PARK FOREST – CHICAGO HEIGHTS SCHOOL DISTRICT 163

Dr. Joyce Carmine
Superintendent

242 S. Orchard Drive, Park Forest, IL 60466 Phone: 708-668-9400 Fax: 708-748-7071

STUDENT RECORD RELEASE

Former School Name: _____

Address: _____

Student's Name: _____

Date of Birth: _____ **Grade:** _____

Parent/Guardian authorization:
The above-mentioned student has enrolled in our district. Please forward all records to:

___ **21st Century Primary Center**
240 S. Orchard
Park Forest, Il 60466
Phone: 708-668-9490

___ **Algonquin Primary Center**
170 Algonquin
Park Forest, Il 60466
Phone: 708-668-9200

___ **Barack Obama School of Leadership and STEM**
401 Concord Drive
Chicago Heights, Il 60411
Phone: 708-668-9100

___ **Blackhawk Primary Center**
130 Blackhawk Drive
Park Forest, Il 60466
Phone: 708-668-9500

___ **Mohawk Primary Center**
301 Mohawk
Park Forest, Il 60466
Phone: 708-668-9300

___ **Michelle Obama School of Technology and the Arts**
530 Lakewood Blvd.
Park Forest, Il 60466
Phone: 708-668-9600

_____ _____
Signature of Parent/Guardian **Date**

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School District 163
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Phone: (708) 668-9400
Fax: (708) 748-7071
www.sd163.com

NEW STUDENT DATA FORM

Date: _____

***Please Print All Information**

Does your student receive any Special Education Services? Yes ☐ No ☐

Has your child ever been retained in a grade? Yes ☐ No ☐ **What Grade**___

Medicaid # _____

Grade Level: _____

Student's Legal Name: _____ _____ _____
Last **First** **Middle**

Date of Birth: _____ Gender (check one) Female ☐ Male ☐

Birth City: _____ Birth State: _____ Birth Country: _____

Ethnicity: (check one) No, Not Hispanic/Latino ☐ Yes, Hispanic/Latino ☐

Race: (check one or more if Multi Racial, check all that apply) American Indian or Alaska Native ☐

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

Home Language if other than English: _____

Primary/1st Parent/Legal Guardian (check one) Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Rev. ☐

This is the student's (check one) Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐

Grandparent ☐ Legal Guardian ☐ *Foster Parent(2nd parent-DCFS) ☐

Name: _____ _____ _____
Last **First** **Middle**

Address: _____

City: _____ State: _____ Zip Code: _____

Home/Primary Phone: _____ Cell Phone: (____) _____

Work Phone: (____) _____ E-Mail Address: _____

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*If 2nd Parent –DCFS Caseworker, Home phone # should be FAX number

Secondary/2nd Parent/Legal Guardian (check one):

Father ☐ Mother ☐ *Foster ☐ Guardian ☐ Step Parent ☐ Grandparent ☐

Name: _____ _____ _____
Last **First** **Middle**

Address: _____

City: _____ State: _____ Zip Code: _____

Home/Primary Phone: (____) _____

Cell Phone: (____) _____ Work Phone: (____) _____

Student Currently Lives with (check one): Parents (Both) ☐ Single Parent Home ☐

Guardian ☐ Foster Parent(s) ☐ Grandparent(s) ☐ Step Parent & Parent ☐

Does the Student have a Parent/Guardian currently serving in the Armed Forces? Yes ☐ No ☐

Is the Parent/Guardian currently deployed to Active Duty or is the Parent/Guardian expected to deploy during the school year? **Yes** ☐ **No** ☐

Is the Child a Foster Child/Ward of the Court? **Yes** ☐ **No** ☐

My child is to do the following in case of an emergency dismissal from school:

1. Come home. My child has a key available and can come into the house until an adult arrives. ☐

2. My child has permission to leave with the emergency contacts listed below. ☐

Emergency Contact # 1: _____ Phone: _____

Cell Phone: _____ Relationship: _____

Emergency Contact # 2: _____ Phone: _____

Cell Phone: _____ Relationship: _____

Emergency Contact # 3: _____ Phone: _____

Cell Phone: _____ Relationship: _____

Parent/Guardian Signature: _____ Date: _____

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STUDENT TRANSPORTATION FORM

Student's Name:_____ Grade:_____

Student's Address:_____

_____Walker _____Bus Rider _____Special Ed. _____Daycare ☐ AM ☐ PM

_____Walks with Siblings:_____

_____Gets picked up by:_____

Daycare Provider:_____Phone:_____

Daycare Contact:_____

Daycare Mode of Pick up: Bus:_____Van:_____Other:_____

Please list any individual(s) that you authorize to pick up your student. (Picture identification will be required).

Name of Individual	Relationship to Student
_____	_____
_____	_____
_____	_____

Although my child qualifies for busing, my student(s) **will not** require bus service at this time. I understand that I may utilize the bus service provided by School District 163 and that I must contact the transportation department in order for my child to begin riding the school bus to and from school.

My Child_____will not be riding the bus to and from school.

