Cook County School District 130
12300 S. Greenwood Avenue
Blue Island, IL 60406
Phone: 708-385-6800 Fax: 708-385-8467

Health Requirements

Any student entering Cook County School District 130 for the first time *must* have a current Illinois Physical examination regardless of grade.

- *Students transferring from another school in Illinois may use the Illinois physical examination from the last school attended, but must be provided to Cook County School District 130 within 30 days.*
- *Students transferring from another state have 30 days to obtain an Illinois physical examination.* ***Please note: No doctor appointment cards will be accepted.***
- *Students entering from outside of the USA must provide a current Illinois physical examination* ***BEFORE*** *starting school.*

- All Kindergarten and 6th grade students require a **new** Illinois physical examination prior to starting school.
- All Kindergarten, 2nd grade and 6th grade students should receive a dental examination or complete a waiver. The exam must be dated between May 15th of the previous school year and May 15th of the current school year.
- All Kindergarten and transfer students (from outside the state of Illinois) are required to have a vision examination. It must be completed by October 15th of the current school year.

All health requirements are due by the first day of school or the student may be excluded from school attendance until such information is received.

Illinois State Law Requirements for school entry by grade

Grade Level	Documentation Needed
Preschool Required documents are included in the screening packet	- Illinois Physical including updated immunizations
Kindergarten Required documents were included in the end of the year registration packet	- New Illinois Physical examination including updated immunizations - Dental Exam - Professional Eye exam
Second Grade Required documents were included in your child's 3rd quarter report card	- Dental Exam
Sixth Grade Required documents were included in your child's 3rd quarter report card	- New Illinois Physical Examination including updated immunizations - Dental Exam

Blank Health Forms are available on the District Website in the registration tab.

May 2016

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Requisitos de Salud

Cualquier estudiante que entre a cualquier escuela en el Distrito de Condado de Cook District 130 por primera vez deberá de obtener un examen físico del estado de Illinois Sin tener en cuenta el grado

- *Los estudiantes que se trasladan de otra escuela en Illinois pueden usar el examen físico de Illinois de la última escuela asistida, pero deben proporcionar una copia al Distrito 130 dentro de 30 días.*
- *Los estudiantes que se trasladan de otro estado tienen 30 días para obtener un examen físico de Illinois.* ***Tenga en cuenta: No se aceptan tarjetas de cita con el médico***
- *Los estudiantes que entran desde fuera de los EE. UU deben proporcionar un examen físico de Illinois corriente* ***ANTES*** *del inicio de escuela.*

Todos los estudiantes de Kínder y 6° grado requieren un **nuevo** examen físico de Illinois antes de iniciar en la escuela.

Todos los estudiantes de Kínder, 2° grado y 6° grado deberán de recibir una examen dental o llenar un formulario de renuncia. El examen deberá de tener la fecha entre 15 de Mayo del año corriente al 15 de Mayo del próximo año escolar.

Se requiere que todos los estudiantes de Kínder y estudiantes que se transfieren a nuestras escuelas del Distrito 130 (desde fuera del estado de Illinois) tengan un examen de visión. Esto debe ser completado para el 15 de octubre del año escolar corriente.

Todos los requisitos de salud deben presentarse antes del primer día de clases si su hijo(a) no cumple con estos requisitos estará en riesgo de ser excluido de la asistencia a la escuela hasta que se reciba dicha información

Requisitos de la ley del Estado de Illinois para el ingreso escolar por grado

Nivel Escolar	Documentación Requerida
Pre escolar documentos requeridos están incluidos en el paquete pre escolar	- Examen físico incluyendo la más reciente boleta de vacunas
Kínder documentos requeridos se incluyeron en el paquete de inscripción anual al final del año escolar	- Examen físico del estado de Illinois **Nuevo** incluyendo la mas reciente boleta de vacunas - Examen Dental - Examen profesional de visión
Segundo Grado documentos requeridos fueron incluidos en la libreta de calificaciones tercer trimestre de su hijo	- Examen Dental
6 Grado documentos requeridos fueron incluidos en la libreta de calificaciones tercer trimestre de su hijo	- Nuevo Examen físico del Estado de Illinois incluyendo la tarjeta de vacunas al corriente - Examen Dental

Formas de Salud están disponibles en el sitio web del distrito en la ficha de inscripción.

May 2016

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						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments:

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
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

Estado de Illinois
Departamento de Salud Pública

FORMULARIO COMPROBANTE DEL EXAMEN DENTAL ESCOLAR

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

Nombre del Estudiante: Apellido	Nombre	Inicial		Fecha de Nacimiento: / / (Mes/Día/Año)
Dirección: Calle	Ciudad	Código Postal		Número de Teléfono:
Nombre de la Escuela:		Grado:		Sexo: ☐ Masculino ☐ Femenino
Nombre del padre/madre o encargado:		Dirección del padre/madre o encargado:		

To be completed by dentist: (Para ser completado por el dentista:)

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

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Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Departamento de Salud Pública de Illinois, División de la Salud Oral
217-785-4899 • TTY (sólo para personas con impedimento auditivo) 800-547-0466 • www.idph.state.il.us

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