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

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

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

INFORMACIÓN IMPORTANTE SOBRE LA INSCRIPCIÓN DE LOS ESTUDIANTES

La inscripción de un estudiante no es definitiva hasta que se hayan completado todos los trámites necesarios. Si la documentación o información que usted presentó está incompleta, la escuela donde su hijo(a) ha sido asignado(a) se comunicará con usted. Por lo tanto, es importante que su información de contacto esté correcta y se mantenga actualizada.

Recuerde: Sólo los estudiantes que residen en el Distrito pueden asistir a una escuela del Distrito 59 sin que tengan que pagar matrícula, excepto en los casos dispuestos por ley. El domicilio del estudiante es el mismo que el de la persona que tiene la custodia legal del estudiante.

Le recordamos que la política de la Junta de Educación autoriza la verificación e investigación del domicilio, para estudiantes nuevos y estudiantes de tercer y sexto grado que regresan que puede incluir la contratación de los servicios de una organización de investigación privada.

Le exhortamos a familiarizarse con nuestras escuelas y el Distrito 59 visitando nuestro sitio en la web (www.ccsd59.org) o comunicándose con su escuela.

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

Clearmont School (847) 593-4372
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1835 Pheasant Trail, Mt. Prospect

Ridge Family Ctr 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

CCSD59

VISIT OUR WEBSITE TO FIND MORE INFORMATION ON THE FOLLOWING:

VISITE NUESTRO SITIO WEB PARA ENCONTRAR MÁS INFORMACIÓN ACERCA DE:

CCSD59.ORG/BACKTOSCHOOL

School Supply Lists
Listas de útiles escolares

Family Reference Guide
Guía de Referencia Familiar

Menus
Menús

Transportation Information
Información sobre transporte

Application for Free and Reduced Price Meals
Solicitud para comidas gratis y a precio reducido

Ability to Pay School Fees and Make Deposits into Your Student's Meal Account
Pago de cuotas escolares y depósitos a la cuenta de almuerzo

Community Consolidated School District 59
Elk Grove Township Schools
1001 Leicester Road Elk Grove Village, IL 60007

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) **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.** (Please note: if your child may be participating in interscholastic athletics, his/her physical exam must take place between June 1 and the start of school.)	• Enter your student's name on both front and back of the form. • Complete the Health History section on the back of the form. Be sure to sign it. • 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. • **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. • **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) • Complete and sign the Parent and Student Consent for Participation in Interscholastic Athletics and the Proof of Insurance forms. • **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, BSN, RN, PEL-CSN
Coordinator of Health Services, District 59

Community Consolidated School District 59
1001 Leicester Road Elk Grove Village, IL 60007

Estimado padres/tutores:

El Código Escolar de Illinois ha cambiado los requisitos de vacunas **para los estudiantes que ingresan al 6º grado.** Esta carta ofrece importante información sobre los nuevos requisitos. Por favor, léala detenidamente y preste atención especial a las fechas indicadas. Comuníquese con la enfermera de su escuela si necesita ayuda. Junto con esta carta se acompañan los siguientes documentos:

Documento/formulario:	Qué hacer antes del primer día de clases:
Certificado de examen de salud del estado de Illinois (H-12) Por favor, tenga en cuenta que su hijo(a) debe recibir la serie de vacunas contra la Hepatitis B, Meningococcal vacunas, un refuerzo de la vacupa Tdap, dos vacunas contra la varicela y dos vacunas contra el MMR antes del primer día de clases. (Por favor, tenga en cuenta que si su hijo(a) va a participar en deportes interescolásticos, debe hacerse un examen físico entre el 1º de junio del el inicio de clases.)	• Escriba el nombre del estudiante en la parte del frente y la parte de atrás del formulario. • Complete la sección de historial de salud en la parte de atrás del formulario. Asegúrese de firmarlo. • Pídale a su médico, enfermera especializada o asociado médico que complete y firme el historial de vacunas, el examen físico y las secciones relacionadas con educación física y los deportes interescolásticos. Asegúrese de que cualquier modificación indicada en la sección de educación física se especifique. • **Devuelva el formulario a la escuela de su hijo(a).**
Formulario de examen dental	• Pídale al dentista de su hijo(a) que complete, firme y escriba la fecha en el formulario. • **Devuelva el formulario a la escuela de su hijo(a).**
Requisitos para participar en deportes interescolásticos	• Lea y retenga la información sobre los deportes interescolásticos y las conmociones cerebrales (págs. 1-4) • Complete y firme el Formulario de consentimiento del padre y el estudiante para la participación en los deportes interescolásticos y el Formulario de prueba de seguro. • **Devuelva el formulario a la escuela de su hijo(a).**

Por favor, tome en cuenta que las únicas excepciones a los requisitos de inmunización son objeciones religiosas o contraindicaciones médicas. Se debe presentar evidencia documentada y adecuada a la oficina de salud de la escuela de su hijo(a). Si tiene preguntas o necesita ayuda, comuníquese con la enfermera de la escuela.

