



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				
EC-10	Proof of Family Income				
YAF	Young Athletes Permission Form				
ILC-1	CCSD59 Software Application Permission Form				
ILC-2	Student Device Responsible Use Form				
ILC-3	Student Device Protection Plan Form (Optional but due no later than 30 days from start of school year)				
Fee Form	Fees Form (for applicable grade only)				
SR-9	Request for Student Records				

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 (H12)	State of IL Cert of Child Health Exam				

***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 OTHER SIDE FOR ADDITIONAL QUESTIONS)

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: _____

BIRTH DATES BY GRADE LEVEL				
BIRTH DATE				
FROM	TO	2018/19	2019/2020	2020/2021
9/2/2004	9/1/2005	8		
9/2/2005	9/1/2006	7	8	
9/2/2006	9/1/2007	6	7	8
9/2/2007	9/1/2008	5	6	7
9/2/2008	9/1/2009	4	5	6
9/2/2009	9/1/2010	3	4	5
9/2/2010	9/1/2011	2	3	4
9/2/2011	9/1/2012	1	2	3
9/2/2012	9/1/2013	K	1	2
9/2/2013	9/1/2014		K	1
9/2/2014	9/1/2015			K



COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59

1001 Leicester Road * Elk Grove Village, IL 60007 Phone: 847-593-4300 Fax: 847-593-4352

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: _____
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A total of three (3) original documents 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:
<input type="checkbox"/> Most recent Real Estate Tax Bill	<input type="checkbox"/> Driver's License or State ID	<input type="checkbox"/> Current Homeowners/Renters Insurance Policy and Premium Payment Receipt	<input type="checkbox"/> Postmarked Mail Addressed to Military Personnel <input type="checkbox"/> Lease Agreement for Occupancy <input type="checkbox"/> Proof of Ownership of Residence
<input type="checkbox"/> Mortgage Papers	<input type="checkbox"/> Vehicle Registration	<input type="checkbox"/> Most Recent Gas, Electric and/or Water Bill	
<input type="checkbox"/> Signed and Dated Lease or Letter from Manager or Proof of Last Month's Payment	<input type="checkbox"/> Voter Registration	<input type="checkbox"/> Mail Received at District Residence	
IMPORTANT: District 59 reserves the right to evaluate the evidence present and merely presenting the items listed below does not guarantee admission.	<input type="checkbox"/> Most Recent Cable or Credit Card Bill	<input type="checkbox"/> Receipt for Moving Company Services Showing Current Address	
	<input type="checkbox"/> Current Public Aid Card	<input type="checkbox"/> Other _____	

Category C: None of the Documents in Categories A & B are Applicable Because:	<input type="checkbox"/> 1. The student is homeless and eligible for enrollment under the Illinois Education for Homeless Children Act <input type="checkbox"/> 2. The student is enrolling based on the determination of the Department of Children & Family Services (<i>Attach DCFS Documentation</i>)
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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: _____	<input type="checkbox"/> All Materials Supplied	
<input type="checkbox"/> Referred for Further Review to: _____	<input type="checkbox"/> Principal <input type="checkbox"/> Homeless Liaison	



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:	Pre-School:	Kindergarten:	Grade:
			<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> FULL DAY & <input type="checkbox"/> 4 Day <input type="checkbox"/> 5 Day	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> FULL DAY	

First Name:		Last Name:			Middle Name:		Birth Date: ____/____/____
							Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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? :		<input type="checkbox"/> Yes <input type="checkbox"/> No
Date Your Student Entered a U.S. School:	If Yes, Which School/s and What Year/s?		Name of Last School Attended & State:		Is Your Child Receiving Any Special Services?		
(Month/Day/Year) ____/____/____					<input type="checkbox"/> Bilingual <input type="checkbox"/> ESL <input type="checkbox"/> Special Education <input type="checkbox"/> Other:		
Country of Birth:	9 Digit Medicaid Number:		(Voluntary & Optional) Military Service Information:		<input type="checkbox"/> I am a member of the United States Armed Forces <input type="checkbox"/> I am on active duty / expected to be deployed to active duty during the school year		
State of Birth:							
City of Birth:							

Title:	First Name:	Last Name:	Work Phone & Extension:	Cell Phone:
Relationship to Student:	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other		Email Address:	
Language Preference:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Polish <input type="checkbox"/> Gujarati <input type="checkbox"/> Other: _____		Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives With: <input type="checkbox"/> Yes <input type="checkbox"/> No
Title:	First Name:	Last Name:	Work Phone & Extension:	Cell Phone:
Relationship to Student:	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other		Email Address:	
Language Preference:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Polish <input type="checkbox"/> Gujarati <input type="checkbox"/> Other: _____		Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives With: <input type="checkbox"/> Yes <input type="checkbox"/> No
Title:	First Name:	Last Name:	Work Phone & Extension:	Cell Phone:
Relationship to Student:	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other		Email Address:	
Language Preference:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Polish <input type="checkbox"/> Gujarati <input type="checkbox"/> Other: _____		Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives With: <input type="checkbox"/> Yes <input type="checkbox"/> No
Title:	First Name:	Last Name:	Work Phone & Extension:	Cell Phone:
Relationship to Student:	<input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-Father <input type="checkbox"/> Step-Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other		Email Address:	
Language Preference:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Polish <input type="checkbox"/> Gujarati <input type="checkbox"/> Other: _____		Custody: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lives With: <input type="checkbox"/> Yes <input type="checkbox"/> No

