5 is marked "yes" or "sometimes," mark Fine Motor item 2 "yes."

PROBLEM SOLVING

1. Does your baby pass a toy back and forth from one hand to the other?



YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. Does your baby pick up two small toys, one in each hand, and hold onto them for about 1 minute?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

3. When holding a toy in his hand, does your baby bang it against another toy on the table?



<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

4. While holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

5. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

6. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? (Be sure the toy is completely hidden.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

PROBLEM SOLVING TOTAL ___

PERSONAL-SOCIAL

1. While your baby is on her back, does she put her foot in her mouth?



YES	SOMETIMES	NOT YET	___
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___

2. Does your baby drink water, juice, or formula from a cup while you hold it?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

3. Does your baby feed himself a cracker or a cookie?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

4. When you hold out your hand and ask for her toy, does your baby offer it to you even if she doesn't let go of it? (If she already lets go of the toy into your hand, mark "yes" for this item.)

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

5. When you dress your baby, does he push his arm through a sleeve once his arm is started in the hole of the sleeve?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

6. When you hold out your hand and ask for her toy, does your baby let go of it into your hand?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	___
-----------------------	-----------------------	-----------------------	-----

PERSONAL-SOCIAL TOTAL ___

OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain:

YES

NO

2. When you help your baby stand, are his feet flat on the surface most of the time?
If no, explain:

YES

NO

3. Do you have concerns that your baby is too quiet or does not make sounds like other babies? If yes, explain:

YES

NO

4. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain:

YES

NO

5. Do you have concerns about your baby's vision? If yes, explain:

YES

NO

6. Has your baby had any medical problems in the last several months? If yes, explain:

YES

NO

OVERALL (continued)

7. Do you have any concerns about your baby's behavior? If yes, explain:

YES

NO

[Empty rounded rectangular box for explanation]

8. Does anything about your baby worry you? If yes, explain:

YES

NO

[Empty rounded rectangular box for explanation]



9 Month ASQ-3 Information Summary

9 months 0 days through
9 months 30 days

Baby's name: _____ Date ASQ completed: _____

Baby's ID #: _____ Date of birth: _____

Administering program/provider: _____ Was age adjusted for prematurity when selecting questionnaire? Yes No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See ASQ-3 User's Guide for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	13.97		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gross Motor	17.82		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fine Motor	31.32		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving	28.72		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Personal-Social	18.91		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See ASQ-3 User's Guide, Chapter 6.

- | | | | | | |
|--|------------|-----------|--|------------|----|
| 1. Uses both hands and both legs equally well?
Comments: | Yes | NO | 5. Concerns about vision?
Comments: | YES | No |
| 2. Feet are flat on the surface most of the time?
Comments: | Yes | NO | 6. Any medical problems?
Comments: | YES | No |
| 3. Concerns about not making sounds?
Comments: | YES | No | 7. Concerns about behavior?
Comments: | YES | No |
| 4. Family history of hearing impairment?
Comments: | YES | No | 8. Other concerns?
Comments: | YES | No |

