Raccoon Grade School Registration Dates

Registration will be held on Tuesday, July 28th from 2:00p.m to 7:00p.m. and Wednesday, July 29th from 10:00a.m. to 4:00p.m.

The school requests that only one parent/guardian comes to register their child or children. Please do not bring any children with you. Please wear a face mask. Social distancing will be promoted. Please enter through the cafeteria doors and you may sit at the cafeteria tables in designated spots and will be called into the registration area when it's your turn.

Please review the following attachments (if applicable for your child) for further guidance for registration.

The school supply list will be updated very soon.

Students entering <u>Kindergarten and all New Students</u> must bring the following documentation from <u>Categories I AND II</u> to registration.

Please submit the following required documentation from **Categories I and II**

Category I (one document establishing property within the District)

a. Most recent property tax bill (homeowners)
b. Mortgage papers (homeowners)
c. Deed
d. Signed and dated lease and proof of last two months' payments if lease is not at its inception (canceled check or receipts required) (renters).
e. Housing letter (military personnel)
f. Letter from manager and proof of last two month's payments (canceled checks or receipts required) (renters or trailer park residents)
g. An agreement of sale for a residential property located within the District, signed by the seller and parent/custodian as buyer, which recites a closing date prior to the first day of attendance (new residents).
h. Notarized affidavit of residency from the resident owner of property within the District where the parent/custodian of the child is living with the owner at no cost (those living with relatives or others).

Category II (one document establishing an address within the district)

a. Driver's license
b. Vehicle registration
c. Current public aid card
d. Current library card and premium payment receipt.
e. Voter registration
f. Most recent utility bill and/or credit card bill
g. Current homeowner/renters insurance policy

RACCOON CONSOLIDATED SCHOOL DISTRICT NO. 1

3601 State Route 161, Centralia, IL 62801
Phone (618) 532-7329 FAX (618) 532-7336

Pre-K Students

Dear Parent/Guardian:

Welcome to Raccoon School! This letter explains what we need from you for your child to attend.

SCHOOL PHYSICAL: Students entering any Illinois school are required to have a current school physical. It must be done on the attached form and can be completed by a physician, physician's assistant, or an advanced practice nurse. Preschool physicals are good for two years prior to the first day of school. Parents must complete and sign the top part of the "health history" prior to the exam.

IMMUNIZATIONS: All students must show proof of a series of immunizations which include: DPT, IPV/OPV, MMR, HEP B, and Varicella. Please make sure the boosters were given on or after the 4th birthday.

LEAD SCREEN: Elevated lead levels in the blood can cause permanent neurological damage. To help prevent this, Illinois has a lead Prevention Act to locate children in certain areas of "high" and "low" risk. Your physician should be doing a lead assessment questionnaire.

BIRTH CERTIFICATE: All students must file a copy of the birth certificate in the office. A hospital certificate is not a legal document. It must be a copy from the courthouse of the county in which the child was born. It will have a "seal".

If your child has any special medical needs or concerns, please notify me. Thank you!

Sincerely,
Kristin Inlow BSN, RN
Raccoon School Nurse
kinlow@raccoonschool.org
Phone: 618-532-7329
Fax: 618-532-7336

Health Requirements for Kindergarten

Birth Certificate: A copy of the state issued official birth certificate, not the certificate from the hospital.

School Physical: ALL students entering Kindergarten must have a school physical exam completed PRIOR TO REGISTRATION!! Please complete the top half of the back page of the "health history" so the physician may review it

Immunizations: Please note these requirements!

Tdap (tetanus, diphtheria, pertussis) – Last dose (booster) on or after 4th birthday (Total of 4 + doses)
Varicella (chicken pox)—must have two doses given at recommended intervals
Polio – Last dose (Booster) on or after 4th birthday (total of 4 doses)
MMR (measles, mumps, rubella) - must have two doses given at recommended intervals

If your family doctor doesn't give immunizations, you can go to the Marion County Health Dept., call 532-6518 or 548-3878 for an appointment.

