Wesclin Community Unit School District #3
699 Wesclin Road
Trenton, IL 62293-2624
(618) 224-7583
FAX (618) 2588-9106

Jennifer C. Filyaw, Superintendent

Pre K Physical Exam/Immunizations
Due September 30, 2017

Spring, 2017

Dear Parents and Guardians of Pre K student,

Your child will be entering Pre-K in August of 2017. The State of Illinois requires all incoming Pre K students to have a completed **physical exam and IDPH immunizations**. This exam can be done up to a year before the start of the school year.

Physical Exam must have the following: DUE Sept 30, 2017

- State of Illinois Certificate of Health Exam form (attached) no other form will be accepted
- Immunization Record- must be in accordance with IDPH and include: DTaP, Polio, HIB booster, Hep B, Varicella, MMR and Pneumococcal Booster
- Parent section completed, signed and dated
- Doctor section completed, signed and dated (includes BMI, B/P, Diabetes screen and Lead questionnaire)

Completed physical/immunizations are to be presented to the school office by September 30, 2017. PUPILS WILL NOT BE ALLOWED TO ATTEND SCHOOL AFTER SEPTEMBER 30, 2017 UNTIL THE PHYSICAL/IMMUNIZATIONS ARE RECEIVED BY THE SCHOOL.

An appointment scheduled after September 30 WILL NOT allow student to remain in school.

If you have any questions, please email or call.

Sincerely,

Rita Wuebbels RN, BSN, PEL-IL
Wesclin District School Nurse
wuebbelsr@wesclin.org

Wesclin Elementary Schools
Wesclin C.U.S.D.#3 — Enrollment Form

Date *fecha:* _____ Student ID # (office use only) *para el uso de la oficina* _____

Pupil's Name: _____ Boy ☐ Girl ☐
Nombre del estudiante (Last/ *apellido*) (First/*nombre*) (Middle Name) *muchacho* *muchacha*

Address: _____ Home Phone _____
Dirección *Número de teléfono*

City: _____ State: _____ Zip _____
Ciudad *Estado* *Código postal*

Pupil's Grade: _____ Birth date: Month _____ Day _____ Year _____
Grado *Fecha de nacimiento* *mes* *día* *año*

Place of Birth: _____ Mother's Maiden Name _____
lugar de nacimiento City/*ciudad* State/*estado* *Nombre de soltera de la Madre*

Name of Mother or Legal Guardian: _____ Cell Phone _____
Nombre de la Madre o Guardián *Número de celular*

Occupation/Employer _____ Work Phone _____
Ocupación/Empleador *Número de teléfono*

Name of Father or Legal Guardian: _____ Cell Phone _____
Nombre del Padre o Guardián *Número de celular*

Occupation/Employer _____ Work Phone _____
Ocupación/Empleador *Número de teléfono*

Status of ***Biological*** Parents (check):
Marque el estado de los padres biológicos:

- ☐ Never Married *Nunca casados*
- ☐ Married *Casados*
- ☐ Separated *Seperados*
- ☐ Divorced *Divorciados*
- ☐ Mother deceased *Madre muerto*
- ☐ Father deceased *Padre muerto*
- ☐ Mother remarried *Madre casado otra vez*
- ☐ Father remarried *Padre casado otra vez*

Child living with */el estudiante vive con:*

- ☐ Both Parents *Ambos Padres*
- ☐ Mother Only *Madre solo*
- ☐ Father Only *Padre solo*
- ☐ Mother/Stepfather *Madre/padrastro*
- ☐ Father/Stepmother *Padre/madrastra*
- ☐ Foster Parent *Padre de crianza*
- ☐ Legal Guardian *Guarda Legal*
- ☐ Other (Give Name Below) *Otro (Nombre)*

_____

I/WE HAVE LEGAL GUARDIANSHIP OF STUDENT:
Yo/Nosotros tengo/tenemos guarda legal del estudiante:

☐ **Mother** *Madre* ☐ **Father** *Padre* ☐ **Both** *Ambos* ☐ **Other** *Otro* _____

(If applicable, legal documents concerning child custody, adoption, & guardianship must be on file in school office.)
(Si aplica, los documentos legales relativos a la custodia del niño, la adopción y tutela debe ser archivada en la oficina de la escuela.)

