CCSD59

NEW STUDENT ENROLLMENT CHECKLIST
For CCSD59 District / School Office Use only
Registered by:_____ Date: _____

Forms due when packet is turned in - Verify all forms are completed, signed, and dated:

Form #	Form Name	ELC	K	1 - 5	JH
SR-13 **OR** SR-5	Verification of Student Residence and Copies of 3 Proofs				
SR-39	New Student Registration/Emergency Contact				
SR-11	Permanent Birth Record and Birth Certificate				
SR-12	Home Language Survey*** (completed only once)				
SR-36	Data Collection Form				
H-29	Status of Physical/Immunization Records				
H-103	Annual Student Health Form				
H-115A	Parent Consent for Athletics/Proof of Medical Insurance				
T-42	Transportation Request Form				
SR-37	Student Photo Permission Form				
SR-38A/B	Annual Authorization for Internet Access				
SR-42	New Form: Discipline Policy Agreement Form				
SR-9	Request for Student Records				
EC-6	Household Income Eligibility App for ECE Program				
None	Young Athletes Permission Form				
None	Fees Form - No Fees for 17-18 SY				
ILC-1	Google Apps for Education Permission Form	Will not be included in 17-18 spring packets			
ILC-2	Student Device Responsible Use Form				

Forms due later:

Form #	Form Name	ELC	K	1 - 5	JH
H-11	IL Dept of Health Dental Exam Form				
H-67	State of IL Eye Exam Report				
IL-444-4737	State of IL Cert of Child Health Exam				
ILC-3	Student Device Protection Plan (optional)	Will not be included in 17-18 spring packets			

***Home Language (SR-12 form): If another language besides English is spoken, enter student on state database check. If required, enter date and time of testing appt: _____

(See reverse side to complete checklist)

Other Additional Considerations:

Did child attend ELC? ____Yes ____No

Does child have an IEP or Special Needs? ____Yes ____No
If yes, date requested and name of organization: _____

Does parent qualify for Free/Reduced Meals? ____Yes ____No

Is parent interested in Dual Language Program? ____Yes ____No

Is parent interested in Ridge (Choice)? ____Yes ____No

Additional Notes or Follow-Up Needed:

CCSD59

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Road * Arlington Heights, IL 60005 #847-593-4300 (Phone), #847-593-4352 (Fax)

PARENT/GUARDIAN VERIFICATION OF STUDENT RESIDENCE

All students attending District 59 schools must be legal residents of the District.

Generally, Illinois law provides that the residence of a student is the same as the person who has legal custody of the student.

STUDENTS ENTERING 3rd & 6th GRADE MUST PROVE RESIDENCY AT THE SCHOOL BETWEEN AUGUST 1 - AUGUST 10
STUDENTS WILL NOT BE ALLOWED TO BEGIN SCHOOL UNTIL RESIDENCY IS PROVEN

NOTICE: Registration of a student who is not a legal resident is a fraudulent act. Illinois law has made it a crime, punishable by imprisonment and fine, to knowingly or willfully present any false information regarding the residency of a student for purposes of enabling that student to attend on a tuition-free basis or to knowingly enroll or attempt to enroll a student on a tuition-free basis when the student is known to be a non-resident of the District. Board of Education policy authorizes the investigation of residency before or after enrollment in accordance with Illinois law and may require additional information to be considered in determining residency. Parents/guardians who fraudulently register a student will be charged tuition for the period the student had been in attendance. The District will seek prosecution to the full extent of the law of any person who the District believes has committed any residency-related crime. Additionally, a civil lawsuit may be initiated by the District.

Student Name:		School Name:	

A total of <u>three</u> (3) <u>original documents</u> from the categories below are required to prove residency (If Unable to Provide Use Form SR-5).