EMERGENCY Contact and Sibling Information - CCSD59

Student First Name:	Student Last Name:	Student Middle Name:
Student ID:	School Name:	Date:

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, Sister/s, Step-Brother/s, Step-Sister/s)

	First Name:	Last Name:	Name of School Attending:	Grade:	Age:
1					
2					
3					
4					
5					

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



COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
1001 Leicester Road * Elk Grove Village, IL 60007
PHONE: 847-593-4300 * FAX: 847-593-4352

PERMANENT BIRTH RECORD

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_____



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 # _____

Has your child attended a District 59 Pre-school program?
 a. Yes School: _____
 b. No

If you answered yes, **do not continue as you have already completed this form upon entering Pre-school.** If your answer was no, please proceed to answer the following questions below.

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 _____



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

1001 Leicester Road * Elk Grove Village, IL 60007

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 date) 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 _____



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: _____

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

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.)

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

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.



Community Consolidated School District 59

Transportation Request Form

School Year 20__ - 20__

INSTRUCTION TO PARENT OR GUARDIAN: Please complete this form **ONLY** if the requested pick-up or drop-off location for your student is **DIFFERENT than the closest stop to your home address or if no transportation is required for drop-off and/or pick-up**. If this form is not completed, the default location will be assigned, which is the stop closest to your home address.

Any changes require a minimum of 3 days notice; changes at the beginning of the school year require 2 weeks notice. These instructions will remain in place for the entire program listed below and cannot be changed without further written authorization.

Submit this signed form to your child's school.

This request is being made for the following CCSD59 Program: Regular School Year Summer School Program (specify): _____

Please print: Student Name: _____

School Name: _____

Grade Level: _____ Kindergarten/PreK: Full Day Program AM Program PM Program

Home Address: _____ City: _____ Zip: _____

Home Phone Number: _____ Language Spoken (if not English): _____

Check only ONE option for pick-up and ONE option for drop-off. All pick-up and drop-off sites must be located within CCSD59 and School boundaries. Alternating days of the week or multiple locations for pick-up or drop-off are not allowed.

Pick-up Information

- No bus is required, parent will transport
- Other: Please provide detailed information below:
 Site Address: _____
 City and Zip: _____
 Phone # for this location: _____
 Relationship to student: _____

Drop-off Information

- No bus is required, parent will transport
- Other: Please provide detailed information below:
 Site Address: _____
 City and Zip: _____
 Phone # for this location: _____
 Relationship to student: _____

Parent or Guardian Signature: _____ Date: _____

This section is for IEP (504) students only: To be completed by CCSD59 authorized coordinators only. The following information must be based on IEP (504) requirements.

Date for service to begin: _____ Type of bus authorized: Lift Able to ride gen ed bus

Type of service authorized: Curb to curb Curb to curb (no escort required) Aide

Special Requirements: Child Securement Child's Weight: _____ Other: _____

Notes: _____

LEA Coordinator Authorization Signature: _____ Date: _____

This section is to be completed by Transportation Department Only

Date received: _____ Route Assignment: _____ Effective Date: _____

Contractor notification date: _____ Parent/School notification date: _____

Processed by: _____



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	
Street	City	Zip Code				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			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 influenza 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
------------------------	------------------	--------------

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	*If yes, refer to local health department.
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)			Parent/Guardian Signature		
Ear/Hearing problems?	Yes No		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		<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	



COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59

1001 Leicester Rd. | Elk Grove Village, IL 60007

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 1/8/19

7:340-AP1, E2

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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.

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



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](http://ccsd59.org/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



PROOF OF FAMILY INCOME

Child's full name: _____ Date of birth: _____

Primary caregiver's name: _____

Relationship to child: _____

Other caregiver's name: _____

Relationship to child: _____

Family's ANNUAL household income \$ _____

FOR OFFICE USE ONLY

Method of Verification: *(Mark all that apply.)*

Public benefits:

- WIC (185% FPL) Medicaid Card (138%, **must** be in parent(s)' name) SNAP (165% FPL)
- TANF (50% FPL) CCAP (162%)

Proof of Income (required only if no proof of public benefits above):

- Payouts (two most recent, consecutive) SSI Tax return (most recent)
- W-2 (most recent) Verification/letter from employer

Family/Household at or below 200% of the Federal Poverty Level? YES NO

I verified the applicant's income eligibility. I have indicated which artifact I used for proof of income above.

