PARK FOREST - CHICAGO HEIGHTS SCHOOL DISTRICT 163

PUPIL HEALTH INFORMATION FOR HEALTH OFFICE

2016-17 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? / Child wakes during night coughing?	Yes / Yes	No / 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**	

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
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

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 _____ (Month/Day/Year) Gender _____ Grade _____

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

IOE H271-09

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*

CONSENT FOR DENTAL SERVICE

The Heart That Smiles has arranged for dental services for eligible children. These services may include exam, cleaning, fluoride treatment, and sealants (a protective coating on the chewing services of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment at an **announced time during the school year. If you would like your child to participate please complete the below information and return it to your child's school. This signed consent includes initial visit and 6-month follow-up if scheduled.** This will also give permission for IDPH Quality Assurance Audits to be performed and providers to return to your school to recheck your child's sealants.

School Name _____ Classroom _____ Home Phone _____

Student Name _____ Date of Birth _____ Grade _____ Gender _____

Home Address _____ Apartment # _____ Zip Code _____

Has your child had any history of, or conditions related to, any of the following:
___ Anemia ___ Chronic Sinusitis __Growth problems __ Seizures ___Asthma ___ Diabetes
___ Hearing __Thyroid ___Bleeding disorders ___Ear aches___ Heart___ Tobacco/ drug use
___Cancer ___ Epilepsy ___ Latex allergy___ Fainting___ Cerebral Palsy___ Pregnancy (teens)
Other_____
Is your child taking any prescription and/or over-the-counter medications at this time? Yes No
If yes, please list: _____
Does your child have any speech difficulties? Yes No
Has your child ever suffered injuries to the mouth, head, or teeth? Yes No

Medicaid/ Illinois ALL KIDS: If your child is covered by ALL KIDS, please include ID number:

_ _ _ _ _ _ _ _ _ _

Name of private dental insurance: _____
Insurance Telephone Number _____- _____Group Number _____
Employer Name _____
Name of Insured _____ Date of Birth of Insured_____
Social Security Number of Insured Person _____

<u>If No Dental Insurance Please Check Box Below</u>

☐ I have no dental insurance and I would like someone to contact me about how I can still receive these great services.

SIGNATURE:_____ **Date:**_____

By signing this form, you give permission to treat your child. Our privacy policy is available on our website. Copies available upon request. A report card will go home with your child following the dental visit. If you do not receive a form please call us at number listed below.

19900 Governors Dr., STE 103, Olympia Fields, IL 60461 | Phone: 708-808-4950 Fax: 708-794-0466 E-Mail: info@heartsmiles.org
Web: www.heartsmiles.org