COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59

## IMPORTANT INFORMATION ABOUT REGISTERING YOUR STUDENT

The enrollment of your student is not final until all required paperwork has been completed. You will be contacted by your assigned school if your paperwork or information is incomplete. Therefore, it is important your contact information is accurate and is kept current.

*Remember:* Only students who are residents of the District may attend a District 59 school without a tuition charge, except as otherwise provided by law. A student's residence is the same as the person who has legal custody of the student.

Please be advised, Board of Education Policy authorizes verification and investigation of residency, which includes the services of a private investigation service.

We encourage you to become familiar with District 59 and our schools by visiting our website at www.ccsd59.org or contacting your school.

**Brentwood School** (847) 593-4401
260 Dulles Rd, Des Plaines

**Clearmont School** (847) 593-4372
280 Clearmont Dr, Elk Grove Village

**Early Learning Center** (847) 593-4306
1900 Lonnquist Blvd, Mt. Prospect

**Robert Frost School** (847) 593-4378
1308 Cypress Dr, Mt. Prospect

**Juliette Low School** (847) 593-4383
1530 Highland Ave, Arlington Hts

**Rupley School** (847) 593-4353
305 East Oakton St, Elk Grove Village

**Friendship Jr. High** (847) 593-4350
550 Elizabeth Ln, Des Plaines

**Holmes Jr. High** (847) 593-4390
1900 Lonnquist Blvd, Mt. Prospect

**Admiral Byrd School** (847) 593-4388
265 Wellington Ave, Elk Grove Village

**Devonshire School** (847) 593-4398
1401 S. Pennsylvania Ave, Des Plaines

**Forest View School** (847) 593-4359
1901 Estates Dr, Mt. Prospect

**John Jay School** (847) 593-4385
1835 Pheasant Trail, Mt. Prospect

**Ridge Family Center for Learning** (847) 593-4070
650 Ridge Ave, Elk Grove Village

**Salt Creek School** (847) 593-4375
65 Kennedy Blvd, Elk Grove Village

**Grove Jr. High** (847) 593-4367
777 Elk Grove Blvd, Elk Grove Village

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59

# WAŻNE INFORMACJE DOTYCZĄCE REJESTRACJI WASZEGO UCZNIA

Zapisanie waszego ucznia do szkoły nie jest zakończone, dopóki cała dokumentacja nie będzie skompletowana. Szkoła, do której wasz uczeń zamierza uczęszczać, skontaktuje się z wami, jeżeli dokumenty lub informacje nie będą kompletne. Dlatego jest ważne, aby twoje dane kontaktowe były dokładne i aktualne.

*Pamiętajcie:* Tylko uczniowie, którzy są rezydentami Dystryktu mogą uczęszczać do szkół Dystryktu 59 bez opłaty, chyba że prawo nakazuje inaczej. Miejsce/adres zamieszkania ucznia musi być taki sam, jak osoby, która ma legalne prawo opieki nad uczniem.

Informujemy, że Zarządzenie Rady Edukacyjnej (Board of Education Policy) daje prawo weryfikacji i sprawdzenia miejsca zamieszkania, także poprzez skorzystanie z usług prywatnej agencji dochodzeniowej.

Zachęcamy Was, byście zapoznali się z naszym Dystryktem 59 i naszymi szkołami, odwiedzając naszą stronę internetową www.ccsd59.org lub kontaktując się ze swoją szkołą.

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CCSD59

# VISIT OUR WEBSITE TO FIND MORE INFORMATION ON THE FOLLOWING:

ODWIEDŹ NASZĄ STRONĘ INTERNETOWĄ PO WIĘCEJ INFORMACJI DOTYCZĄCYCH:

# CCSD59.ORG/BACKTOSCHOOL

### School Supply Lists
Listy przyborów szkolnych

### Family Reference Guide
Przewodnik dla rodzin

### Menus
Menu

### Transportation Information
Informacja dotycząca przewozów

### Application for Free and Reduced Price Meals
Podanie o darmowe lub obniżone ceny posiłków

### Ability to Pay School Fees and Make Deposits into Your Student's Meal Account
Możliwość uiszczenia opłat szkolnych oraz dokonywania wpłat na konto posiłkowe waszego ucznia