Parent Contact Information for SchoolReach *Información de los Padres para el AlcanceEscolar*

(SchoolReach is an instant parent contact system we will be using this school year. Your phone numbers and email addresses are for school use only and will not be shared with any individual or organization.) *(AlcanceEscolar es un sistema de alcance instantáneo para padres de familia que se usará este año escolar. Los teléfonos proporcionados y direcciones de correo electrónico no se compartirán con nadie, son solo para uso escolar.)*

Primary Phone Number: _____ Is this a cell number? ____Yes ____No
Numero primero de teléfono *¿Es este un numero celular?*

Secondary Phone Number: _____ Is this a cell number? ____Yes ____No
Numero segundo de teléfono *¿Es este un numero celular?*

Primary email address: _____
Correo electrónico primero

Secondary email address: _____
Correo electrónico segundo

Has your child ever been enrolled in an IL school? Yes ☐ No ☐
¿Ha asistido su niño en una escuela en Illinois?

Has the student ever attended a school in Wesclin C.U.S.D. #3 before? Yes ☐ No ☐
¿Ha asistido su niño una escuela en Wesclin C.U.S.D #3 antes?
If yes, which school? *¿Cuando?*_____

Has the student ever attended an Early Childhood or Pre-Kindergarten program? Yes ☐ No ☐
¿Ha asistido su niño un programa de Early Childhood o Preescolar?
If yes, which program? *¿Cual?* _____

School Last Attended _____ Grade _____
Escuela atendida por ultimo *Grado*

Address of Last School Attended _____
Dirección de la escuela atendida por ultimo

City _____ State _____ Zip Code _____ Phone _____
Ciudad *Estado* *Código Postal* *Número de teléfono*

List names and birth dates of pupil's brothers and sisters:
Lista los nombres y fechas de nacimiento de hermanos/as del estudiante:

1) _____ 2) _____
3) _____ 4) _____

List the phone numbers of persons you wish the school to contact if we are unable to reach you.
Lista los números de teléfono de la gente que usted desea la escuela para entrar en contacto con si no podemos alcanzarle
(List in order of preferred contact. *Lista en orden de contacto preferido.*)

	Name of Person *Nombre*	Phone Number *Número de teléfono*	Relationship to Child *Relación del estudiante*
1)			
2)			
3)			

Babysitter _____ Phone _____
Sitter de Bebe *Numero de teléfono*
Address _____ City_____
Dirección *Ciudad*

SPECIAL EDUCATIONAL NEEDS INFORMATION
LA EDUCACION NECESITA INFORMATION

SPECIAL EDUCATION *EDUCACION ESPECIAL* YES ☐ NO ☐

Learning Impaired _____ Emotionally Impaired _____ Speech/Language Impaired _____
Dificultad que aprende *Dificultad con emociones* *Dificultad de habla/discurso*
Physically Impaired _____ Visually Impaired _____ Hearing Impaired _____ Other _____
Dificultad físicamente *Dificultad de visión* *Dificultad de audiencia* *Otro*

An IEP (Individual Educational Program) was in effect at previous school. YES ☐ NO ☐
Había un IEP en la escuela atendida por ultimo

I have a copy of my child's IEP. YES ☐ NO ☐
Tengo una copia del IEP de mi niño

REMEDIAL EDUCATION YES ☐ NO ☐

Has your child received extra help in: Math _____ Reading _____
¿Hizo su estudiante recibido ayuda adicional en *Matemáticas?* *Leyendo?*

Does your student have a SECTION 504 PLAN? YES ☐ NO ☐

HEALTH INFORMATION
INFORMACION DE SALUD

SPECIAL PHYSICAL NEEDS YES ☐ NO ☐
NECESITAS ESPECIALES FISICOS

☐ Limited or no physical education (explain) _____
Limitado o no Educación Físico (explique)

☐ Special seating in classroom: Visual _____ Hearing _____
Asiento especial en el salón *Visión* *Audiencia*

☐ Allergies _____
Alergias

☐ My child has been diagnosed as having an attention deficit disorder.
Mi estudiante se ha diagnosticado con desorden de déficit de atención.

