WHITESIDE SCHOOL DISTRICT 115
111 Warrior Way
Belleville, Illinois 62221
Telephone 618 239-0000
Middle School Fax 618 239-9240
Elementary School Fax 618 233-7931
http://www.wssd115.org

Peggy K. Burke
Superintendent
Monica Laurent
Middle School Principal
Jaime Cotto
Middle School Assistant Principal
Nathan Rakers
Elementary Principal
Kevin Johnson
Elementary Assistant Principal

SCHOOL FEES
2017-2018 School Year

The School Board may establish fees and charges to fund certain school activities. It is recognized that some students will be unable to pay these fees. Consequently, students shall not be denied educational services or academic credit due to the inability of parents or guardians to pay fees. **Whiteside School District's textbook & materials fee is currently $65.00 per student for Kindergarten, 1st, 2nd, 3rd, 4th, and 5th Grades; and $75.00 for 6th, 7th, and 8th Grades and should be paid at Registration in July/August. Textbook & materials fee for students (all grades) who qualify for reduced-price meals is $25.00. All 3rd Graders will also be assessed a $5.00 fee for the purchase of a recorder for Music class. Fees MUST be paid in full by October 15, 2017. FEES NOT PAID BY THE DEADLINE WILL BE CHARGED A $10.00 LATE FEE. Fees for students enrolling after the first day of school are due at the time of registration. ALL FEES ARE SUBJECT TO CHANGE.**

NOTE: Fees must be paid in full prior to Middle School Sports Try-outs.

Students whose parents are unable to afford student fees may receive a waiver of the fees based upon approval of a completed Fee Waiver Application. However, these students are not exempt from charges for lost and damaged books, locks, materials, supplies and equipment.

Applications and additional information for the fee wavier will be available in August.

Whiteside Middle School
111 Warrior Way
Belleville, Illinois 62221
618 239-0000
Fax 618 239-9240

Whiteside School District # 115

Registration & Emergency Information
2017-2018

Whiteside Elementary School
2028 Lebanon Avenue
Belleville, Illinois 62221
618 239-0000
Fax 618 233-7931

Student ______________________________ Male____ Female____ Grade ______
(First) (Middle) (Last)

Address ______________________________
(House/Apt. number and street) (City) (State) (Zip)

Phone # ____________ Date of Birth: ____________ Previous Whiteside Student Y / N

Name of student's father: ______________________________

Father's current home address ______________________________
(Street/Apt.#) (City) (State) (Zip)

Home phone ____________ Cell phone ____________ Work phone ____________

Email address: ______________________________

Employer ____________ Currently Military: Yes___ No___ Civil Service: Yes___ No___

Optional: If military active duty or reserves, do you expect to be deployed during the school year?__________

Name of student's mother: ______________________________

Mother's current home address ______________________________
(Street/Apt.#) (City) (State) (Zip)

Home phone ____________ Cell phone ____________ Work phone ____________

Email address: ______________________________

Employer ____________ Currently Military: Yes___ No___ Civil Service: Yes___ No___

Optional: If military active duty or reserves, do you expect to be deployed during the school year?__________

We will try to contact parent/guardian first. Please provide two additional contacts other than the parents in case of emergency.

Emergency Contact 1: ______________________________
Name Relationship

Home Phone: ____________ **Cell #:** ____________ **Work # :** ____________

Emergency Contact 2: ______________________________
Name Relationship

Home Phone: ____________ **Cell #:** ____________ **Work # :** ____________

Doctor:______________________________
Complete Name Office Telephone

Hospital preference: ______________________________

Medicaid: yes____ no_____ **Insurance company and policy number:** ____________

Please list any medical conditions and treatments: ______________________________

____

Allergies (to food or medicine): ______________________________

Medications (given at home or school) **Name:**____________ **Amount:** ____ **Time(s):** ________

Name:____________ **Amount:** ____ **Time(s):** ________

This information may be shared with medical personnel and pertinent school staff. In the event of an emergency, I authorize the school to transport my child to the medical facility of my choice.

