



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-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)				

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: _____

Other Additional Considerations (please note, info may not be available at time of registration):Did child attend ELC? ☐ Yes ☐ NoDoes 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 ☐ NoIs parent interested in Dual Language Program? ☐ Yes ☐ NoIs 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

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

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

INFORMACIÓN IMPORTANTE SOBRE LA INSCRIPCIÓN DE LOS ESTUDIANTES

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

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

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

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

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260 Dulles Rd, Des Plaines

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1530 Highland Ave, Arlington Hts

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650 Ridge Ave, Elk Grove Village

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305 East Oakton St, Elk Grove Village

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1900 Lonnquist Blvd, Mt. Prospect



VISIT OUR WEBSITE TO FIND MORE
INFORMATION ON THE FOLLOWING:

VISITE NUESTRO SITIO WEB PARA ENCONTRAR MÁS INFORMACIÓN ACERCA DE:

CCSD59.ORG/BACKTOSCHOOL

School Supply Lists

Listas de útiles escolares

Family Reference Guide

Guía de Referencia Familiar

Menus

Menús

Transportation Information

Información sobre transporte

Application for Free and Reduced
Price Meals

Solicitud para comidas gratis y a precio reducido

Ability to Pay School Fees and Make
Deposits into Your Student's Meal
Account

Pago de cuotas escolares y depósitos a la
cuenta de almuerzo



Community Consolidated School District 59
1001 Leicester Road | Elk Grove Village, IL 60007
Phone: (847) 593-4300

Dear Parents/Guardians:

The Illinois School Code has changed immunization requirements **for incoming 6th graders**. This letter provides important information about those new requirements. Please read carefully and pay special attention to deadlines. Please contact your building nurse for assistance. Enclosed with this letter are the following:

Document/Form:	What to Do Before the First Day of School:
State of Illinois Certificate of Child Health Examination (H-12) <u>Please note that your child must now receive the Hepatitis B vaccination series, a Tdap booster, Meningococcal Vaccine, two varicella vaccinations, and two MMR vaccinations prior to the first day of school.</u> (Please note: if your child is participating in interscholastic athletics, his/her physical exam should take place between June 1 and the start of school.)	• Enter your student's name on both the front and back of the form. • Complete the Health History section on the back of the form. Be sure to sign it. • Have your child's doctor, nurse practitioner, or physician's assistant complete and sign the Immunization History, Physical Exam, and Physical Education and Interscholastic Sports sections. Be sure that any modifications in the Physical Education section are specified. • Return the completed form to your child's school.
Proof of Dental Examination Form (H-11)	• Have your child's dentist complete, sign, and date the form. • Return the completed form to your child's school.
Interscholastic Athletics Requirements (H-115A)	• Read and keep the information about Interscholastic Athletics and Concussions (pp. 1-4) • Complete and sign the Parent and Student Consent for Participation in Interscholastic Athletics and the Proof of Insurance forms. • Return the completed form to your child's school.

Please note: the only exceptions to immunization requirements are religious objections and medical contraindication for your child. Properly documented evidence must be submitted to your child's school health office. If you have additional questions or need assistance, please contact your building nurse.

Sincerely,
Denise M. Webster, BSN, RN, PEL-CSN
Coordinator of Health Services, District 59

12/21

Form H_31



Community Consolidated School District 59
1001 Leicester Road | Elk Grove Village, IL 60007
(847) 593-4300

Estimado padres/tutores:

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

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

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

Cordialmente,

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



COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59

1001 Leicester Road | Elk Grove Village, IL 60007

Phone: (847) 593-4300 | Fax: (847) 593-4352

IMPORTANT INFORMATION REGARDING ILLINOIS CERTIFICATE OF CHILD HEALTH EXAMINATION FORM

Dear Parent/Guardian,

The Illinois School Code requires that all children entering kindergarten or the first grade, or enrolling in an Illinois school for the first time, regardless of the student's grade (including early childhood, special education, and student's transferring into Illinois), have a physical examination within one year prior to entry into school. There must also be documented evidence that each child has received all required immunizations.