☐ My child is currently taking medication: (see medication policy in school handbook)
Mi estudiante toma medicamento: (ver la política de medicamento en el manual estudiantil)
Condition: _____ Medication: _____
Condición *Medicamento*
How often is it administered: _____
¿Cuántas veces son el dado?

☐ Other (please explain)_____
Otro (explique)

Physician you wish to be called for an emergency: _____ Phone _____
Doctor que usted desea ser llamado en caso de emergencia *Número de teléfono*

List any health conditions such as heart disease, diabetes, epilepsy, severe allergies (including insect, medication, etc.), eye or ear problems, any chronic condition, etc. Please explain:
Lista problemas con la salud o condiciones tales como enfermedad de corazón, diabetes, epilepsia, alergias serias (incluyendo insectos, medicinas, etc.) problemas de los ojos u oídos, enfermedades crónicas, etc. Explique.

_____
_____

When was the last time the condition/problem was noticeable (i.e. seizure date, insulin reaction date, date of bee sting/type of reaction)?
¿Cuando era la última vez la condición era notable? (fecha de ataque, fecha de reacción de insulina, fecha de picadura de abeja/tipo de reacción)

_____
_____

When was the last time this condition was evaluated by the doctor?
¿Cuándo era la última vez la condición fue evaluada por un doctor?
Date _____ Doctor _____
Fecha *Doctor*

List any information about your child that you feel would aid us in providing the best education possible for him/her at our schools. *Háganos saber cualquiera cosa que nos ayudara en proveer la mejor educación posible para su niño.*

_____
_____

Attention Parents: If you have any questions, or if you feel any of the information requested is of a sensitive or confidential nature, please contact the principal for a private conference.

Atención Padres: *Si usted tiene cualesquiera pregunta, o si usted se siente cualquiera de la información solicitada está de una naturaleza sensible o confidencial, por favor entre en contacto con el principal para una conferencia privada.*

_____ I/We have been informed that the Student/Parent Handbook is on the district website and I understand that it is my responsibility to go to the website and read the handbook or request a hard copy if I do not have internet access.
Yo/Nosotros estoy/estamos enterados que la guía estudiantil esta en el sitio web del distrito y entiendo/entendemos que es mi/nuestro responsabilidad visitar el sitio web y leer la guía o pedir una copia de papel si no tengo/tenemos acceso al internet.

(Revised 03/11/2015)

_____
Signature of Father, Mother, Legal Guardian
Firma de Padre, Madre, o Guarda Legal

Please fill out completely.

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

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

ALLERGIES (Food, drug, insect, other)				MEDICATION (List all prescribed or taken on a regular basis.)			
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.			
Bone/Joint problem/injury/scoliosis?	Yes No			**Parent/Guardian Signature** **Date**			

PLEASE NOTE: No medication will be given at school without either a Prescription or Non-Prescription Medication Authorization Form. The Prescription Medication Authorization Form must be filled out and signed by both the parent and the doctor.

WESCLIN ELEMENTARY SCHOOLS AUTHORIZATION FORM
2017-2018

STUDENT'S NAME: _____ Date:_____ Grade: _____

****

Photographic Permission

Pictures of Unnamed Students: Students may occasionally appear in photographs and videotapes taken by school staff members, other students or other individuals authorized by the Building Principals. The school may use these pictures, without identifying the student, in various publications, including the school yearbook, school newspaper, and school website. No consent of notice is needed or will be given before the school uses pictures of unnamed students taken while they are at school or a school-related activity.