Date: ____________ Parent/Guardian Signature: ______________________________

SCHOOL USE ONLY

Student ID__________ Teacher__________ Grade ____ Bus stop____ Bus #____ N/T____ Birth Cert.____

Registration approved by:__________ Start Date________ IL transfer ___ Out of State transfer____ Special Ed ____

NOTE: Any person who knowingly enrolls or attempts to enroll in the schools of a school district on a tuition-free basis a pupil known by that person to be a nonresident of the district or any person who knowingly or willfully presents to any school district any false information regarding the residency of a pupil for the purpose of enabling that pupil to attend any school in that district shall be guilty of a Class C misdemeanor. Anyone who knowingly or willfully provides false information on this form shall be referred for criminal prosecution. A child's legal residence is where his/her legal guardian resides.

School attended last year (Name of School) ______________________________

Address ______________________________
Street City State Zip

Is the student receiving special education services? Yes___ No___ If yes, please indicate program:

SPEECH____ L.D. RESOURCE____ SELF-CONTAINED _____ OTHER(specify) ____________

Was the student in an intervention (RTI) program for reading? Yes___ No ___ Math? Yes___ No ___

Was the student in a gifted/honors program? Yes___ No ___

Does the student speak/understand a language other than English? Yes___ No___ If yes, what language? _______

Student's birthplace ____________________ Is student a U.S. Citizen? Yes__ No__ If no, please explain how student has come to live in the United States: ______________________________

Will the student RIDE THE BUS to/from school? Yes____ No____

Absence Contact: Please provide the name of the person whom we should contact if your child is absent.

____
First/Last name Home telephone Work telephone and extension

Residency Information– PROOF OF RESIDENCY IS REQUIRED

Student lives with: ______________________________ Relationship to child ____________

If student is residing with someone other than parent or legal guardian, you must complete part B.

Are you occupying your present place of residence as: Owner___ Tenant ____ Neither _____

If you rent or lease, please provide the following information and a copy of your lease. If you do not have a lease, your landlord must complete the attached Letter of Residence from Landlord in Lieu of Lease.

____
Landlord's Name Address, City, State, Zip Telephone

If you do not own or rent your residence, describe the arrangement you have with the person who owns or rents the residence and answer the following questions: ______________________________

____

Where does this child eat? ______________________________

Where does this child sleep? ______________________________

Where does this child spend his/her weekends? ______________________________

Who provides medical insurance for this child? ______________________________

Who pays for the support of this child? ______________________________

Who is to be called in case of an emergency at school? ______________________________

Who is authorized to consent to medical treatment for the student? ______________________________

Who claims the student for Federal income tax purposes? ______________________________

Please complete Part A if parents are divorced, separated, or not married.

PART A

Which parent has legal custody of the student? ___Mother ____Father ___Joint

If joint, who is designated as primary custodian? ______________________________

Is there an agreement, judgment or other document giving custody of the student to any person? Yes___ No___

Does a court order or decree prevent either parent from receiving student records or having limited or no access to the student? Yes__ No__ If yes, please provide a copy of the court document to the school.

If parents share joint custody of the student, please answer the following:

How many nights per month does the student spend with the parent requesting enrollment? ______

Where does the student spend holidays and vacations? ______________________________

Who is financially responsible for any damages caused by the student?

____

Who is responsible for the discipline and control of the student? ______________________________

If discipline and control are shared, describe each parent's involvement: ______________________________

____

If the student has brothers or sisters, where do they live? ______________________________

____

Please complete Part B and Form 7:060 E3 if you are not the child's parent.

PART B

What is your relationship to this child? ______________________________

When did the student begin living with you? ______________________________

How long will the student continue to live with you? ______________________________

Why is the student living with you and not the parent? ______________________________

____

I VOLUNTARILY FURNISH THE ABOVE INFORMATION AND HEREBY CERTIFY THAT THE STUDENT LISTED ABOVE AND I ARE LEGAL RESIDENTS OF WHITESIDE SCHOOL DISTRICT 115 RESIDING WITHIN THE BOUNDARY LINES OF SAID DISTRICT AS MANDATED BY THE STATE OF ILLINOIS. I UNDERSTAND THAT I MAY BE CHARGED WITH A CLASS C MISDEMEANOR AND MAY BE REQUIRED TO PAY BACK TUITION FOR PROVIDING FALSE INFORMATION.

______________________________ ______________________________

Signature of parent/legal guardian Date

Whiteside School District #115
on behalf of
Illinois State Board of Education
U.S. Department of Education Race and Ethnicity Data Standards

Student's Name: **SIS #**______________

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 and Part B asks about the student's race. 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 and 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.)