Category A: One (1) Document Required	**Category B: Two (2) Documents Required**		**Military Personnel must provide one of the following within 60 days after the date of student's initial enrollment:**
❒ Most recent Real Estate Tax Bill	❒ Driver's License or State ID	❒ Current Homeowners/Renters Insurance Policy and Premium Payment Receipt	❒ Postmarked Mail Addressed to Military Personnel
❒ Mortgage Papers	❒ Vehicle Registration	❒ Most Recent Gas, Electric and/or Water Bill	❒ Lease Agreement for Occupancy
❒ Signed and Dated Lease or Letter from Manager or Proof of Last Month's Payment	❒ Voter Registration	❒ Mail Received at District Residence	❒ Proof of Ownership of Residence
IMPORTANT: District 59 reserves the right to evaluate the evidence present and merely presenting the items listed below does not guarantee admission.	❒ Most Recent Cable or Credit Card Bill	❒ Receipt for Moving Company Services Showing Current Address	
	❒ Current Public Aid Card	❒ Other _____	

Category C: None of the Documents in Categories A & B are Applicable Because:	❒ 1. The student is homeless and eligible for enrollment under the Illinois Education for Homeless Children Act
	❒ 2. The student is enrolling based on the determination of the Department of Children & Family Services (*Attach DCFS Documentation*)

I affirm that I am a resident of Community Consolidated School District 59 and that the information presented in this form is true, complete and accurate.

Printed Name of Parent / Guardian	Signature of Parent / Guardian	Date

Residency Materials Received By:		❒ All Materials Supplied
❒ Referred for Further Review to:		❒ Principal ❒ Homeless Liaison

SR-13 (REV. 11/16) Distribution: Student's Temporary File

NEW STUDENT REGISTRATION and EMERGENCY CONTACT FORM - CCSD59

Directions: Print & Complete Both Sides. Shaded Section at Top is for Office Use Only.

Student Other ID:	Student State ID:	School:	Grade:

Student Last Name:	Student First Name:	Student Middle Name:	Birth Date: __ __ / __ __ / __ __
			Gender: ☐ Male ☐ Female

Street Address:		Apt. / Lot / Unit #:	
City & Zip Code:		Complex / Mobile Home Park Name:	
Primary Phone Number:		Has Your Student Been Enrolled in District 59 Before? :	☐ Yes ☐ No

Date Your Student Entered a U.S. School:	Name of Last School Attended & State:	Is Your Child Receiving Any Special Services?	If Yes, Which D59 School/s and What Year/s?
(Month / Year) __ __ / __ __ __ __		☐ Bilingual ☐ ESL ☐ Special Education ☐ Other:	

Country of Birth:	9 Digit Medicaid Number:	(Voluntary & Optional) Military Service Information:	☐ I am a member of the United States Armed Forces
State of Birth:			☐ I am on active duty / expected to be deployed to active duty during the school year
City of Birth:			

Custodial Parent / Guardian Information

Title:	First Name:	Last Name:	Work Phone & Extension:	Cell Phone:

Relationship to Student:	☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Guardian	Email Address:			
Language Preference:	☐ English ☐ Spanish ☐ Polish ☐ Gujarati ☐ Other: _____	Custody:	☐ Yes ☐ No	Lives With:	☐ Yes ☐ No

Title:	First Name:	Last Name:	Work Phone & Extension:	Cell Phone:

Relationship to Student:	☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Guardian	Email Address:			
Language Preference:	☐ English ☐ Spanish ☐ Polish ☐ Gujarati ☐ Other: _____	Custody:	☐ Yes ☐ No	Lives With:	☐ Yes ☐ No

Office Use Only

Title:	First Name:	Last Name:	Work Phone & Extension:	Cell Phone:

Relationship to Student:	☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Guardian	Email Address:			
Language Preference:	☐ English ☐ Spanish ☐ Polish ☐ Gujarati ☐ Other: _____	Custody:	☐ Yes ☐ No	Lives With:	☐ Yes ☐ No

Local Persons to Call in an EMERGENCY if Parents/Guardians Cannot Be Reached - List at least Two (2) People				
	First and Last Names:	Relationship:	Language Spoken:	Phone Number:
1				
2				
3				
4				

List ALL other Student's Siblings (Brother/s or Sister/s) in immediate family enrolled in District 59					
	First Name:	Last Name:	Name of School Attending:	Grade:	Age:
1					
2					
3					
4					
5					

Parent/Guardian Name (Please Print):	Parent/Guardian Signature:

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Rd. | Arlington Heights, IL 60005
Phone: 847-593-4300 | Fax: 847-593-4352

PERMANENT BIRTH RECORD

Dear Parent/Guardian:

In accordance with Illinois law (*325 ILCS 50/5, Missing Children's Record Act)* students enrolling in the district for the first time, must provide within 30 days either:

a) a certified copy of the student's birth certificate, ***or***
b) other reliable proof of the student's identity and age (i.e. passport or visa) ***and*** an affidavit explaining the inability to produce a copy of the birth certificate.