Attached is a Certificate of Child Health Examination form. Please be sure the following information is completed on this form before it is returned to school:

- The student's name and information should be entered on both sides of the exam form.
- **Immunization History** must include specific dates. A health care provider's signature is required to verify the immunization dates.
- The **Health History** (on the back) must be completed and signed by a parent/guardian.
- The **physical exam** must be completed, dated, and signed by a physician, nurse practitioner or physician's assistant.
- Approval to participate in **Physical Education and Interscholastic Sports** near the bottom of the page must be checked by the physician. Modifications must be specified.

The only exception to this requirement is based on religious objection or medical contraindication for your child. However, proper documented evidence must be submitted to your child's school health office.

If, for any reason, you are unable to comply with the state requirement, please contact your child's school health office as soon as possible.

We appreciate your cooperation in this matter.

Denise M. Webster, BSN,RN, PEL-CSN
Health Coordinator, District #59

Enclosure: Certificate of Child Health Examination



COMMUNITY CONSOLIDATED SCHOOL DISTRICT 59

1001 Leicester Road | Elk Grove Village, IL 60007

Phone: (847) 593-4300 | Fax: (847) 593-4352

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

Estimado Padre/Tutor,

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

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

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

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

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

Apreciamos su cooperación en este asunto.

Denise M. Webster, BSN,RN, PEL-CSN
Coordinador de Salud del Distrito 59



State of Illinois Certificate of Child Health Examination

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#	
Last First Middle				Month/Day/Year				
Address Street City Zip Code				Parent/Guardian Telephone # Home Work				
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.								
REQUIRED Vaccine / Dose	DOSE 1		DOSE 2		DOSE 3		DOSE 4	
	MO	DA	YR	MO	DA	YR	MO	DA
DTP or DTaP								
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT	
Polio (Check specific type)	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Hib Haemophilus influenza type b								
Pneumococcal Conjugate								
Hepatitis B								
MMR Measles Mumps. Rubella							Comments:	
Varicella (Chickenpox)								
Meningococcal conjugate (MCV4)								
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose								
Hepatitis A								
HPV								
Influenza								
Other: Specify Immunization Administered/Dates								
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.								
Signature				Title		Date		
Signature				Title		Date		
ALTERNATIVE PROOF OF IMMUNITY								
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR								
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. Date of Disease Signature Title								
3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result.								
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.								
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____ Physician Statements of Immunity MUST be submitted to IDPH for review.								

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

LastFirstMiddle			Birth DateMonth/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?			Yes No	Child wakes during night coughing?			Yes No		
Birth defects?			Yes No	Developmental delay?			Yes No		
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes No	Diabetes?			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 _____				Dental ☐ Braces ☐ Bridge ☐ Plate ☐ 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	Parent/Guardian Signature					
Bone/Joint problem/injury/scoliosis?			Yes No	Date					
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					



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 <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.																		
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																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose														Comments:				
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																		
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Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____ Physician Statements of Immunity MUST be submitted to IDPH for review.																		