Note: Data collected on this form must be maintained by the school district for three years. However, when there is litigation, a claim, an audit, or another action involving this record, the original responses must be retained until the completion of the action.

Student Name: ______________________________ Grade____

Illinois Secular Textbook Loan Program
Whiteside School District #115
St. Clair County

Student Request for the Loan of Textbooks

I hereby request the loan of Secular Textbooks in accordance with Illinois Public Act 79-961of 1975. I understand that this request will remain valid as long as the student is enrolled in the Whiteside School District and that I may at any time withdraw this request.

______________________ ____
Parent/Guardian Signature Date

Signing the request form will not guarantee a state loaned book, but will enable the Whiteside School District students to participate in the textbook loan program to the degree state funds are available.

****

Illinois Math/Science Loan Program
Whiteside School District #115
St. Clair County

Student Request for the Loan of Math/Science Equipment and Instructional Materials

I hereby request the loan of math/science equipment and instructional materials in accordance with Section 23.54 of *The School Code*. I understand that this request will remain valid so long as the student is enrolled in the Whiteside School District and that I may at any time withdraw this request.

______________________ ____
Parent/Guardian Signature Date

Signing this request form will not guarantee the loan of math/science equipment and instructional materials, but will enable the Whiteside School District students to participate in the math/science equipment and instructional materials loan program to the degree state funds are available.

Please Sign Both Sections and Return

WHITESIDE SCHOOL DISTRICT 115

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http://www.wssd115.org

AUTHORIZATION TO RELEASE STUDENT RECORDS

Re: ______________________
Name of Student

____
Grade this school year

____
Date of Birth

SEND TO OR RECEIVE RECORDS FROM:

____
School Name

____
Street Address

____
City, State, Zip Code

I hereby consent to the release of the following information on the above child to the Whiteside School District No. 115, Belleville, IL.

1. Permanent Record Information (Identifying information, grades, attendance and health records).
2. Temporary Record Information (Ability and Achievement Test results and other pertinent information).
3. Special Education Records (including MDC and IEP), Individual Psychological Test, and special testing information
4. All School Record Information on file.

K-4 Records mail to: Whiteside Elementary School, 2028 Lebanon Ave., Belleville, IL 62221

5-8 Records mail to: Whiteside Middle School, 111 Warrior Way, Belleville, IL 62221

I understand that the information thus obtained will be treated in a confidential manner.

____
Signed/Relationship to Student

____
Address

Date______________________

Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.

WHITESIDE SCHOOL ANNUAL STUDENT HEALTH HISTORY QUESTIONNAIRE

Please complete as indicated and use the reverse side of this form for any additional information or explanation as needed.

School Year: 20 -20

Name: **Date of Birth:** **Grade:**

A. Medical History: Check the ones that apply to your child and describe under the comment section.

_____Asthma/Breathing problems
_____Wheezing or coughing fits
_____Bee/Insect sting allergy
_____Epi-Pen * Epi-Pen Jr.
_____Birth defects
_____Premature Birth
_____Developmental Delay
_____Autism
_____Cerebral Palsy
_____Down's Syndrome
_____Genetic defect/Disorder
_____Thyroid * Growth Disorder

_____Ear infections/Ear tubes
_____Vision-lazy eye * deformity * cross eyed
_____Color Blindness
_____Hearing Problems/loss R L
_____Headaches/migraines
_____Heart Condition_____________
_____Stomach problem/ Acid Reflux-GERD
_____Bowel problems/constipation
_____Kidney/Urinary Problems, infections
_____Muscle problems,clumsy,weakness
_____Diabetes Type I * Diabetes Type II
_____Hypoglycemia- low sugar

_____Neurological problems/ Head Trauma
_____Staring spells
_____Seizures due to fevers
_____Seizures (type:_______________)
_____VP shunt
_____Nosebleeds
_____Sickle Cell disease/ Blood disorders
_____Cancer: _______________
_____ADD/ADHD
_____Anxiety/Panic Attacks
_____Mental Health: Bipolar * OCD * ODD
_____Broken bones

Explanation//Comments//Other:

B. ALLERGIES: List allergies your child has that may cause a problem at school. What kind of reaction happened?

_____Medicine allergies:(list) _____ No Known Medicine Allergies
_____Food allergies:(list) Treatment:
_____Food allergies:(list) Treatment:
_____Seasonal allergies: mild moderate severe Treatment:
_____Allergy Eyes Treatment:
Other allergies:(ex Latex, grass, insects, animals)

SCHOOL POLICY: * NO STUDENT SHOULD HAVE ANY MEDICATION IN THEIR POSSESSION WHILE AT SCHOOL.
(ONLY EXCEPTION IS EMERGENCY USE ASTHMA INHALERS AND EPI-PENS)
* ALL MEDICINES TO BE GIVEN AT SCHOOL REQUIRE A NEW MEDICATION PERMIT YEARLY.
ALL MED PERMITS MUST BE SIGNED BY A HEALTHCARE PROVIDER AND PARENT.
(ONLY EXCEPTION IS THE EMERGENCY USE OF A SELF-ADMINISTER/SELF CARRY ASTHMA INHALER).
* NO MEDICATIONS (prescription, non-prescription/OTC) WILL BE GIVEN WITHOUT A MEDICATION PERMIT ON FILE.

C. Current Medications: prescription, over the counter, herbals --- include medications taken at home or needed at school

Medication Name/dose	How often?	Why is it taken?	Needs at school?	
			yes	no
			yes	no
			yes	no
			yes	no

D. Hospitalizations, Operations, Injuries: (list dates if known, why hospitalized, type of surgery)

E. General Health Status: (circle)

	Generally Healthy?	yes no	Frequent absences?	yes no	glasses?	yes no
	Frequent Strep Throat?	yes no	4 or more colds/yr. ?	yes no	contacts?	yes no
	Frequent stomach aches	yes no	Constipation problem	yes no	hearing aid? R L	yes no
	Frequent ear infections	yes no	Problem with periods?	yes no	orthodontic braces?	yes no

F. Physician: **phone #:**
Dentist: **phone #:**
Orthodontist **phone #:**

Medical Insurance: YES NO PROVIDER/TYPE & # (ex: Blue Cross, IDPA)

This information may be shared with appropriate personnel for health and educational purposes. In the event of an emergency, I authorize the school to transport my child to the medical facility of my choice. (_______________)

Parent/Guardian signature: **Date:**

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Parent's Right to Know
Qualifications of Educators
School District Information Form

Dear Parent:

This is to inform you that you have the right to request information regarding the professional qualifications of any teacher that is instructing your child. You may request information regarding the following:

- Whether or not the teacher has met state certification requirements;
- Whether or not the teacher is teaching under emergency or provisional status;
- The bachelor's degree major of the teacher, any other certification or degrees held by the teacher and the subject areas of the certification or degrees; and
- Whether your child is provided services by teacher aides/paraprofessionals and, if so, their qualifications.

You will receive a response to your request for information within 10 school days. You may also find qualifications of any teacher or paraprofessional by going to the Illinois State Board of Education website at http://www.isbe.net/ELIS/default.htm and clicking on "public search".

Sincerely,

Peggy K. Burke
Superintendent

WHITESIDE SCHOOL DISTRICT 115

Middle School Fax 618 239-9240
Elementary School Fax 618 233-7931

SCHOOL PHYSICAL AND IMMUNIZATION REQUIREMENTS

(Revised For 2017-2018 School Year)

Students must provide proof of required physicals and immunizations before attending school. Students who transfer to Whiteside from out-of-state will have 30 days to complete these requirements.

SCHOOL PHYSICALS are to be done within 1 year of starting school and are required by state law **before**:

- Entering **Pre-Kindergarten** or **Early Childhood** for the 1st time.
- Entering **Kindergarten**
- Entering **6th** grade
- Entering an Illinois School from **out-of-state** for the first time.

Physicals must include a Diabetes Risk Assessment and include the calculation of the BMI.
Students under age 6 must have a lead assessment.
It is recommended that all physicals be on the current Illinois Health examination form.
All physical exams must meet required Illinois health criteria to be accepted.

