



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

**PG 1 OF 2**

**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)**

ILC-5

New Student Enrollment Checklist

Revision 12/1/20

**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:

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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	



We welcome you and your child to the Community Consolidated School District 59 kindergarten program. We recognize that this is an exciting time in your child's life, and we feel fortunate to contribute to the development of these formative years. Our program will have a strong literacy and social emotional emphasis and a focus on 21st century teaching and learning. As you will see, kindergarten will build a foundation for social, emotional, physical, and intellectual growth for your child.

Preparing students to be successful for life is a primary goal and focus in CCSD59. Kindergarten teachers in Community Consolidated School District 59 are well trained in early education; they know, understand and apply best practice training in order to meet the needs of young children. Your child's teacher will create a warm, caring atmosphere that will be conducive to learning.

The following information will answer questions you might have and to help prepare you and your child for a successful entry to CCSD59. We hope you find this resource to be helpful as you become acquainted with our kindergarten program. If you have other questions, please feel free to contact your child's principal or teacher.

## **Kindergarten Registration - Frequently Asked Questions**

### ***Community Consolidated School District 59 offers the following kindergarten programs:***

- o School District 59 offers full-day kindergarten programs at all elementary schools.
- o Parents still have the option of choosing a half-day (AM) program at their home school. Half-day programs are not available in the District Choice Programs (see below).

### ***At what age is my child eligible to attend kindergarten?***

- o In accordance with Illinois School Code guidelines, children must be 5 years old on or before September 1st to be eligible for kindergarten. ***\*\* Children who attend Ridge Family Center for Learning, which operates on a balanced calendar, must turn 5 within 30 days of the start of the Ridge school year.***
- o You will need to provide an original, official government issued (not a hospital issued) birth certificate or passport as required by Illinois law (325 ILCS 50/5, Missing Children's Record Act).

### ***Can my child go to any school in District 59?***

- o All residents in District 59 are assigned to a school based on established boundaries.
- o Some programs, such as the English Learner Program or Educational Life Skills Program, are only available at specific sites. Parents should still register their child at the assigned school or at the Administration Center.
- o District 59 offers two Choice Programs. One is the school choice program at the Ridge Family Center for Learning which operates on the balanced calendar. The other is the Spanish Two-way Dual Language program with locations at Salt Creek, Juliette Low, and John Jay. The Spanish Two-way Dual Language programs operate on the traditional school calendar. Students attending Choice Programs receive transportation to the choice site, provided they are eligible for transportation.

### ***How can I find out more about the Choice Programs?***

- o Information about the choice programs, including application instructions, is available in all elementary school offices and on the district website.
- o Applications for the Two-way Dual Language and Ridge Family Center for Learning Choice Programs are due on Tuesday, April 6, 2021. If the number of applicants on April 6th exceeds the space available in the program, a lottery will be held on Thursday, April 8th. If space remains after Thursday, April 8th, the application process will be ongoing.
- o Parents who wish to apply for the Two-way Dual Language Choice Program should go to their home school to register. Parents who wish to apply for the Ridge Choice Program should go to Ridge Family Center for Learning to register.
- o If your child does not receive a place in a Choice Program, your registration materials will be transferred to your home school. This will not impact your class placement at your home school.

***When and where can I register my child?***

- o Registration begins at all elementary schools beginning on the evening of February 18, 2021, and is currently scheduled by appointment only. Please contact your school's office for additional information and to schedule a date and time that works for you, as no walk-in registrations can be accepted. Please bring your completed kindergarten registration materials with you to your appointment. If you have questions, please contact your school's office for additional information,
- o During the summer, new student registrations will be accepted by appointment only at the Administration Center (1001 Leicester Road, Elk Grove Village, IL 60007) on Monday – Thursday. Please call (847) 593-4300 to schedule an appointment if you are registering your child while school buildings are closed over the summer.