Staff Signature: _____ Date: _____

Number of persons in Family/Household _____



2018 Federal Poverty Guidelines

Source: Federal Register /Vol. 83, No. 12 /January 31, 2018 /Notices

Persons in Family/Household	50% of Federal Poverty Level	100% of Federal Poverty Level	200% of Federal Poverty Level
1	\$6,070	\$12,140	\$24,280
2	\$8,230	\$16,460	\$32,920
3	\$10,390	\$20,780	\$41,560
4	\$12,550	\$25,100	\$50,200
5	\$14,710	\$29,420	\$58,840
6	\$16,870	\$33,740	\$67,480

*For families/households with more than 6 persons, add \$4,320 for each additional person at 100% FPL level (\$2,160 at 50% FPL and \$8,640 at 200% FPL)

1900 Lonquist Blvd. - Mount Prospect, IL 60056

P: (847) 593-4306 | F: (847) 593-7199 | elc.ccsd59.org

EC-10 October 2018 Distribution: district file, team file



Dear Parent/Guardian,

Your son/daughter's school has been selected and will be participating in the Young Athletes program. This is a program that will take place at the Early Learning Center during motor time with their teacher. The Young Athletes program is a program offered free of charge through Special Olympics Illinois.

The Young Athletes program is an all-inclusive sports play program for children with and without intellectual disabilities. This program is designed to introduce all children ages 2-7 into the world of sports. Young Athletes will prove enormous benefits on multiple levels, allowing your child to improve physically, cognitively and socially.

This program is designed to address two specific levels of play. Level 1 includes physical activities focused on developing fundamental motor skills and eye-hand coordination. Level 2 concentrates on the application of these physical activities through a sports skills activity program and developing skills consistent with Special Olympics sports play. The activities will consist of foundational skills, walking & running, balance & jumping, trapping & catching, throwing, striking, kicking and advanced skills. I hope this program will also raise awareness of the Special Olympics program and serve as an introduction for you to the resources and support available within Special Olympics.

In the eyes of Special Olympics Illinois, this is a training program only; however, all students active in the Young Athletes program will participate in our Culminating Event. This event will be held at the Early Learning Center in the springtime. At this time, each student will receive a t-shirt and awards for their participation, followed by drinks and snacks for all our Young Athletes and their family members.

We are very excited about this program and your family's participation! Please complete and sign the attached permission form and return it to your child's teacher allowing them to participate in this program. **The permission form is due at the time of registration if you would like your child to participate in the Young Athletes program!** If you should have any questions about the program, would like to get further involved or have questions in regards to Special Olympics, please contact :
Marlyn Orozco, Family Facilitator, at 847-472-3677 or orozco.marlyn@ccsdCCSD59.org.

Sincerely,

Marlyn Orozco, Family Facilitator

Young Athletes™ Registration Form (SO ILL Rev8-1-2014)

Special Olympics Illinois

605 E. Willow St., Normal, IL 61761-2682 | 309-888-2551



Athlete's Name: _____ Parent/Guardian Name: _____
(Last/Family) (First/Given) (Last/Family) (First/Given)

Address: _____ City, State, Zip: _____

Birth Date (MM/DD/YY): _____ Gender: ___ Male ___ Female

Home Phone: _____ Cell Phone: _____ Email: _____

Secondary Contact Name: _____ Phone: _____

Athlete T-Shirt Size: [] Child Small [] Child Medium [] Child Large [] Adult Small [] Adult Medium

Basic Health Information:

Heart Problems [] Yes [] No Blind [] Yes [] No

Diabetic [] Yes [] No Deaf [] Yes [] No

Epileptic/Seizure [] Yes [] No Hepatitis [] Yes [] No

Down Syndrome [] Yes [] No If yes, clear AAI: [] Yes [] No

Other: _____ Allergies: _____

Ethnicity: [] White [] African American [] Asian [] Hispanic/Latino [] Other: _____

Young Athlete is being registered as a: [] Traditional Young Athlete (with Intellectual Disability) [] Peer Partner (without Intellectual Disability)

Young Athletes Release Form

I am the parent/guardian of the minor participant, on whose behalf I have submitted the attached application for participation in Special Olympics. The participant has my permission to participate in Special Olympics activities. I further represent and warrant that to the best of my knowledge and belief, the participant is physically and mentally able to participate in Special Olympics.

In permitting the participant to participate, I am specifically granting my permission to Special Olympics to use the participant's likeness, voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities. I also understand that group data collected from the Young Athletes Program will be used to plan, evaluate, and improve the program.

If a medical emergency should arise during the participant's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the participant's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the participant is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the participant's health and well-being. (IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CONTACT SPECIAL OLYMPICS ILLINOIS - MANAGER OF YOUNG ATHLETES).

I am the parent (guardian) of the participant named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the participant. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the participant named above. I hereby give my permission for the participant named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent/Guardian

Print Name

Date

Original parent/guardian signature is required by the office of Special Olympics Illinois. Form valid until individuals ninth birthday with continued participation.

Program Information (To Be Completed By Site Coordinator Only)

A program may have multiple sites. Site is defined as the specific location of the Young Athletes Activities. The Young Athlete site this child will attend is (select one of the following):

[] A group site- Special Olympics Agency [] At home (implemented by you or a family member at home)

Agency Name: _____ School Name: _____

Teacher Name: _____

Class Time: ___ AM ___ PM ___ All Day

Agency SOAD/Site Coordinator _____