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-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, no fees for elementary schools for 2022-23)				
SR-9	Request for Student Records				
RR Form	Ready Rosie Registration Form (ELC **new** students)				

** ILC2 & ILC3 forms not available for ELC at time of printing. Will need to distribute to parents once available.

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 DATE		GRADE LEVEL		
FROM	TO	2021-2022	2022-2023	2023-2024
9/2/2007	9/1/2008	8		
9/2/2008	9/1/2009	7	8	
9/2/2009	9/1/2010	6	7	8
9/2/2010	9/1/2011	5	6	7
9/2/2011	9/1/2012	4	5	6
9/2/2012	9/1/2013	3	4	5
9/2/2013	9/1/2014	2	3	4
9/2/2014	9/1/2015	1	2	3
9/2/2015	9/1/2016	K	1	2
9/2/2016	9/1/2017		K	1
9/2/2017	9/1/2018			K

CCSD59

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59

1001 Leicester Road | Elk Grove Village, IL 60007 Ph: (847) 593-4300 | Fax: (847) 593-4352

PARENT/GUARDIAN VERIFICATION OF STUDENT RESIDENCE

All students attending CCSD59 schools must be legal residents of the District. Generally, IL law provides that the residence of a student is the same as the person who has legal custody of the student.

PARENTS OF NEW STUDENTS & TRANSFERRING STUDENTS MUST PROVE RESIDENCY AT TIME OF REGISTRATION.
STUDENTS WILL NOT BE ALLOWED TO BEGIN SCHOOL UNTIL RESIDENCY IS PROVEN.

NOTICE: Registration of a student who is not a legal resident is a fraudulent act. Illinois law has made it a crime, punishable by imprisonment and fine, to knowingly or willfully present any false information regarding the residency of a student for purposes of enabling that student to attend on a tuition-free basis or to knowingly enroll or attempt to enroll a student on a tuition-free basis when the student is known to be a non-resident of the District. Board of Education policy authorizes the investigation of residency before or after enrollment in accordance with Illinois law and may require additional information to be considered in determining residency. Parents/guardians who fraudulently register a student will be charged tuition for the period the student had been in attendance. The District will seek prosecution to the full extent of the law of any person who the District believes has committed any residency-related crime. Additionally, a civil lawsuit may be initiated by the District.

Student Name:		School Name:	

A total of three (3) original documents from the categories below are required to prove residency (If unable to provide use Form SR-5).

Category A: One (1) Document Required	**Category B: Two (2) Documents Required**		**Military Personnel must provide one of the following within 60 days after the date of student's initial enrollment:**
❒ Most recent Real Estate Tax bill	❒ Driver's License or State ID	❒ Current homeowners/renters Insurance policy and premium payment receipt	❒ Postmarked mail addressed to military personnel
❒ Mortgage papers	❒ Vehicle registration	❒ Most recent gas, electric and/or water Bill	❒ Lease Agreement for occupancy
❒ Signed and dated lease or letter from Manager (effective 1st day of school) or proof of last month's payment	❒ Voter registration	❒ Mail received at District residence	❒ Proof of ownership of residence
IMPORTANT: District 59 reserves the right to evaluate the evidence present and merely presenting the items listed below does not guarantee admission.	❒ Most recent cable or credit card bill	❒ Receipt for moving company services showing current address	
	❒ Current Public Aid card	❒ Other _____	

Category C: None of the documents in Categories A & B are applicable because:	❒ 1. The student is homeless and eligible for enrollment under the Illinois Education for Homeless Children Act
	❒ 2. The student is enrolling based on the determination of the Department of Children & Family Services (*Attach DCFS Documentation*)

I affirm that I am a resident of Community Consolidated School District 59 and that the information presented in this form is true, complete and accurate.