IMMUNIZATION REQUIREMENTS

- **Diphtheria, pertussis, tetanus (DPT, DTaP)**
  Early Childhood/Pre K- 4 doses
  First Entry Kdg./1st grade- 4 or more doses, last shot being given on/after the 4th birthday.
  2nd – 8th grade - 3 or more doses, last dose given on/after 4th birthday
- **Tdap** 1 dose required for those students in grades 6, 7 and 8.
- **Polio** Early Childhood/Pre K- 3 doses
  First Entry Kdg./1st grade- 4 or more doses of the same Polio vaccine, last given on/after 4th birthday*

*Progressive compliance vaccine- for 2017-2018 yr. Only students in Kdg. must have 4 same polio immunizations.
Those students in 2nd - 8th grade- 3 or more doses, last dose given on/after 4th birthday

- **Hepatitis B series** Early Childhood/Pre K, 6th, 7th and 8th grade- 3 doses
- **Measles, Mumps, Rubella (MMR)**
  Early Childhood/Pre K- 1 dose live vaccine given on/after 1st birthday
  Kdg-8th- 2 doses live measles, mumps, rubella or MMR vaccine required
- **H. Influenza type B (HIB)** and **Invasive Pneumococcal Disease (PCV)**
  Early Childhood/PreK (under age 5 students only) -vaccinations as per ACIP recommendations.
- **Varicella**
  All students must show proof of at least 1 dose of Varicella given on/after the child's first birthday.
  Kdg. and 6th grade students must have two doses of varicella vaccine*

*Progressive compliance vaccine- for 2017-2018 yr. all Kdg, 1, 2,3, 6, 7, and 8th grade students must have 2 doses.

- **Meningococcal Disease**
  Students in grades 6, 7 and 8 must have 1 dose of meningococcal vaccine on/after the 11th birthday.

Eye Examinations- Eye examinations are due by October 15th for all students entering kindergarten or for those students in 1st grade and above who are entering an Illinois Public School for the 1st time.

Dental examinations- Dental exams are due by May 15th for students in kindergarten, 2nd and 6th grades.

Healthcare Agency Contact Information

Note: This information is provided for convenience only and is not intended as an endorsement by Whiteside Dist. #115

- Immunizations: St Clair County Health Department, Belleville......... ph. 618-233-6170
- Physicals and immunizations:
  - Southern Illinois Health Care Foundation......ph. 618-337-8153
  - Prime Time Clinic ....ph. 618-222-4763
  - Take Care Clinic, Walgreen's Pharmacy........ ph.1-866-825-3227
  - Express Medical Care.............................. ph. 618-212-6800
  - Med Express.... ....ph. 618-235-0605
- Low cost or free Health Insurance: Illinois' ALL KIDS .... ph. 1-866-ALL-KIDS
- Eye Exams that accept all types of medical insurance, including Medicaid- Wal-Mart Vision (near Sam's), Crown Optical
- Dentists that accept all types of medical insurance including Medicaid- call the nurse's office for phone numbers.

You can contact the Nurse's Office at the following numbers:

Julie Mongeon BSN, RN, NCSN
NURSE'S OFFICE ELEMENTARY SCHOOL ....239-0000 EXT. 2313, Fax: 233-7931

Amanda Eversgerd, BSN, RN, PEL-CSN
NURSE'S OFFICE MIDDLE SCHOOL .... 239-0000 EXT. 3366, Fax: 239-9240

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

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

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

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

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

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

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

Address **Phone**

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

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

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

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

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

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

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

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

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

☐ **Other** — periodontal, orthodontic

Please note ______________________________

Signature of Dentist ______________________ Date of Exam ______________

Address ______________________ Telephone ______________
Street City ZIP Code

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

IOCI 0600-10

Printed by Authority of the State of Illinois

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

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

Birth Date ____________ Gender ______ Grade _____
(Month/Day/Year)

Parent or Guardian ______________________________________
(Last) (First)

Phone ____________________
(Area Code)

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

County ____________________

To Be Completed By Examining Doctor

Case History

Date of exam ____________

Ocular history: ❑ Normal or Positive for ____________________

Medical history: ❑ Normal or Positive for ____________________

Drug allergies: ❑ NKDA or Allergic to ____________________

Other information ____________________

Examination

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

Was refraction performed with dilation? ❑ Yes ❑ No

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

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

Diagnosis

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

Other ____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes
   Comments ______________________________
   ____

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

4. ______________________________

5. ______________________________

Print name ______________________
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 __________)

Printed by Authority of the State of Illinois
6/09

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