Pictures of Named Students: Many times, however, the school will want to identify a student in a school picture. School officials want to acknowledge those students who participate in a school activity or deserve special recognition. In order for the school to publish a picture with a student identified by name, one of the student's parents or guardians must sign a consent form. Please complete and sign this form to allow the school to publish and otherwise use photographs and videotapes, with your child or ward identified, while he or she is enrolled in this school.

I grant consent to Wesclin School District to identify a picture of my child or ward, by full name and/or the school he or she attends, in any school sponsored material, publication, videotape, or website. This consent is valid for the entire time my child or ward is enrolled in Trenton Elementary/New Baden Elementary. I may revoke this consent at any time by notifying the Building Principal.

X_____
Parent/Guardian Signature

****

Wesclin Elementary Schools Skating Permission Form – (1st – 3rd Grade ONLY)

We will have a skating unit in physical education for grades 1st -3rd.
I give my child permission to participate in the physical education skating program for the 2017-2018 school year.

X_____
Parent/Guardian Signature

****

Wesclin Elementary Schools In-District Field Trips

Throughout the school year your child may be on several field trips within our district, all of which will have educational value. We are asking you to fill out this permission form that is good for all in-district trips throughout the 2017-2018 school year. Each trip will include careful planning, teacher chaperones, and a meaningful follow-up. The teacher and/or principal will notify you ahead of time about each in-district trip.

I give my permission for my child to participate in the in-district field trip programs for the 2017-2018 school year.

X_____
Parent/Guardian Signature

****

Wesclin Elementary Schools Handbook Authorization

I understand that the Wesclin Elementary Handbook outlines the policies and procedures used to govern Wesclin Elementary Schools and that my student and I are responsible for reading and understanding this material, which can be found online.

X_____
Parent/Guardian Signature

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Jennifer C. Filyaw, Superintendent

Home Language Survey

The state requires the district to collect a Home Language Survey for every new student. 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.

Please answer the questions below and return this survey to your child's school.

Student's Name: _____

1. What is the primary language spoken in your home?

   _____

2. Does your child primarily speak another language at home?

   Yes _____ No _____

   What language? _____

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

_____ _____
Parent/Legal Guardian Signature Date

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Illinois State Board of Education
New U.S. Department of Education Race and Ethnicity Data Standards

Student's Name: _____ **SIS ID:** _____ **Grade:** _____

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 all that apply.**

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. (American Indian or Alaska Native)

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.(Asian)

A person having origins in any of the black racial groups of Africa.(Black or African American)

A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.(Native Hawaiian or Other Pacific Islander)

A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.(White or Caucasian)

_____ _____
Parent/Guardian Signature **Date**

For Office Use Only:
Selection made by O/I :_____
Staff Initial

New Baden Elementary School
700 Marilyn Dr.
New Baden, IL 62265
(618) 588-3535
FAX (618) 588-4364

Trenton Elementary School
308 North Washington St.
Trenton, IL 62293
(618) 224-9411
FAX (618) 224-9417

Wesclin Middle School
10003 State Route 160
Trenton, IL 62293
(618) 224-7355
FAX (618) 224-7085

Wesclin High School
699 Wesclin Road
Trenton, IL 62293
(618) 224-7341
FAX (618) 588-9106

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Jennifer C. Filyaw, Superintendent

By mandate of the Illinois State Board of Education and the Board of Education of Wesclin CUSD # 3 anyone seeking to enroll a student is required to be able to prove that the students attending its schools are truly a resident of this school district. You will find residency requirements listed below. Please bring all documents with you to your appointment.

- A certified or registered birth certificate for the student
- Proof of residency within the District by providing the required number of documents from each of the following categories:

Category I (One document required)

Most recent property tax bill **and** proof of payment, e.g., cancelled check or Form 1098 (homeowners)

Mortgage papers (homeowner)

Signed and dated lease **and** proof of last month's payment, e.g., canceled check or receipt (renters)
Letter from manager **and** proof of last month's payment, e.g., canceled check or receipt (trailer park residents)

Letter of residence from landlord in lieu of lease.

Letter of residence to be used when the person seeking to enroll a student is living with a District resident.