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

Apellido			Nombre			Inicial			Fecha de Nacimiento			Sexo			Escuela			Grado/Núm. de Ident.					
Mes / Día / Año																							
HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD																							
ALERGIAS (Alimentos, drogas, insectos, otro)			Sí No			Anótelas todas:						MEDICINAS (Anote todas las recetas o tomadas con regularidad)			Sí No								
¿Tiene diagnóstico de asthma?						Sí No						¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)						Sí No					
¿Despierta el niño tosiendo en la noche?																							
¿Tiene defectos de nacimiento?						Sí No						¿Ha sido hospitalizado?						Sí No					
¿Tiene retrasos del desarrollo?						Sí No						¿Cuándo? ¿Para qué?											
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro						Sí No						¿Ha tenido alguna cirugía?(anótelas todas)						Sí No					
¿Tiene diabetes?						Sí No						¿Cuándo? ¿Para qué?											
¿Tiene heridas en la cabeza/golpe/desmayo?						Sí No						¿Ha tenido heridas graves o enfermedades?						Sí No					
¿Tiene convulsiones? Cómo se manifiestan?						Sí No						¿Prueba positiva de TB (Pasado o Presente)?						Sí No					
¿Tiene problemas cardiacos/No respira bien?						Sí No						¿Enfermedad de TB (Pasado o Presente)?						Sí No					
¿Tiene soplo en el corazón/presión arterial alta?						Sí No						¿Usa tabaco (tipo, frecuencia)?						Sí No					
¿Tiene mareos o dolor de pecho al hacer ejercicios?						Sí No						¿Toma alcohol/drogas?						Sí No					
¿Tiene historial de familiares de muerte repentina antes de los 50 años? ¿Causa?						Sí No																	
¿Problemas con los ojos/visión? _____ Lentes ☐ Lentes de Contacto ☐ Último examen _____ ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)												Dental ☐ Ganchos ☐ Puente ☐ Placas Otro											
¿Tiene problemas de los oídos/no oye bien?						Sí No						La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.											
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?						Sí No						Firma del Padre/Tutor Fecha											
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI B/P																							
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes ☐ No ☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes ☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ At Risk Yes ☐ No ☐																							
LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)																							
Questionnaire Administered? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result																							
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm . No test needed ☐ Test performed ☐ Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____ Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value																							
LAB TESTS (Recommended)			Date			Results						Date			Results								
Hemoglobin or Hematocrit									Sickle Cell (when indicated)														
Urinalysis									Developmental Screening Tool														
SYSTEM REVIEW		Normal		Comments/Follow-up/Needs									Normal		Comments/Follow-up/Needs								
Skin											Endocrine												
Ears				Screening Result:							Gastrointestinal												
Eyes				Screening Result:							Genito-Urinary				LMP								
Nose											Neurological												
Throat											Musculoskeletal												
Mouth/Dental											Spinal Exam												
Cardiovascular/HTN											Nutritional status												
Respiratory				☐ Diagnosis of Asthma							Mental Health												
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)										Other													
NEEDS/MODIFICATIONS required in the school setting										DIETARY Needs/Restrictions													
SPECIAL INSTRUCTIONS/DEVICES e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																							
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal																							
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes ☐ No ☐ If yes, please describe.																							
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified please attach explanation.) PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐																							
Print Name										(MD,DO, APN, PA) Signature										Date			
Address										Phone													



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: _____





FORMULARIO COMPROBANTE DEL EXAMEN DENTAL ESCOLAR

La ley de Illinois (Child Health Examination Code, 77 Ill. Código Administrativo 665) índice que todos los niños en kínder, segundo, sexto, y noveno grados en escuela pública, privado, o parroquial adquieran examinación dental. La examinación se tiene que haber hecho entre 18 meses antes de 15 Mayo del año escolar. Un dentista licenciado tiene que hacer el examen, firmar y ponerle fecha a esta Formulario Comprobante de Examen Dental Escolar. Si no puede obtener este examen requerido, completa el Formulario de Renuncia Voluntaria del Examen Dental Escolar

Este examen importante le dejara saber si hay algún problema que requiere atención de un dentista. Los Niños necesitan buena salud bucal para habla con confianza, expresar se, ser saludables y ser listos para aprender. La salud bucal malo ha sido relacionado con bajo actuación escolar, malas relaciones sociales, y menos éxito más adelante in la vida. Por esta razón, le damos gracia por su contribución al salud y bien estar de su niño.

Para ser completado por el padre/madre (por favor impresión):

Nombre del Estudiante:	Apellido	Nombre	Inicial	Fecha de Nacimiento: (Mes/Dia/Año)
Dirección:	Calle	Ciudad	Código Postal	
Nombre de la Escuela:	Código Postal	Grado:	Sexo: ☐ Masculino ☐ Femenino	
Nombre del padre/madre o encargado				
Raza/Etnicidad del Estudiante: ☐ Blanco ☐ Hispano/Latino ☐ Asiático ☐ Otro ☐ Nativo de Alaska o Indio Americano ☐ Afroamericano ☐ Multirracial ☐ Desconocido ☐ Nativo de Hawái o otras islas del Pacífico				

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: _____



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 _____



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 _____

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 _____)