**Community Consolidated School District 59**
**2123 S. Arlington Heights Road**
**Arlington Heights, IL 60005**

***Note: For Parents of Incoming 6th Graders Only - Please Disregard this notice if your child is not an incoming 6th grader.***

Dear Parents/Guardians:

The Illinois School Code has changed immunization requirements for incoming 6th graders. This letter provides important information about those new requirements. Please read carefully and pay special attention to deadlines. Please contact your building nurse for assistance. Enclosed with this letter are the following:

| Document/Form: | What to Do Before the First Day of School: |
|---|---|
| State of Illinois Certificate of Child Health Examination (H-12)<br><br>**Please note that your child must now receive the Hepatitis B vaccination series, a Tdap booster, Meningococcal Vaccine, two varicella vaccinations, and two MMR vaccinations prior to the first day of school.**<br><br>(Please note: if your child may be participating in interscholastic athletics, his/her physical exam must take place between June 1, 2017 and the start of school.) | • Enter your student's name on both front and back of the form.<br>• Complete the Health History section on the back of the form. Be sure to sign it.<br>• Have your child's doctor, nurse practitioner, or physician's assistant complete and sign the Immunization History, Physical Exam, and Physical Education and Interscholastic Sports sections. Be sure that any modifications in the Physical Education section are specified.<br>• **Return the completed form to your child's school.** |
| Proof of Dental Examination Form (H-11) | • Have your child's dentist complete, sign, and date the form.<br>• **Return the completed form to your child's school.** |
| Interscholastic Athletics Requirements | • Read and keep the information about Interscholastic Athletics and Concussions (pp. 1-4)<br>• Complete and sign the Parent and Student Consent for Participation in Interscholastic Athletics and the Proof of Insurance forms.<br>• **Return the completed form to your child's school.** |

Please note: the only exceptions to immunization requirements are religious objections and medical contraindication for your child. Proper documented evidence must be submitted to your child's school health office. If you have additional questions or need assistance, please contact your building nurse.

Sincerely,
Denise M. Webster, RN, BSN, PEL-CSN
Coordinator of Health Services, District 59

**Community Consolidated School District 59**
**2123 S. Arlington Heights Road | Arlington Heights, IL 60005**

***Uwaga: Tylko dla rodziców rozpoczynających naukę 6-klasistów - Proszę pominąć tę wiadomość, jeśli twoje dziecko nie jest 6-klasistą.***

Drodzy Rodzice/Opiekunowie:

Regulamin Szkół w Illinois (Illinois School Code) wprowadza zmiany w wymogach dotyczących szczepień dla uczniów przyszłych klas 6-tych. Ten list zawiera ważne informacje dotyczące nowych wymogów. Proszę, przeczytajcie uważnie i zwróćcie uwagę na obowiązujące daty. Proszę, kontaktujcie się z pielęgniarką w swojej szkole, aby uzyskać pomoc. Do listu dołączone są następujące dokumenty i objaśnienia:

| Dokument/Formularz: | Co zrobić przed pierwszym dniem w szkole: |
|---|---|
| State of Illinois Certificate of Child Health Examination (H-12) (Zaświadczenie lekarskie o stanie zdrowia dziecka stanu Illinois) (H-12)<br><br>**Proszę zwrócić uwagę na to, że twoje dziecko musi otrzymać serię szczepień Hepatitis B (przeciwko wirusowemu zapaleniu wątroby), Tdap booster (p/krztuścowi), przeciwko meningokokom, dwa szczepienia przeciwko odrze, śwince i różyczce - jeszcze przed rozpoczęciem pierwszego dnia szkoły.**<br><br>(Uwaga: jeśli twoje dziecko zamierza uczestniczyć w szkolnych zajęciach sportowych, jej/jego badania lekarskie muszą być przeprowadzone między 1 czerwca 2017, a dniem rozpoczęcia szkoły). | • Wpisz nazwisko ucznia na obu stronach formularza.<br>• Skompletuj część Health History (Kartę zdrowia) na odwrocie formularza. Upewnij się, że podpisałeś.<br>• Poproś lekarza swojego dziecka, dyplomowaną pielęgniarkę lub asystenta lekarza o wypełnienie i podpisanie historii szczepień, badania lekarskiego i części dotyczącej udziału w zajęciach wychowania fizycznego oraz w międzyszkolnych zawodach sportowych. Upewnij się, że wszelkie zmiany w części związanej z wychowaniem fizycznym są wyszczególnione.<br>• **Zwróć wypełniony formularz do szkoły twojego dziecka.** |
| Formularz dowodu badania dentystycznego (H-11) | • Poproś dentystę twojego dziecka o wypełnienie, podpisanie i datowanie formularza.<br>• **Zwróć wypełniony formularz do szkoły twojego dziecka.** |
| Wymagania wobec uczniów biorących udział w międzyszkolnych zawodach sportowych | • Przeczytaj i zachowaj informację dotyczącą Interscholastic Athletics and Concussions (pp.1-4) (udziału w międzyszkolnych zawodach sportowych oraz wstrząsu mózgu).<br>• Wypełnij i podpisz formularz zgody rodziców i ucznia na uczestniczenie w zawodach międzyszkolnych i formularz potwierdzający posiadanie ubezpieczenia zdrowotnego.<br>• **Zwróć wypełniony formularz do szkoły twojego dziecka.** |

Uwaga: Jedynymi wyjątkami od wymagań dotyczących szczepień są zastrzeżenia religijne i przeciwwskazania medyczne dla twojego dziecka. Właściwie udokumentowane zastrzeżenia muszą być dostarczone do gabinetu pielęgniarskiego szkoły twojego dziecka. Jeżeli masz dodatkowe pytania lub potrzebujesz pomocy, skontaktuj się z twoją pielęgniarką szkolną.

Z poważaniem,
Denise M. Webster, RN, BSN, PEL-CSN
Coordinator of Health Services, District 59 (Koordynator Usług Medycznych Dystryktu 59)

CCSD59

**COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59**
**2123 S. ARLINGTON HEIGHTS RD. | ARLINGTON HEIGHTS IL 60005**
Phone: 847-593-4300 | Fax: 847-593-4352

## IMPORTANT INFORMATION REGARDING ILLINOIS CERTIFICATE OF CHILD HEALTH EXAMINATION FORM

Dear Parent/Guardian,

The Illinois School Code requires that all children entering kindergarten or the first grade, or enrolling in an Illinois school for the first time, regardless of the student's grade (including early childhood, special education, and students transferring into Illinois), have a physical examination within one year prior to entry into school. There must also be documented evidence that each child has received all required immunizations.

Attached is a Certificate of Child Health Examination form. Please be sure the following information is completed on this form before it is returned to school:

- The student's name and information should be entered on both sides of the exam form.
- **Immunization History** must include specific dates. A health care provider's signature is required to verify the immunization dates.
- The **Health History** (on the back) must be completed and signed by a parent/guardian.
- The **physical exam** must be completed, dated, and signed by a physician, nurse practitioner or physician's assistant.
- Approval to participate in **Physical Education and Interscholastic Sports** near the bottom of the page must be checked by the physician. Modifications must be specified.

The only exception to this requirement is based on religious objection or medical contraindication for your child. However, proper documented evidence must be submitted to your child's school health office.

If, for any reason, you are unable to comply with the state requirement, please contact your child's school health office as soon as possible.

We appreciate your cooperation in this matter.