Cordialmente,

Denise M. Webster, BSN, RN, CSN-PEL
Coordinadora de Servicios de Salud de Distrito 59

CCSD59

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59
1001 Leicester Road * Elk Grove Village, IL 60007
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 student's 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, BSN,RN, PEL-CSN
Health Coordinator, District #59

Enclosure: Certificate of Child Health Examination

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

INFORMACION IMPORTANTE ACERCA DEL CERTIFICADO DE ILLINOIS/FORMA DE EXAMINACION DE SALUD PARA NINOS

Estimado Padre/Tutor,
El Código Escolar de Illinois requiere que todos los niños que entran a kindergarten o primer grado, o que se inscriben en una escuela de Illinois por primera vez, independientemente del grado del estudiante (incluyendo educación temprana, educación especial, y el estudiante que se transfiere a Illinois), someterse a un examen físico en el plazo de un año antes de la entrada a la escuela. También deben existir pruebas documentales de que cada niño ha recibido todas las vacunas necesarias.

Se adjunta un formulario para un examen de Certificado de Salud del Niño. Por favor, asegúrese de que la siguiente información se complete en este formulario antes de devolverlo a la escuela:

- El nombre del estudiante y la información debe ser inscrito en ambos lados de la forma del examen.
- El **Historial de Vacunas** debe incluir fechas específicas. La firma del médico es necesaria para verificar las fechas de vacunación.
- El **Historial de Salud** (en la parte posterior) debe ser completado y firmado por un padre/tutor.
- El **examen físico** debe ser completado, fechado y firmado por un médico, enfermera o asistente médico.
- La autorización para participar en Educación Física y Deportes Ínter escolares en la parte inferior de la página debe ser comprobada por el médico. Las modificaciones deben ser especificados.

La única excepción a este requisito se basa en la objeción religiosa o contraindicación médica para su hijo. Sin embargo, la evidencia convenientemente documentada deberá presentarse a la oficina de salud en la escuela de su hijo.

Si, por alguna razón, no pueden cumplir con el requisito del estado, por favor comuníquese con la oficina de salud de la escuela de su hijo tan pronto como sea posible.

Apreciamos su cooperación en este asunto.
Denise M. Webster, BSN,RN, PEL-CSN
Coordinador de Salud del Distrito 59

State of Illinois
Certificate of Child Health Examination

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

IMMUNIZATIONS: **To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine / Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:**		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR** ****MUMPS MO DA YR** **HEPATITIS B MO DA YR** **VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed ☐** **Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm_____**
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

State of Illinois
Certificate of Child Health Examination

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

IMMUNIZATIONS: **To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine / Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:**		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR** ****MUMPS MO DA YR** **HEPATITIS B MO DA YR** **VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.

HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)	Sí No	Anótelas todas:	MEDICINAS (Anote todas las recetadas o tomadas con regularidad)	Sí No	
¿Tiene diagnóstico de asthma? ¿Despierta el niño tosiendo en la noche?	Sí No		¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí No	
¿Tiene defectos de nacimiento?	Sí No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	Sí No	
¿Tiene retrasos del desarrollo?	Sí No				
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	Sí No	
¿Tiene diabetes?	Sí No		¿Ha tenido heridas graves o enfermedades?	Sí No	
¿Tiene heridas en la cabeza/golpe/desmayo?	Sí No		¿Prueba positiva de TB (Pasado o Presente)?	Sí No	*Si contestó sí, refiera al departamento de salud local
¿Tiene convulsiones? Cómo se manifiestan?	Sí No		¿Enfermedad de TB (Pasado o Presente)?	Sí No	
¿Tiene problemas cardiacos/No respira bien?	Sí No		¿Usa tabaco (tipo, frecuencia)?	Sí No	
¿Tiene soplo en el corazón/presión arterial alta?	Sí No		¿Toma alcohol/drogas?	Sí No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	Sí No	
¿Problemas con los ojos/visión? _____ Lentes ☐ Lentes de Contacto ☐ Último examen _____ ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)			Dental ☐ Ganchos ☐ Puente ☐ Placas Otro		
¿Tiene problemas de los oídos/no oye bien?	Sí No		La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	Sí No		**Firma del Padre/Tutor**		**Fecha**

PHYSICAL EXAMINATION REQUIREMENTS

Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed ☐** **Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm_____**

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		
NEEDS/MODIFICATIONS required in the school setting			**DIETARY** Needs/Restrictions		

SPECIAL INSTRUCTIONS/DEVICES e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

Illinois Department of Public Health
PROOF OF DENTAL EXAMINATION FORM

To be completed by the parent (please print):

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

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

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

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

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

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

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

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

☐ **Other** — periodontal, orthodontic

Please note_____

Signature of Dentist _____ Date _____

Address _____ Telephone _____
Street City ZIP Code

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

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State of Illinois
Eye Examination Report

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

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

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

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

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

County _____

To Be Completed By Examining Doctor

Case History

Date of Exam _____

Ocular History: ❑ Normal or Positive for _____

Medical History: ❑ Normal or Positive for _____

Drug Allergies: ❑ NKDA or Allergic to _____

Other Information _____

Examination

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

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

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

Diagnosis

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

Other _____

Continued on back

H-67 Revised 12/10 Distribution: Health File

State of Illinois
Eye Examination Report

Recommendations

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

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

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

   ❑ Other _____

4. _____

5. _____

Print name_____
Optometrist or Physician who provides eye examinations

Address _____

_____

Phone _____

Signature _____
Optometrist or Physician who provides eye examinations

Consent of Parent or Guardian

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

_____
(Parent or Guardian's Signature)

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

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5/08
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