Parent Signature_____Date_____

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NEW STUDENT HISTORICAL INFORMATION PROFILE

Student's Name: _____ Birthdate: _____ Grade:_____

Has your child ever been retained in a grade? Yes ☐ No ☐

Has your child ever been enrolled in an Early Childhood Program, other than regular preschool?

Yes ☐ No ☐

Was the first language your child learned English? Yes ☐ No ☐

Can your child speak a language other than English? Yes ☐ No ☐

If yes, what language? _____

List previous school(s) your child has attended:

Kindergarten: _____ Fourth: _____
First: _____ Fifth: _____
Second: _____ Sixth: _____
Third: _____

Has your child ever received Physical or Occupational Therapy? Yes ☐ No ☐

What are your perceptions of your child's previous school experiences? _____
_____
_____

List any additional information that could help us to insure a successful year for your child: _____
_____
_____

Illinois State Board of Education

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

Note: The student's parents or guardians should respond to both questions (Part A and Part B). If the parents or guardians decline to respond to either question (Part A or Part B), school district staff are required to provide the missing information by observer identification.

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

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.

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Home Language Survey

Student's Name: _____

School: _____

Grade:_____

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 that need to be assessed for English language proficiency.

1. Is a language other than English spoken in your home? Yes ☐ No ☐

If yes, what language? _____

2. Does your child speak a language other than English? Yes ☐ No ☐

If yes, what language? _____

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

Parent/Guardian Signature: _____ Date: _____

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AUTHORIZATION FOR PHOTO/DIGITAL IMAGE

Safe Learning Environment

I understand that in order to maintain a safe learning environment for all children, the School District has installed audio/visual recording devices on school buses and in the common areas of the schools, that my child is subject to recording by these devices, and that these devices may be used by the District without the consent of me or my child. I understand that these recordings are not student directory information.

Use of Photo/Digital Image

I understand that the District has no control over a third parties' (for example, the parent of another student or a news media outlet) use or publication of photos, images, or videos it has taken of my child while s/he is participating in school or in school-sponsored activities, organizations, or athletics.

I understand that many opportunities exist at school and school related activities for my child to be photographed and/or video recorded. I understand that Park Forest – Chicago Heights School District 163 has the right to create these recordings of my child without the consent of me or my child.

I understand that the District uses photographs of students participating in school, school-sponsored activities, organization and athletics in its publications. I hereby give consent to the District to make use of and publish photographs and images of my child and to identify my child in District publications and materials including, but not limited to: newspapers, yearbooks, social media, and on District web pages. I understand that by giving my consent, the District may use images/photographs of my child without my prior approval of the particular image/photograph. I further understand that no compensation will be provided on the basis of the District's use of images/photographs of my child. I waive any rights that I or my child may have to the images/photographs of my child. I understand that I may revoke this consent at any time by *notifying* the building principal in writing; however, my child will still be subject to recording at school and school related activities, in school buses and in school common areas for security and safety purposes as specified above under Safe Learning Environment. This consent is valid for the 2016-2017 school year.

☐ **I DO give consent to the District to make use of and publish photographs and images of my child.**

☐ **I DO NOT give consent to the District to make use of and publish photographs and images of my child.**

☐ **I DO NOT give consent to the District to make use of and publish photographs of my child with EXCEPTION of the school yearbook.**

☐ **Child is Foster/Ward of the court.**

Child's Name: _____ Attendance Building: _____

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PARENTAL CONSENT FORM

Authorization for Electronic Network Access Form

Use of Internet

I understand and will abide by Park Forest – Chicago Heights School District 163's Authorization for **Electronic Network Access.** I understand that the District and/or its agents may access and monitor my use of the Internet, including my e-mail and downloaded material, without prior notice to me. I further understand that should I commit any violation, my access privileges may be revoked, and school disciplinary action and/or appropriate legal action may be taken. In consideration for using the District's electronic network connection and having access to public networks, I hereby release the School District and its Board members, employees, and agents from any claims and damages arising from my use of, or inability to use the Internet.

*** Students are required to have a parent/guardian read and agree to the following:**

I have read Park Forest – Chicago Heights School District 163's Authorization for Electronic Network Access. I understand that access is designed for educational purposes and that the District has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the District to restrict access to all controversial and inappropriate materials. I will hold harmless the District, its employees, agents, or Board members, for any harm caused by materials or software obtained via the network. I have discussed the terms of this Authorization with my child.

I hereby request that my child be allowed access to the District's Electronic Networks. I am aware that any unauthorized or misuse of the electronic network, or school technology, may result in loss of privileges, disciplinary action, possible referral for legal action, possible suspension, and/or expulsion. I will notify the school principal in writing, should I decide to revoke this decision.

Student/User Name (print)	Student Signature	Date
Parent/Guardian Name (print)	Parent/Guardian Signature	Date

Children's Names:

_____ _____

_____ _____

_____ _____

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PARENT/GUARDIAN – SCHOOL COMPACT

School: _____ Student: _____

School District 163 believes that all students can achieve, and that parent/guardian involvement helps to guarantee that success.