Printed Name of Parent / Guardian	Signature of Parent / Guardian	Date

Residency Materials Received By:		❒ All Materials Supplied
❒ Referred for Further Review to:		❒ Principal ❒ Homeless Liaison

SR-13 (REV. 12/21) Distribution: Student's Temporary File

CCSD59

New Student Registration and Emergency Contact Form

Please Print and Complete Both Sides

Student ID	School	Grade

Office Use Only

Student Name: _____

Last First Middle

Gender of Student: Male ___ Female ___

Student Birthdate: *(mm/dd/yyyy)* _ _ / _ _ / ____ **Place of Birth**_____

Address: _____ **City:** _____

Zip Code: _____ **Primary Phone Number:** _____

Apt./ Lot/ Unit #: _____ **Complex/Mobile Home Park Name:** _____

Date Your Student Entered a U.S. School/Pre-School/Day Care: (*mm/dd/yyyy)* _ _ / _ _ / _ _ _ _

Name of Last School/Pre-School/Day Care Attended & State: _____ , _____

Is Your Student Receiving any Special Services? Special Education ____ English Learner ____

Primary Parent/Guardian Name:_____

Mr. Mrs. Ms. Dr. Last First

Relationship to Student: Mother_____ Father_____ Other_____

Custody: Yes____ No____ Lives With: Yes____ No____ Pick Up: Yes____ No____

Primary Parent Email: _____

Cell Phone #_____ **Work Phone #**_____

Secondary Parent/Guardian Name: _____

Mr. Mrs. Ms. Dr. Last First

Relationship to Student: Mother_____ Father_____ Other_____

Custody: Yes____ No____ Lives With: Yes____ No____ Pick Up: Yes____ No____

Secondary Parent Email: _____

Cell Phone # _____ **Work Phone #**_____

Optional:

I am a member of the United States Armed Forces or Full Time National Guard: Yes____ No____

Active Duty Start Date: _ _ / _ _ / _ _ _ _

I am on active duty / expected to be deployed to active duty during the school year: Yes____ No____

EMERGENCY CONTACT INFORMATION *other than Parent(s):*

Name	Phone	Relationship	Language Spoken

List all student's siblings currently enrolled in District 59 schools (Brother(s), Sister(s), Step-Brother(s), Step-Sister(s)

Name	School Name	Birthdate	Grade

Parent Printed Name: _____

Parent Signature: _____

Date: _____

Additional Notes-Office Use Only:

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

PERMANENT BIRTH RECORD

Parent/Guardian:

In accordance with Illinois law (*325 ILCS 50/5, Missing Children's Record Act)* students enrolling in the district for the first time, must provide within 30 days either:

a) a certified copy of the student's birth certificate, ***or***
b) other reliable proof of the student's identity and age (i.e. passport or visa) ***and*** an affidavit explaining the inability to produce a copy of the birth certificate.

Upon the failure of the person enrolling the student to provide the required evidence, the District will notify the local law enforcement agency of such failure, and notify the person enrolling the student in writing that he/she has 10 additional days to comply, or the case will be referred to the local law enforcement agency for investigation. Any affidavit presented which appears to be inaccurate or suspicious in form or content will immediately be reported to the local law enforcement agency.

_____ _____
Student's Last Name First Middle Date of Birth

Place of Birth (City, State, Country)_____

Proof of Birth and Age (mark one and attach copy of document to this form):

❒ Birth Certificate State_____
Number_____

❒ Passport Country_____
Number_____

❒ Visa Country_____
Number_____

❒ Other_____

I am unable to provide a certified copy of a birth certificate for the above named student because:

_____

_____

_____ _____ _____
Name of Parent/Guardian (PRINTED) Signature of Parent/Guardian Date

(for office use only)

Documentation Requirement: ❒ Met ❒ Not Met

Verified by:_____ School _____ Date_____

SR-11 (Rev. 12/2021) Distribution: Student's Temporary File

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

HOME LANGUAGE SURVEY

All students new to the district must have this survey completed and signed by a parent/guardian in accordance with state regulations (*23 Illinois Administrative Code Part 228).* This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency.

