**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 (ELC **all** students) | | | | |
| YAF | Young Athletes Permission Form (ELC New Students) | | | | |
| 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 the start of the school year) | | | | |
| Fee Form | Fees Form (for applicable grade only) | | | | |
| SR-9 | Request for Student Records | | | | |
| RR Form | Ready Rosie Registration Form (ELC New Students) | | | | |

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. Parents of kinder students who went to ELC should not complete this form (as noted on the form).
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 | 2020/2021 | 2021/2022 | 2022/2023 |
| 9/2/2006 | 9/1/2007 | 8 | | |
| 9/2/2007 | 9/1/2008 | 7 | 8 | |
| 9/2/2008 | 9/1/2009 | 6 | 7 | 8 |
| 9/2/2009 | 9/1/2010 | 5 | 6 | 7 |
| 9/2/2010 | 9/1/2011 | 4 | 5 | 6 |
| 9/2/2011 | 9/1/2012 | 3 | 4 | 5 |
| 9/2/2012 | 9/1/2013 | 2 | 3 | 4 |
| 9/2/2013 | 9/1/2014 | 1 | 2 | 3 |
| 9/2/2014 | 9/1/2015 | K | 1 | 2 |
| 9/2/2015 | 9/1/2016 | | K | 1 |
| 9/2/2016 | 9/7/2017 | | | 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

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

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

# State of Illinois
# Certificate of Child Health Examination

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

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

| REQUIRED Vaccine / Dose | DOSE 1<br>MO DA YR | DOSE 2<br>MO DA YR | DOSE 3<br>MO DA YR | DOSE 4<br>MO DA YR | DOSE 5<br>MO DA YR | DOSE 6<br>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:** * indicates invalid dose | | |
| **Varicella** (Chickenpox) | | | | | | |
| **Meningococcal conjugate (MCV4)** | | | | | | |
| **RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose** | | | | | | |
| **Hepatitis A** | | | | | | |
| **HPV** | | | | | | |
| **Influenza** | | | | | | |
| **Other: Specify Immunization Administered/Dates** | | | | | | |

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

**Signature** **Title** **Date**

**Signature** **Title** **Date**

**ALTERNATIVE PROOF OF IMMUNITY**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**NEEDS/MODIFICATIONS** required in the school setting

**DIETARY** Needs/Restrictions

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

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

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

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

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

**Address** **Phone**

**State of Illinois**
Illinois Department of Public Health

# PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

## To be completed by the parent or guardian (please print):

| | | | |
|---|---|---|---|
| Student's Name: Last First Middle | | | Birth Date: (Month/Day/Year) |
| Address: Street City ZIP Code | | | |
| Name of School: ZIP Code | | Grade Level: | Gender: ☐ Male ☐ Female |
| Parent or Guardian: Last Name First Name | | | |
| Student's Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown ☐ Other_____ | | | |

**To be completed by dentist:**

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

**Oral Health Status (check all that apply)**

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

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

**Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.**

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____

☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Additional comments: _____

Signature of Dentist _____ License #:_____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

**State of Illinois**
Illinois Department of Public Health

# State of Illinois
# Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides 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 the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

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

Birth Date _____ Gender _____ 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**

| | **Distance** | | | **Near** |
|---|---|---|---|---|
| | Right | Left | Both | Both |
| Uncorrected visual acuity | 20/ | 20/ | 20/ | 20/ |
| Best corrected visual acuity | 20/ | 20/ | 20/ | 20/ |

Was refraction performed with dilation? ❑ Yes ❑ No

| | Normal | Abnormal | Not Able to Assess | Comments |
|---|---|---|---|---|
| External exam (lids, lashes, cornea, etc.) | ❑ | ❑ | ❑ | _____ |
| Internal exam (vitreous, lens, fundus, etc.) | ❑ | ❑ | ❑ | _____ |
| Pupillary reflex (pupils) | ❑ | ❑ | ❑ | _____ |
| Binocular function (stereopsis) | ❑ | ❑ | ❑ | _____ |
| Accommodation and vergence | ❑ | ❑ | ❑ | _____ |
| Color vision | ❑ | ❑ | ❑ | _____ |
| Glaucoma evaluation | ❑ | ❑ | ❑ | _____ |
| Oculomotor assessment | ❑ | ❑ | ❑ | _____ |
| Other _____ | ❑ | ❑ | ❑ | _____ |

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

**Diagnosis**

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

Other _____



*Continued on back*

# State of Illinois
# Eye Examination Report

**Recommendations**

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts 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 _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

Address _____
_____

Phone _____

**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)

_____
(Date)

Signature _____ Date _____

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



Printed by Authority of the State of Illinois

IOCI 15-391