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

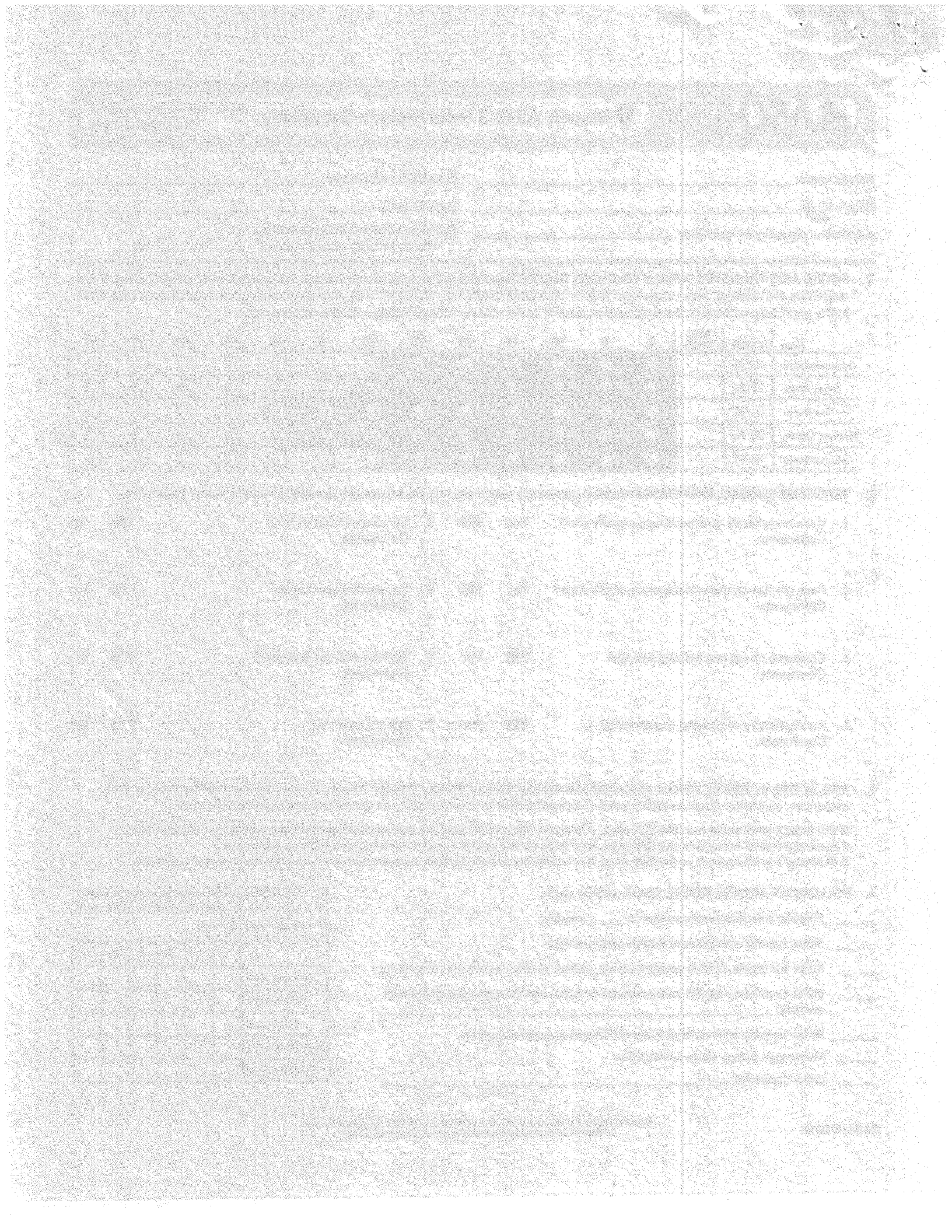
If the baby's total score is in the area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

- Provide activities and rescreen in _____ months.
- Share results with primary health care provider.
- Refer for (circle all that apply) hearing, vision, and/or behavioral screening.
- Refer to primary health care provider or other community agency (specify reason): _____
- Refer to early intervention/early childhood special education.
- No further action taken at this time
- Other (specify): _____

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

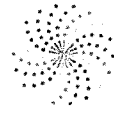
	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						



Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By Jane Squires, Diane Bricker, & Elizabeth Twombly
with assistance from Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim
Copyright © 2002 by Paul H. Brookes Publishing Co.



12 Month/1 Year Questionnaire



(For children ages 9 through 14 months)



Important Points to Remember:

- Please return this questionnaire by _____ .
- If you have any questions or concerns about your child or about this questionnaire, please call: _____ .
- Thank you and please look forward to filling out another ASQ:SE questionnaire in _____ months.



Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By Jane Squires, Diane Bricker, & Elizabeth Twombly
with assistance from Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim
Copyright © 2002 by Paul H. Brookes Publishing Co.

12 Month/1 Year ASQ:SE Questionnaire

(For children ages 9 through 14 months)



Please provide the following information.