Upon the failure of the person enrolling the student to provide the required evidence, the District will notify the local law enforcement agency of such failure, and notify the person enrolling the student in writing that he/she has 10 additional days to comply, or the case will be referred to the local law enforcement agency for investigation. Any affidavit presented which appears to be inaccurate or suspicious in form or content will immediately be reported to the local law enforcement agency.

_____

Student's Last Name First Middle Date of Birth

Place of Birth (City, State, Country)_____

Proof of Birth and Age (mark one and attach copy of document to this form):

❒ Birth Certificate State_____
Number_____

❒ Passport Country_____
Number_____

❒ Visa Country_____
Number_____

❒ Other_____

I am unable to provide a certified copy of a birth certificate for the above named student because:

_____

_____

_____ _____ _____

Name of Parent/Guardian (PRINTED) Signature of Parent/Guardian Date

---

(for office use only)

Documentation Requirement: ❒ Met ❒ Not Met

Verified by:_____ School _____ Date_____

SR-11 (Rev. 1/2016) Distribution: Student's Temporary File

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Rd. | Arlington Heights, IL 60005
Phone: 847-593-4300 | Fax: 847-593-4352

HOME LANGUAGE SURVEY

All students new to the district must have this survey completed and signed by a parent/guardian in accordance with state regulations (*23 Illinois Administrative Code Part 228).* This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency.

_____ _____ ❒ Male ❒ Female
Student's Last Name First Middle Date of Birth

School_____ SIS ID # _____

1. Is a language other than English spoken in your home?
   a. Yes ____ What language?_____
   b. No ____

2. Does your child speak a language other than English?
   a. Yes ____ What language? _____
   b. No ____

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

Parent/Guardian (Print)_____Relationship to Student_____ Date_____

Parent/Guardian Signature_____Staff Member who Registered Child_____

(For Office Use Only)

Language_____ Language Code #_____ Grade Assignment_____

Request for Language Assessment from ELL Personnel: ❒ Yes ❒ No Date_____

CCSD59

Community Consolidated School District 59
U.S. Department of Education Race and Ethnicity Data Standards

DATA COLLECTION FORM

Student's Name: _____ **School** _____

IMPORTANT INFORMATION: The U.S. Department of Education requires this form to be completed upon a student's enrollment into a school district. The data is used in reporting and analyzing State-required test results by race and ethnicity. The information will not be used to check immigration status, and the confidentiality of the individual student information will be protected.

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, and both questions must be answered. Part A asks about the student's ethnicity (refers to culture and language) and Part B asks about the student's race (refers to geographic or national origin). PLEASE NOTE: If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
Choose only one:

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue to respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.

Part B. What is the student's race? Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

_____ _____
Parent/Guardian Signature Date

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Rd. | Arlington Heights, IL 60005
Phone: 847-593-4300 | Fax: 847-593-4352

STATUS OF PHYSICAL & IMMUNIZATION RECORDS FOR INCOMING STUDENTS

Date: _____

Dear Parent(s)/Guardian(s) of _____

In accordance with District 59 policy, students who enter District 59 are given a 30-day period to show evidence of a current physical examination and immunizations are up-to-date.

Your student who is named above, is being admitted to school on a provisional basis until his/her current physical examination and immunization records are received from the parent(s)/guardian(s) or the previous school of attendance.

The district is required by the Illinois State Board of Education to use a standard form furnished by the state to record and verify the physical examination and immunization data. This form, entitled "Certificate of Child Health Examination" is available at the school office.

Failure to comply with the 30-day timeline will result in exclusion from school.

Sincerely,

School Nurse/Health Care Assistant

Parent/Guardian Completes This Section

I understand my child's current physical examination (including immunization data) is to be submitted to _____ School by _____ which is 30 days from the above enrollment date. Failure to comply with the 30-day timeline will result in exclusion from school.