Category II (Two documents *showing proper address* are required)

Driver's license

Vehicle registration

Voter registration

Most recent cable television and/or credit card bill

Current public aid card

Current homeowners/renters insurance policy and premium payment receipt

Most recent gas, electric, and/or water bill

Current library card (if it lists your name and address)

Receipt for moving van rental

Mail received at new residences

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Military Personnel Enrolling a Student for the First Time in the District

Must provide one of the following within 60 days after the date of student's initial enrollment

Postmarked mail addressed to military personnel

Lease agreement for occupancy

Proof of ownership of residence

Military Personnel Wanting to Keep Child/Ward Enrolled in the District Despite having Changed Residence Due to a Military Service Obligation. Upon submitting a written request, the student's residence will be deemed to be unchanged for the duration of the custodian's military service obligation. The District, however, is not responsible for the student's transportation to or from school.

Anyone with a Custody Order Seeking to Enroll a Student

Must present court order, agreement, judgment, or decree that awards or gives custody of the student to any person (including divorce decrees awarding custody to one or both parents.)

Non-Parent Seeking to Enroll a Student

Must complete and sign Evidence of Non-Parent's Custody, Control, and Responsibility of a Student form.

Important:

The School District reserves the right to evaluate the evidence presented, and merely presenting the items listed in this Procedure does not guarantee admission.

WARNING:

If a student is determined to be a nonresident of the District for whom tuition must be charged, the persons enrolling the student are liable for non-resident tuition from the date the student began attending a District school as a non-resident.

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A person who knowingly enrolls or attempts to enroll in this School District on a tuition-free basis a student known by that person to be a nonresident of the District is guilty of a Class C misdemeanor, except in very limited situations as defined in State law.

A person who knowingly or willfully presents to the School District any false information regarding the residency of a student for the purpose of enabling that student to attend any school in that District without the payment of a nonresident tuition charge is guilty of a Class C misdemeanor.

VERIFICATION OF IN-DISTRICT RESIDENCY

By mandate of the Illinois State Board of Education, the Board of Education of Wesclin CUD #3 is required to be able to prove that the students attending its schools are truly residents of this School. The only exception is for homeless children as defined by law. If parents/guardians wish to challenge the District's determination of non-residency they may do so in accordance with the policies adopted for such challenges which determination is final. Therefore, it is required that you provide the following residency verification.

I/We, the undersigned parent/guardian of the student provide the following information to Wesclin CUD # 3 to support our representation that the student is a legal resident of the District, and is entitled to attend the school as a resident without charge for tuition, but with a charge for certain fees.

Student's Name _____ **Date of Birth**_____

Student's Address: **Street** _____

City and Zip Code _____

Telephone(s) _____

Names of Adult(s) with whom student resides in District: _____

Relationship of adult(s) named above to student (mark one and explain if necessary):

_____ **Parent (includes natural and adoptive parents)**

_____ **Legal Guardian with Court Order (attach Court Order)**

_____ **Other (explain in detail why student is living with adult, and attach all relevant documentation)**

If student does not live with parent/guardian, please list parents'/guardian's residence.

_____

Attach any court order, decree, or other document establishing the custody and/or residency of the student.

If this student's parents/guardians have students enrolled in other districts, please list those districts.

_____

Certificate of Residency

I/We certify that the above information is accurate, and that the student is a resident of Wesclin School District. I/We understand that the District may request additional information from us. I /WE agree to notify the District within 7 days of any change of residence or change of address. I/We understand that should any information on this form, or any information otherwise provided the District be wrong, or if it is determined that the student is not a resident of the District, the student may be dismissed immediately from the District's school. The student and responsible adults shall reimburse the District for costs, including tuition for the time during which the student attended the District's schools. I/We recognize that any person who knowingly registers or attempts to register a student known by that person to be a non-resident of the District shall be subject to criminal prosecution.

DATED: _____

Signatures of Student's Parents/Guardian

_____

_____

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:**		
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?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	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	
Bone/Joint problem/injury/scoliosis?	Yes	No	

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian Signature **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** **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**