***When I come to register my student, what do I need to bring to prove I am a resident of CCSD59?***

**Please note, a total of THREE documents are required:**

Category A (1 document required)	
Most recent real estate tax bill	
Mortgage papers	
Signed and dated lease or letter from manager or proof of last month's payment	

Category B (TWO of these documents required)	
Driver's license	Current homeowner's/renter's insurance policy and premium payment receipt
Vehicle registration	Most recent gas, electric and/or water bill
Voter registration	First Class mail received at District residence
Most recent cable or credit card bill	Receipt for moving company services showing current address
Current public aid card	

***If I choose to have my child attend a half-day program, may I request morning (AM) or afternoon (PM) kindergarten placement?***

- o Due to the kindergarten program design, all students whose families choose a half-day program will be assigned to the morning session. Afternoon sessions will not be available to half-day students.

***What if I need daycare before and/or after school?***

- o District 59 does not offer daycare but the local park districts offer before and after school programs at many of our school buildings. In addition, many local area daycare centers provide transportation to and from school.

***What happens if a language other than English is spoken in the home?***

- o In accordance with Illinois School Code guidelines, if a language other than English is spoken in the home, your child will be tested for English language services. A certified teacher will administer the test and the results will be discussed with you before any placement decision is made.

***Can my child ride a school bus?***

- o Bus transportation will be provided if you live more than one and a half miles from school or if the route your child would walk is considered to be hazardous as defined by the Illinois Department of Transportation.
- o If your child qualifies for transportation, he/she will be expected to ride the bus on their first day of school.

***Will my child need a physical?***

- o Yes, all kindergarten students are required by Illinois School Code to have current (within the last 12 months) Illinois physical, as well as up-to-date immunizations *before* starting school.
- o Dental examinations are required prior to May 15th.
- o Vision examinations are required prior to October 15th.
- o All examination forms are available in the school office and on the District's website.

***What happens on the first day of school?***

- o Your school will notify you of what to expect on your child's first day of school.

***Whom do I call with questions?***

- o The best place to call is your school.
- o If your school is not in session, please contact the Administration Building at (847) 593-4300.
- o You may also find additional information on the District 59 website: [www.ccsd59.org](http://www.ccsd59.org).

## 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](http://www.ccsd59.org) or contacting your school.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



## Kindergarten Transportation Information

Community Consolidated School District 59 allows kindergarten students free transportation if they reside one mile or more from school or reside in an area designated by the Board of Education as a “hazardous area” for walking (i.e. crossing a busy roadway). If you have any questions about eligibility for free transportation please contact Transportation Services at (847) 593-4379.

Parents of kindergarten students who are **requesting different bus stops than have been assigned** must complete the enclosed Transportation Request Form (T-42). Completion of this form will assist in accurately assigning your child to the appropriate route. Pick-up and drop-off locations must be within the assigned school boundary and will be limited to the home or one designated location, i.e., home and one babysitter. Alternating days of the week/multiple locations for pick-up and drop-off will not be allowed. There will be no exceptions. This policy is for your child’s safety. **This form must be completed and forwarded to Transportation Services by July 1.**

### **FULL DAY KINDERGARTEN STUDENTS**

Students who attend full day programs will be assigned a regular bus stop with other students from their school. After school, students will get off the bus at a regular bus stop with other students from their school. It is expected that someone will be there or at home to meet the student; however, the bus driver **does not wait** until they see an adult.

### **HALF DAY KINDERGARTEN STUDENTS**

Kindergarten students will be assigned a regular bus stop with other students from their school except during noon-hour routes. For kindergarten routes that operate during this noon-hour period, a bus stop will be assigned at the student’s home or a designated central location within an apartment/mobile home complex. It is expected that an adult will meet the bus. The driver will not leave the student unless an adult is seen or they see the student enter the home. Students without an escort will be returned to the child’s assigned school.

### **BUS CHANGES**

Your student will be assigned a bus stop based on your home address. Any other pick-up or drop-off location, such as a daycare, babysitter, etc., must be requested by completing the Transportation Request Form and submitting it to the Transportation Department by July 1. These locations **must be within the attending school boundary at an existing stop. No changes will be accepted during the first two weeks of school.** Parents will be expected to provide transportation until changes are effective. Changes after the first two weeks will require a minimum of three attendance days to process.

### **PAY TRANSPORTATION**

Kindergarten students are not eligible to choose to pay for bus service during noon hour routes.

Prior to the start of the new school year, District 59 “Back to School” materials will include more detailed information regarding bus routes and stops. This information will also be available at your home school. If you have any questions, please contact Transportation Services at (847) 593-4379. Thank you.