_____ _____ ❒ Male ❒ Female
Student's Last Name First Middle Date of Birth

School_____ SIS ID # _____

1. Is a language other than English spoken in your home?
   a. Yes ____ What language?_____
   b. No ____

2. Does your child speak a language other than English?
   a. Yes ____ What language? _____
   b. No ____

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

Parent/Guardian (Print)_____Relationship to Student_____ Date_____

Parent/Guardian Signature_____Staff Member who Registered Child_____

(For Office Use Only)

Parent Language Preference for School Mailings: English____ Spanish____ Polish____

Community Consolidated School District 59
U.S. Department of Education Race and Ethnicity Data Standards

DATA COLLECTION FORM

Student's Name: _____ **School** _____

IMPORTANT INFORMATION: The U.S. Department of Education requires this form to be completed upon a student's enrollment into a school district. The data is used in reporting and analyzing State-required test results by race and ethnicity. The information will not be used to check immigration status, and the confidentiality of the individual student information will be protected.

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, and both questions must be answered. Part A asks about the student's ethnicity (refers to culture and language) and Part B asks about the student's race (refers to geographic or national origin). PLEASE NOTE: If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)
Choose only one:

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue to respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.

Part B. What is the student's race? Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

_____ _____
Parent/Guardian Signature Date

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

STATUS OF PHYSICAL & IMMUNIZATION RECORDS FOR INCOMING STUDENTS

Date: _____

Dear Parent(s)/Guardian(s) of _____

In accordance with District 59 policy, students who enter District 59 are given a 30-day period to show evidence of a current physical examination and immunizations are up-to-date.

Your student who is named above is being admitted to school on a provisional basis until his/her current physical examination and immunization records are received from the parent(s)/guardian(s) or the previous school of attendance.

The district is required by the Illinois State Board of Education to use a standard form furnished by the state to record and verify the physical examination and immunization data. This form, entitled "Certificate of Child Health Examination" is available at the school office.

Failure to comply with the 30-day timeline will result in exclusion from school.

Sincerely,

School Nurse

Parent/Guardian Completes This Section

I understand my child's current physical examination (including immunization date) is to be submitted to _____ School by_____ which is 30 days from the above enrollment date. Failure to comply with the 30-day timeline will result in exclusion from school.

Previous school of attendance:_____

Address of previous school _____

Signature of Parent/Guardian _____

H-29 12/21 Distribution: Parent, Health File

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

ANNUAL STUDENT HEALTH FORM
20 ___ - 20 ___ SCHOOL YEAR

Student: _____ Birth date _____
(last) (First)
Grade _____ Sex _____ School _____

Annual Health History Update	YES	NO
1. Does this child have: Allergies to food, medications or insect stings	___	___
Asthma	___	___
Any chronic illness	___	___
A seizure disorder	___	___
Any physical limitations	___	___
Diabetes	___	___
Glasses	___	___

Explain:_____
_____

2. During the past 12 months has this child been:	YES	NO
Hospitalized (include surgery)	___	___
Seriously injured	___	___

Explain:
_____
_____

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

Explain: _____
(If medications, inhaler or glucose monitoring, etc., needs to be done at school, please refer to the appropriate forms “Medication Guidelines” H-24; “School Medication Authorization” H-25; “Hold Harmless and Indemnification for the Self-Administration of Asthma Medication and/or Possession of an Epinephrine Auto-Injector (Epi-Pen®)” H-26. Complete proper form(s)and return it to the school nurse.)

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

Explain: _____

Physician Contact Information

Physician Name: _____Phone:_____

Name of Practice: _____

Physician Address: _____

Parent(Guardian) Name (please print):_____

Parent (Guardian) Signature_____Date_____

Please return to your child’s school health office.

H-103 (Rev. 12/21 Distribution: health file)

Community Consolidated School District 59

Transportation Request Form

School Year 20___ - 20____

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

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

Submit this signed form to your child's school.