Denise M. Webster, RN, CSN
Health Coordinator, District #59

Enclosure: Certificate of Child Health Examination

**COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59**
**2123 S. ARLINGTON HEIGHTS RD. | ARLINGTON HEIGHTS IL 60005**
Phone: 847-593-4300 | Fax: 847-593-4352

# WAŻNE INFORMACJE DOTYCZĄCE ILLINOIS CERTIFICATE OF CHILD HEALTH EXAMINATION (BADAŃ ZDROWOTNYCH DZIECKA)

Drogi Rodzicu/Opiekunie,

Przepisy szkolne stanu Illinois (Illinois School Code) wymagają, by wszystkie dzieci zapisujące się do klasy zerowej lub klasy pierwszej albo rejestrujące się do szkoły w stanie Illinois po raz pierwszy, bez względu na klasę (włączając przedszkole, edukację specjalną, uczniów przenoszących się z innego stanu do Illinois), miały aktualne badania lekarskie z ostatniego roku, jeszcze przed zapisaniem się do szkoły. Musi być także dostarczone zaświadczenie potwierdzające, że każde dziecko otrzymało wszystkie wymagane szczepienia.

W załączeniu znajdziecie Państwo formularz zaświadczenia lekarskiego o stanie zdrowia dziecka (Certificate of Child Health Examination). Proszę, upewnijcie się, że następujące informacje zawarte w tym formularzu są kompletne, zanim zostaną oddane do szkoły:

- Nazwisko ucznia i informacje powinny być wprowadzone na obydwu stronach formularza.
- **Historia szczepień** musi zawierać konkretne daty. Podpis pracownika służby zdrowia jest niezbędny, aby można było zweryfikować daty szczepień.
- **Historia zdrowia** (na odwrocie) musi być wypełniona i podpisana przez rodzica/opiekuna.
- **Badanie lekarskie** musi być kompletne, datowane, podpisane przez lekarza, pielęgniarkę dyplomowaną lub asystenta lekarza.
- Zezwolenie na uczestniczenie w **zajęciach fizycznych i międzyszkolnych zawodach sportowych** musi być odnotowane na końcu strony przez lekarza. Wszelkie zmiany muszą być wyszczególnione.

Jedynymi wyjątkami od wymagań dotyczących szczepień są zastrzeżenia natury religijnej lub przeciwwskazania medyczne dla Twojego dziecka. Niemniej jednak, właściwie udokumentowane zastrzeżenia muszą być dostarczone do gabinetu pielęgniarskiego szkoły twojego dziecka.
Jeśli z jakiegokolwiek powodu nie jesteś w stanie sprostać stanowym wymogom, proszę, skontaktuj się z gabinetem pielęgniarskim szkoły twojego dziecka tak szybko, jak to możliwe.

Będziemy wdzięczni za współpracę w tej materii.
Denise M. Webster, RN, CSN
Health Coordinator, District #59 (Koordynator d/s Zdrowia Dystryktu 59)

W załączeniu: Zaświadczenie lekarskie o stanie zdrowia dziecka (Certificate of Child Health Examination)

# State of Illinois
# Certificate of Child Health Examination

| Student's Name<br>Last First Middle | Birth Date<br>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?<br>Child wakes during night coughing? | Yes No<br>Yes No | | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes No | | |
| Birth defects? | Yes No | | | Hospitalizations?<br>When? What for? | Yes No | | |
| Developmental delay? | Yes No | | | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes No | | | Surgery? (List all.)<br>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 _____<br>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.<br>**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:<br>☐ Quick-relief medication (e.g. Short Acting Beta Agonist)<br>☐ 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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P.O.#346085 5M 10/05