VISIT OUR WEBSITE TO FIND MORE  
INFORMATION ON THE FOLLOWING:

VISITE NUESTRO SITIO WEB PARA ENCONTRAR MÁS INFORMACIÓN ACERCA DE:

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**CCSD59.ORG/BACKTOSCHOOL**

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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

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

<b>Student's Name</b>				<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>	
Last First Middle				Month/Day/Year				
Address Street City Zip Code				Parent/Guardian Telephone # Home Work				
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> 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.</b>								
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>		<b>DOSE 2</b>		<b>DOSE 3</b>		<b>DOSE 4</b>	
	MO	DA	YR	MO	DA	YR	MO	DA
<b>DTP or DTaP</b>								
<b>Tdap; Td or Pediatric DT</b> (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	
<b>Polio</b> (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	
<b>Hib</b> Haemophilus influenza type b								
<b>Pneumococcal Conjugate</b>								
<b>Hepatitis B</b>								
<b>MMR</b> Measles Mumps. Rubella							<b>Comments:</b>	
<b>Varicella</b> (Chickenpox)								
<b>Meningococcal conjugate (MCV4)</b>								
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>								
<b>Hepatitis A</b>								
<b>HPV</b>								
<b>Influenza</b>								
<b>Other: Specify Immunization Administered/Dates</b>								
<b>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.</b>								
<b>Signature</b>				<b>Title</b>			<b>Date</b>	
<b>Signature</b>				<b>Title</b>			<b>Date</b>	
<b>ALTERNATIVE PROOF OF IMMUNITY</b>								
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b>								
*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR								
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b>								
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.								
<b>Date of Disease</b>			<b>Signature</b>			<b>Title</b>		
<b>3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella Attach copy of lab result.</b>								
*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.								
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b>								
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
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes No	List:		<b>MEDICATION</b> (Prescribed or taken on a regular basis.)		Yes No
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?		Yes No
Birth defects?		Yes	No		When? What for?		
Developmental delay?		Yes	No		Surgery? (List all.)		Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes	No		When? What for?		
Diabetes?		Yes	No		Serious injury or illness?		Yes No
Head injury/Concussion/Passed out?		Yes	No		TB skin test positive (past/present)?		Yes* No
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 <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?		Yes	No		<b>Parent/Guardian</b>		
Bone/Joint problem/injury/scoliosis?		Yes	No		<b>Signature</b>		
					<b>Date</b>		
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI	BMI PERCENTILE
							B/P
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>LEAD RISK QUESTIONNAIRE:</b> 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.)							
<b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Blood Test Date</b>		<b>Result</b>	
<b>TB SKIN OR BLOOD TEST</b> 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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____							
<b>LAB TESTS (Recommended)</b>		Date	Results		Date		Results
Hemoglobin or Hematocrit					Sickle Cell (when indicated)		
Urinalysis					Developmental Screening Tool		
<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs		
<b>Skin</b>				<b>Endocrine</b>			
<b>Ears</b>		Screening Result:		<b>Gastrointestinal</b>			
<b>Eyes</b>		Screening Result:		<b>Genito-Urinary</b>	LMP		
<b>Nose</b>				<b>Neurological</b>			
<b>Throat</b>				<b>Musculoskeletal</b>			
<b>Mouth/Dental</b>				<b>Spinal Exam</b>			
<b>Cardiovascular/HTN</b>				<b>Nutritional status</b>			
<b>Respiratory</b>		<input type="checkbox"/> Diagnosis of Asthma		<b>Mental Health</b>			
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)				<b>Other</b>			
<b>NEEDS/MODIFICATIONS</b> required in the school setting				<b>DIETARY</b> Needs/Restrictions			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
<b>MENTAL HEALTH/OTHER</b> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal							
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> 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.)							
<b>PHYSICAL EDUCATION</b>		Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>	<b>INTERSCHOLASTIC SPORTS</b>		Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		
Print Name (MD,DO, APN, PA)				Signature		Date	
Address				Phone			



## 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Last Name	First Name		
Student's Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> 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 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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 \_\_\_\_\_



**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 \_\_\_\_\_  
Optometrist or physician (such as an ophthalmologist)  
who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

**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)

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