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

Please print: Student Name:_____ID #_____

School Name:_____ Program_____

Grade Level:_____Kindergarten/PreK: ☐ Full Day Program ☐ AM Program ☐ PM Program

Home Address:_____ City:_____ Zip:_____

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

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

Pick-up Information

☐ No bus is required, parent will transport

☐ Other: Please provide detailed information below:
Site Address:_____
City and Zip:_____
Phone # for this location: _____
Relationship to student: _____

Drop-off Information

☐ No bus is required, parent will transport

☐ Other: Please provide detailed information below:
Site Address:_____
City and Zip:_____
Phone # for this location: _____
Relationship to student: _____

Parent or Guardian Signature:_____ Date:_____

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

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

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

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

Other pertinent information:_____

LEA Coordinator Authorization Signature:_____ Date:_____

This section is to be completed by Transportation Department Only

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

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

Processed by:_____

State of Illinois
Certificate of Child Health Examination

Student's Name 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:** * 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? 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** **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: ☐ 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**

Annual Authorization for Internet and Electronic Network Access

INTRODUCTION

The District's Electronic Network provides Internet and other electronic access in support of education and/or research. The goal in providing this access is to promote educational excellence by facilitating resource sharing, innovation, productivity, and communication. Parents (guardians) must annually grant permission for their student(s) to access these resources. Students must also agree to abide by the District's and school's electronic network rules and regulations. Violation of applicable policies, regulations or procedures may result in the loss of the privilege to use this resource, District disciplinary action, and/or referral to law enforcement.

The District takes precautions to prevent access to materials that may be defamatory, inaccurate, offensive, or otherwise inappropriate in the school setting. Each District computer with Internet access has a filtering device when on the district network that blocks entry to visual depictions that are (1) obscene, (2) pornographic, or (3) harmful or inappropriate for students, as defined by the Children's Internet Protection Act and as determined by the Superintendent or designee. However, it is impossible to control all material and a user may discover inappropriate material. Ultimately, staff members and/or parent(s)/guardian(s) are responsible for setting and conveying the standards that their students, children, or wards should follow. To that end, the District supports and respects each individual's right to decide whether or not to authorize electronic network access. Parents are responsible for filtering home internet access.

Parents (guardians) and students are required to read Board Policy 6.235 and Administrative Regulation 6.235R2, and are required annually to authorize a student's use of this resource.

SR_38A (12/21)

Distribution: Parent

Annual Authorization for Internet and Electronic Network Access

STUDENT'S NAME_____**STUDENT I.D.**_____

SCHOOL_____ **SCHOOL YEAR:** _____ **GRADE LEVEL**_____

Student (or Parent on Behalf of the Student) Release

I have read and will abide by Student Use of the District's Electronic Network Administrative Regulation 6.235-R2. I understand that use of the Internet is a privilege and it may be revoked at any time. I also understand should I commit any violation, my access privileges may be revoked, and school disciplinary action and/or appropriate legal action may be taken. In consideration for using the District's Internet connection and having access to public networks, I hereby release the Community Consolidated School District 59 and its Board of Education members, employees, and agents from any claims and damages arising from my use or inability to use the Internet.

_____

Student's Name (Please Print)

_____ _____

Student's Signature (student or parent on behalf of the student) Date

Parent/Guardian Release (Required in Addition to Student Release)

I have read this Authorization for Internet and Electronic Network Access. I understand that access is designed for educational purposes and that the District has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the District to restrict access to all controversial and inappropriate materials. I will hold harmless Community Consolidated School District 59, its employees, agents, or Board of Education members, for any harm caused by materials or software obtained via the network. I accept full responsibility for supervision if and when my child's use is not in a school setting. I have discussed the terms of this Authorization with my child. I hereby request that my child be allowed access to the District's Internet and Electronic Networks.

