



NEW STUDENT ENROLLMENT CHECKLIST
For CCSD59 Office Use only (Parents/Guardians, do not complete)

Registration Staff - Please complete both sides of this form!

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	Discipline Policy Agreement Form				
None	Fees Form (for applicable grade only)				
ILC-3	CCSD59 Student Device Protection Plan Form (JHS)				
SR-9	Request for Student Records				
EC-6	Household Income Eligibility App for ECE Program				
None	Young Athletes Permission Form				
ILC-1	Google Apps for Education Permission Form	Will not be included in 18-19 spring packets- distribute upon start of SY			
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) Distributed at start of SY for grades K-5 for SY 18-19				

***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: _____

Other Additional Considerations (please note, info may not be available at time of registration):

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:

Registered by: _____ Date: _____

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 for new students and returning 3rd and 6th graders, 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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAŻNE INFORMACJE DOTYCZĄCE REJESTRACJI WASZEGO UCZNIĄ

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 bezpłatnie, chyba że prawo nakazuje inaczej. Miejsce/adres zamieszkania ucznia musi być taki sam, jak osoby, która jest opiekunem prawnym ucznia.

Informujemy, że Zarządzenie Rady Edukacyjnej (Board of Education Policy) daje prawo weryfikacji i sprawdzenia miejsca zamieszkania dla uczniów nowych i powracających uczniów klas 3-ej i 6-ej., 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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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 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



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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. W każdym przypadku 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 kwestii.

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				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle		Month/Day/Year			
Address				Parent/Guardian	Telephone #	Home	Work
Street				City		Zip Code	

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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6					
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR			
DTP or DTaP																					
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT					
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV					
Hib Haemophilus influenzae type b																					
Pneumococcal Conjugate																					
Hepatitis B																					
MMR Measles Mumps. Rubella																					
Varicella (Chickenpox)																					
Meningococcal conjugate (MCV4)																					
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																					
Hepatitis A																					
HPV																					
Influenza																					
Other: Specify Immunization Administered/Dates																					

Comments:

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
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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
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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?		Yes No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes No
Child wakes during night coughing?		Yes No	Hospitalizations? When? What for?		Yes No
Birth defects?		Yes No	Surgery? (List all.) When? What for?		Yes No
Developmental delay?		Yes No	Serious injury or illness?		Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes No	TB skin test positive (past/present)?	Yes*	No
Diabetes?		Yes No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?		Yes No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?		Yes No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?		Yes No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?		Yes No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?		Yes No	Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____					
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?		Yes No	Parent/Guardian Signature		
Bone/Joint problem/injury/scoliosis?		Yes No	Date		

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	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		<input type="checkbox"/> Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (media, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Integrity (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and Vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IOP (glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other _____



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 _____)