Previous School of Attendance: _____

Address of Previous School _____

Signature of Parent/Guardian _____

H-29 4/03 Distribution: Parent, Health File

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Road * Arlington Heights, IL 60005
Phone: 847-593-4300

ANNUAL STUDENT HEALTH FORM

20 ___ - 20 ___ SCHOOL YEAR

Student: _____ Birth date _____
(last) (First)
Grade _____ Sex _____ School _____

Annual Health History Update	YES	NO
1. Does this child have: Allergies to food, medications or insect stings	_____	_____
Asthma	_____	_____
Any chronic illness	_____	_____
A seizure disorder	_____	_____
Any physical limitations	_____	_____
Diabetes	_____	_____
Glasses	_____	_____

Explain:
_____
_____

2. During the past 12 months has this child been:	YES	NO
Hospitalized (include surgery)	_____	_____
Seriously injured	_____	_____

Explain:
_____
_____

	YES	NO
3. Does this child take medication on a regular basis?	_____	_____

Explain: _____
(If medications, inhaler or glucose monitoring, etc., needs to be done at school, please refer to the appropriate forms “Medication Guidelines” H-24; “School Medication Authorization” H-25; “Hold Harmless and Indemnification for the Self-Administration of Asthma Medication and/or Possession of an Epinephrine Auto-Injector (Epi-Pen®)” H-26. Complete proper form(s)and return it to the school nurse.)

	YES	NO
4. Are there any other health concerns that the nurse/teacher should be aware of?	_____	_____

Explain: _____

Physician Contact Information

Physician Name: _____Phone:_____

Name of Practice: _____

Physician Address: _____

Parent(Guardian) Name (please print):_____

Parent (Guardian) Signature_____Date_____

Return to your child’s school health office. H-103 (Rev. 1/16) Distribution: health file

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Rd. | Arlington Heights, IL 60005
Phone: 847-593-4300 | Fax: 847-593-4352

Students

Exhibit - Using a Photograph or Video Recording of a Student

Student Name _____ **School year**_____

Photographs, Videos or Digital Images of Students

Photographs, videos, or digital images used for informational or news-related purposes (whether by a media outlet or by the school) of a student participating in school or school-sponsored activities, organizations, and athletics that appear in school publications, such as yearbooks, newspapers, or sporting or fine arts program are considered "directory information" under the *Illinois School Student Records Act* and 23 Illinois Administrative Code Section 375.80. "Directory Information" may be released to the general public unless a parent/guardian requests that any or all the directory information not be released on his/her child. In the absence of parent/guardian request that such information not be released, the school may use such photographs, videos, or digital images in various publications, including the school yearbook, school newspaper, and school website. No consent or notice is needed or will be given before the school uses photographs, videos, or digital images of students taken while they are at school or a school-related activity.

Request to Exclude Child from Release of Directory Information

- ❑ I do NOT allow the school to release or publish my child's voice, image, works, photographs or audio or video recordings as directory information. I further understand that this means my child will not be featured in publicity about the achievements or activities of my child or my child's classmates or school.

Parent/Guardian Name_____

Parent/Guardian signature_____ Date_____

Pictures of Students Taken By Non-School Agencies

While the school limits access to school buildings by outside photographers, it has no control over news media or other entities that may publish a picture of a named or unnamed student.

SR-37 Updated 1/26/16

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CCSD59

Annual Authorization for Internet and Electronic Network Access

INTRODUCTION

The District's Electronic Network provides Internet and other electronic access in support of education and/or research. The goal in providing this access is to promote educational excellence by facilitating resource sharing, innovation, productivity, and communication. Parents (guardians) must annually grant permission for their student(s) to access these resources. Students must also agree to abide by the District's and school's electronic network rules and regulations. Violation of applicable policies, regulations or procedures may result in the loss of the privilege to use this resource, District disciplinary action, and/or referral to law enforcement.