_____

Parent/Guardian's Name (Please Print)

_____ _____

Parent/Guardian's Signature Date

CCSD59

Availability of Student Disciplinary Policies and Procedures

STUDENT'S NAME_____ SCHOOL YEAR _____

SCHOOL_____

Parent/Guardian Release

I have been informed that student disciplinary policies and procedures are available online through the District 59 Family Reference Guide at ccsd59.org/family-reference-guide/ or in hard copy per my request. I have also been informed that I can obtain a paper copy of this document at the District 59 Administrative Office or my child's school.

I understand that it is my parental responsibility to review these policies and procedures with my child. I also understand that assistance will be made available to me if I am unable to read or understand these policies and procedures by contacting the District 59 Administrative Office or my child's school.

_____

Parent/Guardian's Name (Please Print)

_____ _____

Parent/Guardian's Signature Date

The state of Illinois requires the following information be collected and reported in the student information system for every child entering the preschool program.

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

Number of people living in your home:

ANNUAL household income (This includes any income from any individual living in the home):

$

Does your child attend daycare? ☐ Yes ☐ No

If YES, which type (choose only one)?

☐ Licensed daycare center ☐ Licensed in home daycare 4 to 12 children attend)

☐ Family/babysitter

My family/child receives the following public benefits (check all that apply):

☐ Women Infants & Children (WIC) ☐ Medicaid

☐ Supplemental Nutrition Assistance Program (SNAP/Food Stamps)

☐ Temporary Assistance for Needy Families (TANF) ☐ Child Care Assistance Program (CCAP)

☐ Housing Subsidy

FOR OFFICE USE ONLY

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

Public benefits:

☐WIC (185% FPL) ☐Medicaid Card (138%, ***must*** be in parent(s)' name) ☐SNAP (165% FPL)

☐ TANF (50% FPL) ☐ CCAP (200%)

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

☐Paystubs (two most recent, consecutive) ☐SSI ☐ Tax return (most recent)

☐ W-2 (most recent) ☐ Verification/letter from employer

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

Staff Signature:_____ **Date:**_____

1900 Lonnquist Blvd. - Mount Prospect, IL 60056

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

YOUNG ATHLETES REGISTRATION

State Special Olympics Program:_____

Are you new to Special Olympics or re-registering? ☐ New ☐ Re-Registering

YOUNG ATHLETE INFORMATION	
First Name:	**Last Name:**
Date of Birth:	☐ **Female** ☐ **Male**
Has an Intellectual or Developmental Disability:	❒ **Yes** ❒ **No**

Race/Ethnicity (Optional):

☐ Prefer not to answer

☐ American Indian/Alaskan Native ☐ Asian American ☐ More than one Race

☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander

☐ White or Caucasian ☐ Hispanic or Latinx

Language(s) Spoken in Young Athlete's Home (Optional): Check all that apply

❒ English ❒ Spanish ❒ Other (please list):

Shirt Size: ❒ Youth Small ❒ Youth Medium ❒ Youth Large

❒ **Requires Wheelchair Accessible Locations**

❒ **Language Needs:**

❒ **Medical Conditions:**

❒ **Special Diet:**

❒ **Other:**

PARENT / GUARDIAN INFORMATION	
Name:	
Relationship:	
Address:	**City:**
State/Province:	**Postal Code:**
Phone:	**E-mail:**

EMERGENCY CONTACT INFORMATION	
☐ **Same as Guardian/Parent**	
Name:	
Phone:	**Relationship:**

YOUNG ATHLETES RELEASE FORM

I am the Parent or Guardian of the Young Athletes participant named below and agree to the following:

1. **Able to Participate.** The Young Athlete is physically able to take part in Special Olympics.

2. **Likeness Release.** I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") to use the Young Athlete's likeness, photo, video, name, voice, words, and biographical information to promote Special Olympics and raise funds for Special Olympics.

3. **Risk of Concussion and Other Injury.** I know there is a risk of injury. I understand the risk of continuing to participate with or after a concussion or other injury. The Young Athlete may have to get medical care if there is a suspected concussion or other injury. The Young Athlete also may have to wait 7 days or more and get permission from a doctor before playing sports again.