# 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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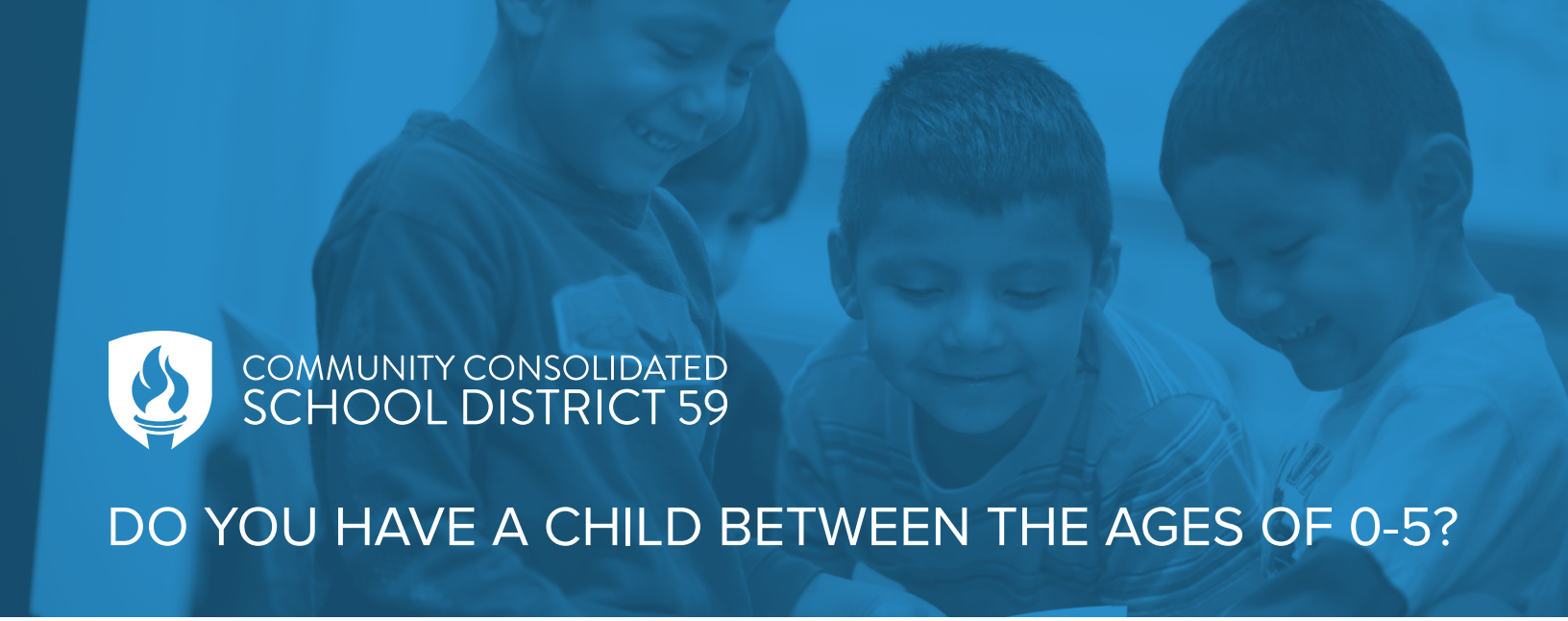
5/08
IISG08-1048



COMMUNITY CONSOLIDATED
SCHOOL DISTRICT 59

# DO YOU HAVE A CHILD BETWEEN THE AGES OF 0-5?

Prior to a student walking through the school's door on the first day of kindergarten, it's important that parents play an active role in preparing their children to be successful for life. The READY! for Kindergarten program at CCSD59 was created to help provide parents with the necessary resources and training to ensure their children have a successful start to their formal education.

## The program includes:

- Free books
- Classes for parents
- Free binder & Ready kit
- Information on how to make learning at home fun
- Free babysitting while parents are in class