Child's name: _____

Child's date of birth: _____

Today's date: _____

Person filling out this questionnaire: _____

What is your relationship to the child? _____

Your telephone: _____

Your mailing address: _____

City: _____

State: _____ ZIP code: _____

List people assisting in questionnaire completion: _____

Administering program or provider: _____



Please read each question carefully and

1. Check the box that best describes your child's behavior *and*
2. Check the circle if this behavior is a concern

MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
------------------	-----------	-----------------	----------------------------

1. Does your baby laugh or smile at you and other family members?



<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

2. Does your baby look for you when a stranger approaches?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

3. Does your baby like to play near and be with family members and friends?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

4. Does your baby like to be picked up and held?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

5. When upset, can your baby calm down within a half hour?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

6. Does your baby stiffen and arch her back when picked up?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

7. Does your baby like to play games like Peekaboo?



<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

8. Is your baby's body relaxed?

<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

9. Does your baby cry, scream, or have tantrums for long periods of time?

<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
----------------------------	----------------------------	----------------------------	-----------------------

TOTAL POINTS ON PAGE ____

MOST OF THE TIME RARELY OR NEVER CHECK IF THIS IS A CONCERN

SOMETIMES

10. Is your baby able to calm himself down (for example, by sucking on his hand or a pacifier)?



z v x

11. Is your baby interested in things around her, such as people, toys, and foods?

z v x

12. Does it take longer than 30 minutes to feed your baby?

x v z

13. Do you and your baby enjoy mealtimes together?

z v x

14. Does your baby have any eating problems, such as gagging, vomiting, or _____ ?
(You may write in another problem.)

x v z

15. Does your baby have trouble falling asleep at naptime or at night?

x v z

16. Does your baby make babbling sounds? For example, does he put sounds together, like "ba-ba-ba-ba" or "na-na-na-na"? (If your child often babbles, mark "most of the time.")

z v x

17. Does your baby sleep at least 10 hours in a 24-hour period?



z v x

TOTAL POINTS ON PAGE _____

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your baby get constipated or have diarrhea?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
19. Does your baby let you know when she is hungry, hurt, or tired?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
20. When you talk to your baby, does he turn his head, look, or smile?	<input type="checkbox"/> z	<input type="checkbox"/> v	<input type="checkbox"/> x	<input type="radio"/>
21. Does your baby try to hurt other children, adults, or animals (for example, by kicking or biting)?	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>
22. Has anyone expressed concerns about your baby's behaviors? If you checked "sometimes" or "most of the time," please explain:	<input type="checkbox"/> x	<input type="checkbox"/> v	<input type="checkbox"/> z	<input type="radio"/>

23. Do you have concerns about your baby's eating or sleeping behaviors? If so, please explain:				

TOTAL POINTS ON PAGE ____				

24. Is there anything that worries you about your baby? If so, please explain:

25. What things do you enjoy most about your baby?

12 Month/1 Year ASQ:SE Information Summary

Child's name: _____ Child's date of birth: _____
 Person filling out the ASQ:SE: _____ Relationship to child: _____
 Mailing address: _____ City: _____ State: _____ ZIP: _____
 Telephone: _____ Assisting in ASQ:SE completion: _____
 Today's date: _____ Administering program/provider: _____

.....
SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

- Z (for zero) next to the checked box = 0 points
- V (for Roman numeral V) next to the checked box = 5 points
- X (for Roman numeral X) next to the checked box = 10 points
- Checked concern = 5 points

Add together:

- Total points on page 3 = _____
- Total points on page 4 = _____
- Total points on page 5 = _____
- Child's total score = _____

SCORE INTERPRETATION

1. *Review questionnaires*
 Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
 In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
12 months/1 year	48	

3. *Referral criteria*
 Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
 It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
 - Setting/time factors
 (e.g., Is the child's behavior the same at home as at school?)
 - Development factors
 (e.g., Is the child's behavior related to a developmental stage or a developmental delay?, Have there been any stressful events in the child's life recently?)
 - Health factors
 (e.g., Is the child's behavior related to health or biological factors?)
 - Family/cultural factors
 (e.g., Is the child's behavior acceptable given cultural or family context?)