4. **Emergency Care.** If a parent or guardian is unavailable to consent or make medical decisions in an emergency, I authorize Special Olympics to seek medical care for the Young Athlete, unless I mark one of these boxes:

   ☐ I have a religious or other objection to receiving medical treatment. (Not common.)
   ☐ I do not consent to blood transfusions. (Not common.)
   (If either box is marked, an EMERGENCY MEDICAL CARE REFUSAL FORM must be completed.)

5. **Health Programs.** If the Young Athlete takes part in a Special Olympics health program, I consent to health activities, exams, and treatment for the Young Athlete. This should not replace regular health care. I can say no to treatment or anything else any time for the Young Athlete.

6. **Personal Information.** I understand that Special Olympics will be collecting the Young Athlete's personal information as part of participation, including name, image, address, telephone number, health information, and other personally identifying and health related information provided to Special Olympics ("personal information").
   - I agree and consent to Special Olympics:
     - using the personal information in order to: confirm eligibility and safe participation; run trainings and events; share competition results (including on the Web and in news media); provide health treatment if the Young Athlete participates in a health program; analyze data for the purposes of improving programming and identifying and responding to the needs of Special Olympics participants; perform computer operations, quality assurance, testing, and other related activities; and provide event-related services.
     - using the personal information for communications and marketing purposes, including direct digital marketing through email, text message, and social media.
     - sharing personal information with (i) researchers, such as universities and public health agencies, that are studying intellectual disabilities and the impact of Special Olympics activities, (ii) medical professionals in an emergency, and (iii) government authorities for the purpose of assisting with any visas required for international travel to Special Olympics events and for any other purpose necessary to protect public safety, respond to government requests, and report information as required by law.
   - I have the right to ask to see the personal information or to be informed about the personal information that is processed. I have the right to ask to correct and delete the personal information, and to restrict the processing of personal information if it is inconsistent with this consent.
   - *Privacy Policy.* Personal information may be used and shared consistent with this form and as further explained in the Special Olympics privacy policy at www.SpecialOlympics.org/Privacy-Policy.aspx.

Young Athlete Name:	
PARENT/GUARDIAN SIGNATURE	
I am a parent or guardian of the Young Athlete. I have read and understand this form. By signing, I agree to this form on my own behalf and on behalf of the Young Athlete.	
Parent/Guardian Signature:	**Date:**
Printed Name:	**Relationship:**

YOUNG ATHLETES LIKENESS RELEASE FOR SPONSORS (OPTIONAL)

Special Olympics relies on sponsors and partners to help support our mission. We often use photos, videos and stories of our athletes to show the impact of support by companies that sponsor Special Olympics. If you wish to allow the Young Athlete's likeness to be used in this way, please read and sign below.

I agree to the following:

- I give permission to Special Olympics, Inc., Special Olympics games organizing committees, and Special Olympics accredited Programs (collectively "Special Olympics") and their sponsors and partners to use the Young Athlete's likeness, photo, video, name, voice, and words ("Likeness") to acknowledge the sponsors' and partners' support for Special Olympics.
- Special Olympics and its sponsors and partners will not use the Young Athlete's Likeness to endorse commercial products or services.
- I understand neither the Young Athlete nor I will not be compensated for the use of the Young Athlete's Likeness.

Young Athlete Name:	
PARENT/GUARDIAN SIGNATURE	
I am a parent or guardian of the Young Athlete. I have read and understand this form. By signing, I agree to this form on my own behalf and on behalf of the Young Athlete.	
Parent/Guardian Signature:	**Date:**
Printed Name:	**Relationship:**

Dear Parents,

Your school has purchased a web-based resource for families of 0-5 year olds involved in our programs called ReadyRosie. ReadyRosie is an online resource that delivers video-based emails and text messages in both English or Spanish to parents and caregivers. The ReadyRosie videos feature real families modeling quick activities that can be done at home to promote success in school. Learn more about ReadyRosie on their website at readyrosie.com.