READY!© for Kindergarten

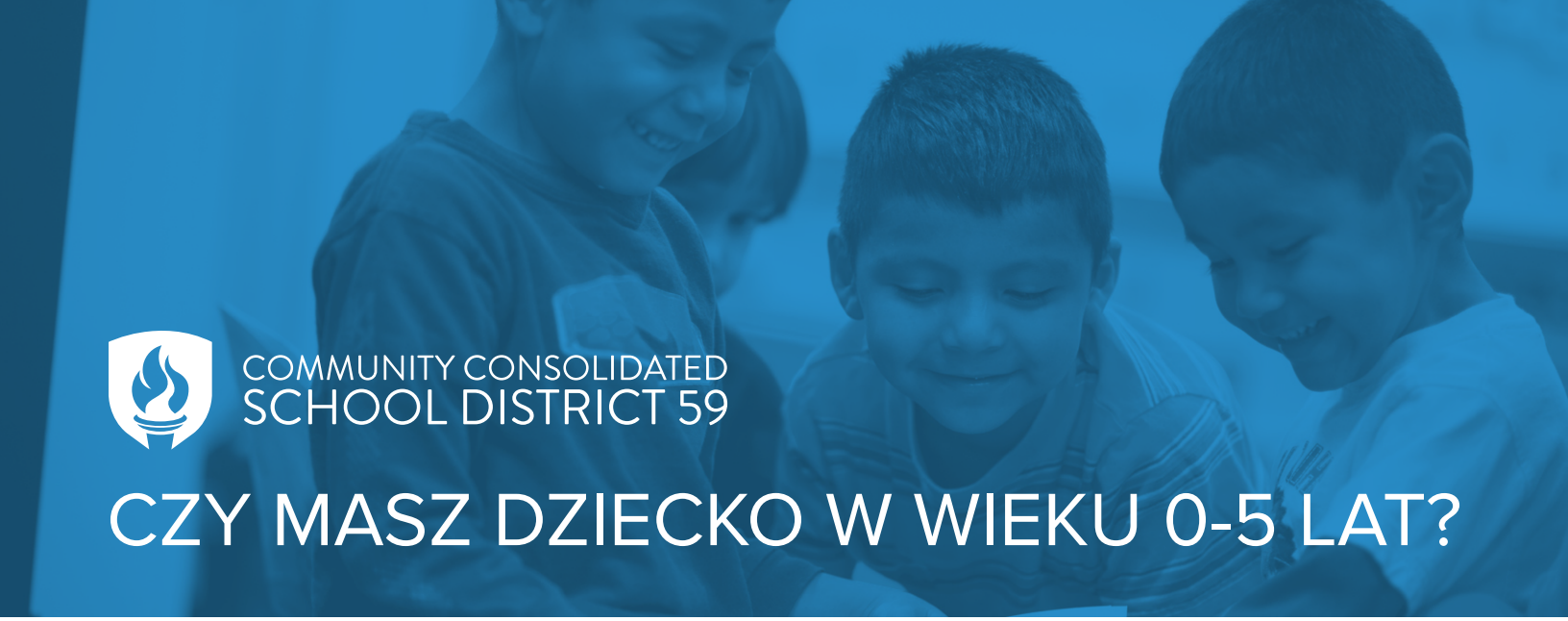
For more information on the Ready program and to register for upcoming classes in February and April, visit

ccsd59.org/instruction/parent-resources

Ready is for all families who reside within the boundaries of Community Consolidated School District 59.

Please contact Nancy Torres at 847-593-4305 with any questions.

CCSD59.ORG



COMMUNITY CONSOLIDATED
SCHOOL DISTRICT 59

# CZY MASZ DZIECKO W WIEKU 0-5 LAT?

Zanim uczeń przekroczy po raz pierwszy drzwi przedszkola, ważne jest, by rodzice aktywnie włączyli się w przygotowanie go do tego, by w przyszłości odniósł życiowy sukces. GOTOWE! - czyli READY! program dla Przedszkola stworzony został przez CCSD59 po to, by zagwarantować rodzicom konieczne materiały i szkolenia, mogące zapewnić ich dzieciom udany start w oficjalnej edukacji.

## Program obejmuje:

- Darmowe książki
- Zajęcia dla rodziców
- Darmowy folder& Gotowy zestaw
- Informacje na temat tego, jak można uczenie się w domu zamienić w zabawę.
- Darmowa opieka nad dziećmi, gdy rodzice uczestniczą w zajęciach.

READY!©
for Kindergarten

Aby uzyskać więcej informacji na temat programu Gotowe! i zapisać się na najbliższe zajęcia, które odbędą się w lutym i kwietniu, odwiedź stronę

ccsd59.org/instruction/parent-resources

Program Ready/Gotowy przeznaczony jest dla wszystkich rodzin, które mieszkają w granicach Społeczności Zjednoczonej w School District 59.

W razie jakichkolwiek pytań prosimy o kontakt z Nancy Torres na 847-593-4305

CCSD59.ORG