The District takes precautions to prevent access to materials that may be defamatory, inaccurate, offensive, or otherwise inappropriate in the school setting. Each District computer with Internet access has a filtering device when on the district network that blocks entry to visual depictions that are (1) obscene, (2) pornographic, or (3) harmful or inappropriate for students, as defined by the Children's Internet Protection Act and as determined by the Superintendent or designee. However, it is impossible to control all material and a user may discover inappropriate material. Ultimately, staff members and/or parent(s)/guardian(s) are responsible for setting and conveying the standards that their students, children, or wards should follow. To that end, the District supports and respects each individual's right to decide whether or not to authorize electronic network access. Parents are responsible for filtering home internet access.

Parents (guardians) and students are required to read Board Policy 6.235 and Administrative Regulation 6.235R2, and are required annually to authorize a student's use of this resource.

SR_38A (1/2016)

Distribution: Parent

CCSD59

Annual Authorization for Internet and Electronic Network Access

STUDENT'S NAME_____**STUDENT I.D.**_____

SCHOOL_____ **SCHOOL YEAR:** _____ **GRADE LEVEL**_____

Student (or Parent on Behalf of the Student) Release

I have read and will abide by Student Use of the District's Electronic Network Administrative Regulation 6.235-R2. . I understand that use of the Internet is a privilege and it may be revoked at any time. I also understand should I commit any violation, my access privileges may be revoked, and school disciplinary action and/or appropriate legal action may be taken. In consideration for using the District's Internet connection and having access to public networks, I hereby release the Community Consolidated School District 59 and its Board of Education members, employees, and agents from any claims and damages arising from my use or inability to use the Internet.

_____

Student's Name (Please Print)

_____ _____

Student's Signature (student or parent on behalf of the student) Date

Parent/Guardian Release (Required in Addition to Student Release)

I have read this Authorization for Internet and Electronic Network Access. I understand that access is designed for educational purposes and that the District has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the District to restrict access to all controversial and inappropriate materials. I will hold harmless Community Consolidated School District 59, its employees, agents, or Board of Education members, for any harm caused by materials or software obtained via the network. I accept full responsibility for supervision if and when my child's use is not in a school setting. I have discussed the terms of this Authorization with my child. I hereby request that my child be allowed access to the District's Internet and Electronic Networks.

_____

Parent/Guardian's Name (Please Print)

_____ _____

Parent/Guardian's Signature Date

CCSD59

Availability of Student Disciplinary Policies and Procedures

STUDENT'S NAME_____ **SCHOOL YEAR** _____

SCHOOL_____

Parent/Guardian Release

I have been informed that student disciplinary policies and procedures are available online through the District 59 Family Reference Guide at ccsd59.org/family-reference-guide/ or in hard copy per my request. I have also been informed that I can obtain a paper copy of this document at the District 59 Administrative Office or my child's school.

I understand that it is my parental responsibility to review these policies and procedures with my child. I also understand that assistance will be made available to me if I am unable to read or understand these policies and procedures by contacting the District 59 Administrative Office or my child's school.

_____

Parent/Guardian's Name (Please Print)

_____ _____

Parent/Guardian's Signature Date

CCSD59

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
2123 S. Arlington Heights Road, Arlington Heights, IL 60005
Phone: (847)593-4300 Fax: (847)593-4352

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Student's Last Name | **First Name** | **Middle Initial** | **Birth Date**

Name of School or Agency Releasing Records | **Address** | **City** | **State** | **Zip**

I/we hereby authorize that the following information will be released/exchanged:

☐ All permanent records (including, but not limited to, basic identifying information, birth certificate or other proof of student's identity, academic transcript, attendance records, health records, and where applicable),

☐ All temporary records (including, but not limited to, scores on State Assessments administered in grades K-8, discipline records, health-related information, accident reports, family background information, psychological evaluation reports, aptitude and achievement test results, report cards, honors and awards, progress monitoring information, IDEA/special education records, and Section 504 records).

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 *et seq.),* and the *Illinois Mental Health and Developmental Disability Confidentiality Act (740 ILCS 110/1 et seq.),** and are to be made for the purpose of:

☐ Educational evaluation and/or planning
☐ Other (specify):_____

*Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the *Health Insurance Portability and Accountability Act* ("HIPAA").