Our Title I grant requires that we have a Parent/Guardian – School Compact designed to outline activities which will help students succeed in school. We are asking all parents/guardians to help their child by verifying the following:

- I will review the school handbook.
- I will review the discipline policies with my child.
- I will establish a place in our house for my child to do homework.
- I will read notices sent home by the school.
- I will call the school to share my concerns.
- I will talk with my child, about school, several times a week.
- I will periodically review my child's homework.

THE SCHOOL WILL:

- Send home notices in a timely fashion
- Communicate concerns early
- Notify parents/guardians of student performance difficulties
- Review all homework
- Return student work in an appropriate time frame
- Review discipline policies at the beginning of the school year
- Establish and maintain a safe, secure learning environment
- Provide copies of all handbooks, rules and procedures
- Listen to your concerns and feedback

Signature: _____

Relationship: _____

Together We Can Help Our Students Achieve More

Rev. 5/16

PARK FOREST - CHICAGO HEIGHTS SCHOOL DISTRICT 163

PUPIL HEALTH INFORMATION FOR HEALTH OFFICE

2017 - 2018 SCHOOL YEAR

School: ☐ 21st Century ☐ Algonquin ☐ Barack Obama ☐ Blackhawk ☐ Mohawk ☐ M.O.S.T.A.

STUDENT'S NAME:_____ DOB:_____SEX:____GRADE:_____

PARENT'S/GUARDIAN'S NAME:_____ PHONE #:_____

ADDRESS:_____

In order to provide continuity of health care, please provide the following health information:

ALLERGIES: (list)_____

Does your child need an epipen at school for allergies: [ ] Yes [ ] No

ASTHMA: [ ] Yes [ ] No Age of Onset_____ Restrictions_____

CARDIAC CONDITION: [ ] Yes [ ] No Age of Onset_____ Restrictions_____

DIABETES: [ ] Yes [ ] No Age of Onset_____ Restrictions_____

DISABILITY: _____ Restrictions: _____

SEIZURE DISORDER: [ ] Yes [ ] No Frequency: _____ Date of Last Seizure: _____

Does your child have an emergency action plan for any of the above conditions and have you given the school a copy: [ ] Yes [ ] No

GLASSES: [ ] Yes [ ] No HEARING AID: [ ] Yes [ ] No

SURGERY: [ ] Yes [ ] No Type: _____ Age(s): _____

HOSPITALIZATIONS: (Ages) _____ (Reasons) _____

MEDICATIONS: Name:_____ Dosage: _____ Time: _____
(At home or at school)

OTHER: _____

_____

PREVIOUS SCHOOL ATTENDED IN DISTRICT 163 (Check all applicable):
☐ 21st Century ☐ Algonquin ☐ Barack Obama ☐ Blackhawk ☐ Mohawk ☐ M.O.S.T.A.

In case of accident or serious illness, I request that school personnel contact me. If I cannot be reached, I hereby authorize school personnel to call the paramedics to treat and transport my child to a medical facility at my expense.

I authorize the release of medical information including dental, vision, physicals and/or immunization records.

Signature: _____ Date: _____

D-7 Revised 4/16

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		Information may be shared with appropriate personnel for health and educational purposes				
Bone/Joint problem/injury/scoliosis?	Yes / No		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

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 _____

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)

Signature _____ Date _____

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

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

State of Illinois
Department of Public Health

DENTAL EXAMINATION WAIVER FORM

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):	

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).

☐ My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature _____ Date _____

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

December 2006

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

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Insert Sponsor Name

Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE
SCHOOL/FACILITY NAME	ADDRESS (Street, City, State, Zip Code)	

Parent/Guardian:

This school/facility participates in a federally-funded Child Nutrition Program and any meals, milk, and snacks served must meet program requirements. Reasonable food accommodations must be made when the accommodation requested is due to a disability and supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact _____ (*Name*) at _____ (*Telephone (Include Area Code)*).

PHYSICIAN STATEMENT

1. Does child have a disability according to 7 CFR Part 15d that requires food accommodation? *(Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?)*
   - ☐ No **If no, go to item 2 below.**
   - ☐ Yes **If yes, provide the following information and complete items 3, 4, and 5 below.**
   - a. What is the disability? _____
   - b. What major life activity is affected? _____
   - c. How does the disability restrict the diet? _____
2. Child has no disability but requires a special diet. Identify medical problem which restricts the child's diet and complete items 3, 4, and 5 below.
3. List food/type of food to be omitted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.
4. List food/type of food to be substituted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.
5. _____ (*Date*) _____ (*Signature of Physician*)
6. _____ (*Date*) _____ (*Signature of Parent/Guardian*)

FOR SCHOOL USE ONLY:

- ☐ Form received on _____.
- ☐ Form incomplete. Parent contacted on _____.
- ☐ Form complete. Accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable
- ☐ Form complete. Accommodations will begin on _____.

_____ (*Date*) _____ (*Signature of Food Service Director/Contact*)