Each ReadyRosie video models an activity that you can do with your child to help them succeed academically. We know you will enjoy receiving the reminders and doing the activities with your child(ren).

Register to receive your free videos by completing the form below:

How would you like to receive your ReadyRosie videos?

☐ Email
☐ Text message
☐ Both email and text message

What is your preferred language? *(Videos are currently offered in English and Spanish only).*

☐ English
☐ Spanish

_____ _____

Parent First Name **Parent Last Name**

_____ _____

Email **Cell Phone Number**

_____

Child's Name

Thanks for your time and thanks for your attention to this exciting opportunity! Please return this form to your teacher.

COMMUNITY CONSOLIDATED
SCHOOL DISTRICT 59

CCSD59 SOFTWARE APPLICATIONS PERMISSION FORM 2022-23

CCSD59 utilizes various technology resources to support student learning, including but not limited to third-party online and cloud-based service providers. These resources include third-party software applications, commonly known as "apps". CCSD59 Board policies govern the use of third-party apps with students, including Policy 6:60 (Curriculum Content) and Policy 6:235 (Access to Electronic Networks). CCSD59 also has an approval process for using third-party apps. Your child's personally identifiable information that is input into these apps by your child and/or school staff (for example, student name, school email address, class work) may be accessed by the third-party providers that run the apps. This permission form must be completed and returned before your child will be granted access to any CCSD59-approved apps.

BY SIGNING BELOW, I, THE PARENT/GUARDIAN OF THE STUDENT NAMED BELOW, CONFIRM THAT I UNDERSTAND AND AGREE TO THE FOLLOWING:

1. I have had the opportunity to review CCSD59's Board Policy 6:235 (Access to Electronic Networks). I understand that my child must comply with Policy 6:235 and all other District policies and rules concerning the use of CCSD59-approved applications.

2. I understand that my child is responsible for his/her use of CCSD59-approved applications at all times. I accept full responsibility for supervision if and when my child uses CCSD59-approved applications outside of school.

3. I understand that my child's failure to follow all CCSD59 policies and rules for using third-party applications may result in the loss of privileges, disciplinary action (which may include suspension or expulsion), and/or appropriate legal action.

4. I understand CCSD59 has an approval process for third-party applications, and, once approved, the third-party provider is a CCSD59 "school official" that may access my child's personally identifiable information that is available within the third-party provider's application without my prior consent or prior notice given to me.

5. I understand that when my child uses CCSD59-approved applications, information about my child that has been input into the third-party provider's application by my child and/or CCSD59 employees will be collected and stored electronically by the third-party provider. I understand that such stored information may be accessible to someone other than my child, me and CCSD59 employees or school officials by virtue of this online environment.

6. I understand that CCSD59 employees and school officials may access and monitor my child's use of CCSD59-approved applications, including accessing and searching any material stored, transmitted, or received through the applications.

7. I understand that access to CCSD59-approved applications is designed for educational purposes and that CCSD59 takes precautions to eliminate controversial material. However, I also recognize that it is

impossible for CCSD59 to restrict access to all controversial and inappropriate materials. I will hold harmless CCSD59, its employees, agents, or Board members for any harm caused by materials obtained via CCSD59-approved applications.

8. I understand that I may revoke my consent for my child to access and use CCSD59-approved applications at any time in writing.

9. I understand that I may ask for my child's account/information to be removed from third-party application providers at any time.

_____ **YES**, I understand and agree with the above terms and give permission for my child to use any CCSD59-approved applications during this school year.

_____ **NO**, I do not give permission for my child to use any CCSD59-approved applications during this school year.

Student Name: (Print) _____ Grade: _____

Student ID # (if known): _____ School: _____

Parent/Guardian Signature:_____ Date: _____

Please sign and return this form to your child's classroom teacher.