PRE-ELEMENTARY SCHOOL

☐ **Early Learning Center,** 1900 Lonnquist Blvd, Mount Prospect, IL 60056	P: (847) 593-4306	F:(847) 593-7199

ELEMENTARY SCHOOLS

☐ **Brentwood,** 260 Dulles Rd, Des Plaines, IL 60016	P: (847) 593-4401	F: (847) 593-7184
☐ **Admiral Byrd,** 265 Wellington Ave, Elk Grove Village, IL 60007	P: (847) 593-4388	F: (847) 593-7188
☐ **Clearmont,** 280 Clearmont Dr, Elk Grove Village, IL 60007	P: (847) 593-4372	F: (847) 593-7194
☐ **Devonshire,** 1401 S. Pennsylvania Ave, Des Plaines, IL 60018	P: (847) 593-4398	F: (847) 593-7183
☐ **Forest View,** 1901 Estates Dr, Mount Prospect, IL 60056	P: (847) 593-4359	F: (847) 593-4360
☐ **Robert Frost,** 1308 S Cypress Dr, Mount Prospect, IL 60056	P: (847) 593-4378	F: (847) 593-4365
☐ **John Jay,** 1835 Pheasant Trl, Mount Prospect, IL 60056	P: (847) 593-4385	F: (847) 593-8656
☐ **Juliette Low,** 1530 Highland Ave, Arlington Heights, IL 60005	P: (847) 593-4383	F: (847) 593-7291
☐ **Ridge Family Center for Learning,** 650 Ridge Ave, Elk Grove Village, IL 60007	P: (847) 593-4070	F: (847) 593-4075
☐ **Ira R. Rupley,** 305 E. Oakton St, Elk Grove Village, IL 60007	P: (847) 593-4353	F: (847) 593-4405
☐ **Salt Creek,** 65 Kennedy Blvd, Elk Grove Village, IL 60007	P: (847) 593-4375	F: (847) 593-7390

JUNIOR HIGH SCHOOLS

☐ **Friendship,** 550 Elizabeth Ln, Des Plaines, IL 60018	P: (847) 593-4350	F: (847) 593-7182
☐ **Grove,** 777 Elk Grove Blvd, Elk Grove Village, IL 60007	P: (847) 593-4367	F: (847) 472-3001
☐ **Holmes,** 1900 Lonnquist Blvd, Mount Prospect, IL 60056	P: (847) 593-4390	F: (847) 593-7386

I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the student. This consent expires one year from the date indicated below. However, I understand that I have the right to revoke this consent in writing at any time.

Parent/Guardian Printed Name | Parent/Guardian Signature | Date

Witness Signature (required for mental health/developmental disability records) | Date

Student Signature (required for mental health/developmental disability records, if student is age 12 or older) | Date

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** **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**

Illinois Department of Public Health
PROOF OF DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address: Street	City	ZIP Code	Telephone:
Name of School:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note_____

Signature of Dentist _____ Date _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health, 535 W. Jefferson St., Springfield, IL 62761
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to October 15 of the year the child enters an Illinois school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Sex _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of Exam _____

Ocular History: ❑ Normal or Positive for _____

Medical History: ❑ Normal or Positive for _____

Drug Allergies: ❑ NKDA or Allergic to _____

Other Information _____

Examination

Refraction:	**Distance**			**Near**
	Right	Left	Both	Both
Unaided Visual Acuity	20/	20/	20/	20/
Best Corrected Visual Acuity	20/	20/	20/	20/

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	❑	❑	❑	_____
Internal Exam (media, lens, fundus, etc.)	❑	❑	❑	_____
Neurological Integrity (pupils)	❑	❑	❑	_____
Binocular Function (stereopsis)	❑	❑	❑	_____
Accommodation and Vergence	❑	❑	❑	_____
Color Vision	❑	❑	❑	_____
IOP (glaucoma)	❑	❑	❑	_____
Oculomotor Assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

H-67 Revised 12/10 Distribution: Health File

State of Illinois
Eye Examination Report

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses should be worn for:
   ❑ Constant Wear ❑ Near Vision ❑ Far Vision
   ❑ May Be Removed for Physical Education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name_____
Optometrist or Physician who provides eye examinations

Address _____

_____

Phone _____

Signature _____
Optometrist or Physician who provides eye examinations

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

(Source: Amended at 32 Ill. Reg. _____, effective _____)

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5/08
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