Dental Exams: ALL students entering Kindergarten must have a dental exam. If you do not have a family dentist, Miles of Smiles will be coming to the school next year to provide exams and some treatments as needed. You can sign up during registration day.

Vision Exams: ALL students entering Kindergarten must have a vision exam completed PRIOR to registration.

Steps to remember:
1. Call today for physical exam appointment.
2. Call today for immunization appointment if needed.
3. Complete the top half of the back side of the physical form.
4. Bring the completed form on registration day next August, or you can turn in to the Raccoon nurse anytime this spring if done before school is out.

ATTENTION!!!!
Last year at registration there were 20+ students who did not have physicals/immunizations done nor appointments made and most said they knew nothing about the requirement.

If you do not have the required physical and immunizations by registration, you **must** have it completed before the 1st day of school or your child will not be able to attend. If you are unable to get in to the doctor before school starts, I will have to have proof of an appointment before they will be allowed to attend.

Please take this seriously to avoid any interruption in your child's education and please share this information with anyone you know who has a student entering Kindergarten.

Please call with any questions or concerns.

Kristin Inlow RN, BSN
School Nurse
kinlow@raccoonschool.org
Phone: 532-7329
Fax: 532-7336

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING (410 ILCS 45/6.2)

Name _____ Today's Date _____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes No Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher?	Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area?	Yes No Don't Know

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _____ Test 2: Blood Lead Result_____mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_____ _____

Signature of Doctor/Nurse Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

Health Requirements for 2nd grade

Dental Exams: ALL students entering 2nd grade must have a dental exam completed by a dentist. If you do not have a family dentist, Miles of Smiles will be coming to the school next year to provide exams and some treatments as needed. You can sign up during the registration day.

Steps to remember:

1. Call today for Dental Exam appointment
2. Bring the completed form on registration day, or you can turn in to the Raccoon nurse anytime this spring if done before school is out.

Please call with any questions or concerns.

Kristin Inlow RN, BSN
School Nurse
kinlow@raccoonschool.org
Phone: 532-7329
Fax: 532-7336

Health Requirements for 6th grade

School Physical: ALL students entering 6th grade must have a school physical exam completed PRIOR TO REGISTRATION!! This physical exam will also meet the requirement for sports as long as the healthcare provider marks the appropriate box on the back of the form. If your child plays a sport over the summer, please keep an extra copy of the physical for registration day. Make sure to complete the top half of the back page, the "health history", so the primary care provider can review it.

Immunizations: Please note these requirements!

Tdap (tetanus, diphtheria, pertussis)—one dose should be given
Meningococcal—one dose should be given (first dose given on or after 11th birthday and second dose will be given after 16th birthday)

If your family doctor doesn't give immunizations, you can go to the Marion County Health Dept., call 532-6518 or 548-3878 for an appointment.

Dental Exams: ALL students entering 6th grade must have a dental exam completed by a dentist. If you do not have a family dentist, Miles of Smiles will be coming to the school next year to provide exams and some treatments as needed. You can sign up during the registration day.

Steps to remember:

1. Call today for physical exam appointment.
2. Call today for immunization appointment if needed.
3. Complete the top half of the back side of the physical form.
4. Call today to make an appointment for the dental exam.
5. Bring the completed forms on registration day or you can turn in to the Raccoon nurse anytime this spring if done before school is out.

ATTENTION!!!!

Last year at registration there were 20+ students who did not have physicals done nor appointments made and most said they knew nothing about the requirement.

If you do not have the required physical and immunizations by registration, you must have it completed before the 1st day of school or your child will not be able to attend. If you are unable to get in to the doctor before school starts, I will have to have proof of an appointment before they will be allowed to attend.

Please take this seriously to avoid any interruption in your child's education and please share this information with anyone you know who has a student entering 6th grade.

Please call with any questions or concerns.

Kristin Inlow RN, BSN
School Nurse

State of Illinois
Certificate of Child Health Examination

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle		Month/Day/Year			
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.

↓To Be filled out by Parent or Guardian ↓

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

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 ☐

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 _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

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)

Address _____

_____

Phone _____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois
6/09

IOC11271-09