Childhood Lead Risk Questionnaire

STATE LAW REQUIRES:

All children 6 years of age or younger must be evaluated for lead exposure.

All children must be assessed for risk of lead exposure and tested if necessary for enrollment into daycare, preschool, and kindergarten.

Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children ages 12 and 24 months of age (at minimum) and once a year at annual well-child-visits at ages 3, 4, 5, and 6 years.

- If responses to all the questions are "NO," re-evaluate at next age referenced above or more often if deemed necessary.
- If any response is "YES" or "DON'T KNOW," a blood lead test *must* be obtained.
- If there are any "YES" or "DON'T KNOW" answers **and**
 - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 4.9 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 4.9 µg/dL or less, and
 - ✓ there has been no change in address of the child's home/residential building, child care facility, school, or other frequently visited facilities and
 - ✓ risks of exposure to lead have not changed, further blood lead tests are not necessary.

Child's name _____ Today's date _____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.

RESPONSE

- | | Yes | No | Don't Know |
|---|-----|----|------------|
| 1. Does this child reside or regularly visit a home/residential building, child-care setting, school or other facility built before 1978 or in a high risk ZIP code area? (see reverse side of page for high risk ZIP code area list) | Yes | No | Don't Know |
| 2. Is this child eligible for or enrolled in Medicaid, All Kids, Head Start, WIC, or any HFS medical program?
<i>***All Medicaid-eligible children and children enrolled in HFS medical programs shall have a blood lead test at 12 and at 24 months of age. If a Medicaid-eligible child or HFS medical program enrolled child between 36 months and 72 months of age has not been previously tested, a blood lead test shall be performed.</i> | Yes | No | Don't Know |
| 3. Does this child have a sibling with a confirmed blood lead level of 5 µg/dL or higher? | Yes | No | Don't Know |
| 4. In the past year, has this child been exposed to repairs, repainting, or renovation of a building/home built before 1978? | Yes | No | Don't Know |
| 5. Is this child a refugee, adoptee, or recent visitor of any foreign country? | Yes | No | Don't Know |
| 6. Is this child frequently exposed to imported items (such as, ayurvedic medicine, folk medicines, cosmetics, toys, glazed pottery, spices or other food items, sindoor, or kumkum)? | 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, bridge construction, plumbing, furniture refinishing, work with automobile batteries or radiators, lead solder, leaded glass, bullets, lead fishing sinkers, or recycling facility work)? | Yes | No | Don't Know |
| 8. If the child is younger than 12 months of age, did the child's mother have a past confirmed blood lead level of 5 µg/dL or higher? | Yes | No | Don't Know |
| 9. Has the water in your home/residential building, child-care setting, school, or other regularly visited facility been tested and had a confirmed level of lead (5 ppb or higher)? | Yes | No | Don't Know |
| 10. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead? | Yes | No | Don't Know |

*****ALL blood lead test results MUST be submitted to the Illinois Lead Program.
Fax: 217-557-1188 Phone: 866-909-3572**

Signature of Doctor/Nurse Date

**Illinois Lead Program 866-909-3572 or 217-782-3517 email: dph.lead@illinois.gov
TTY (hearing impaired use only) 800-547-0466**



Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams 62301 62320 62324 62339 62346 62348 62349 62365	Christian 62083 62510 62517 62540 62546 62555 62556 62557 62570	DuPage 60519 Edgar 61917 61924 61932 61933 61940 61944 61949 Edwards 62420 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	Grundy 60437 60474 Hamilton 62817 62828 62829 62859 Hancock 61450 62311 62313 62316 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 61434 61443 61468 61490 Iroquois 60911 60912 60924 60926 60930 60931 60938 60945 60951 60953 60955 60966 60967 60968 60973	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 61324 61331 61353 61378	Livingston 60420 60460 60920 60921 60929 60934 61311 61313 61333 61740 61741 61743 61769 61775 Logan 62512 62518 62519 62548 60910 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	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	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
--	---	---	--	---	--	---	---	--	---