



Registration & Residency Requirements

All students must register each year in the school that they will be attending.

When a child is registering in District 204 for the first time, a parent or guardian must provide proof of identity and age by providing one of the following documents:

- original or certified copy of a birth certificate,
- valid passport, or
- other record recognized by a court of law.

In addition, the parent or guardian must provide disease immunization records as required by State law, the required physical examination signed by the student's physician, a vision examination, and proof of residence. Proof of residency is also required when a change of address occurs.

To meet the proof of residency requirements, a parent / guardian must submit one document from each of the following groups (for a total of three documents):

- **Group A:** Title evidence, mortgage, or lease agreement;
- **Group B:** Utility Bill (such as an electric bill, gas bill, or home phone bill); a cell phone bill is not a utility bill and will not be accepted
- **Group C:** Illinois Drivers License, Illinois State Identification Card, other acceptable photo identification, tax bill, voter's registration card, library card, loan payment book, home insurance policy, bank account paperwork, medical card, Green card.

Transfer students must provide student records and a "good standing" letter from the transfer school.

The building principal or designee is responsible for collecting this information before enrollment.

Please submit the required documents to the school office where the student will be attending. If you have questions about these documents or other registration and enrollment procedures, please do not hesitate to contact the school office or the IPSD 204 District Education Center at 630.375.3020.

2008-2009 New Student Registration

School: _____ 2008 – 2009 Grade: ____ Entry Date: ___/___/___

STUDENT INFORMATION

Student Name: _____
First Middle Last Jr., Sr., III
 Sex: F M Social Security Number: ____ - ____ - ____ US Citizen: Y N
Circle one Circle one
 Birthday: ___/___/___ Birth Place: _____ First Year in US School: Y N
Circle one
 Ethnicity **: ____ Country of Birth: _____

Mother's Maiden Name:

Has this student attended a District 204 school before? : Y N
Circle one

PREVIOUS SCHOOL ATTENDED
 Name: _____ Telephone: _____
 Address: _____
 City/State/Zip: _____

**** Statement of Voluntary Ethnic Information:**

Government agencies require periodic reports on the sex and ethnicity of students. This data is for analysis & reporting only.
 Submission of information is voluntary.

The codes available are as follows: WN = White (Non-Hispanic) BN = Black (Non-Hispanic) HS = Hispanic MR = Multi-Racial
 AP = Asian or Pacific Islander AA = American Indian or Alaskan Native UU = Unknown/Undeclared

HOUSEHOLD / PARENT / GUARDIAN INFORMATION

Parent/Guardian Name: _____ Cell Phone: (____) ____ - ____ Pager: (____) ____ - ____
First Middle Last
 Household: Primary Secondary Relationship: _____ E-Mail 1: _____
Circle one
 Address: _____ APT: _____ E-Mail 2: _____
 City, State, and Zip: _____ Home Telephone: (____) ____ - ____
 Subdivision: _____ Work Phone: (____) ____ - ____ EXT: _____
 Employer Name: _____ Alternate Telephone: (____) ____ - ____
 Do you wish the address to be kept private: Y N Do you wish the phone to be kept private: Y N
Circle one Circle one
 Do you wish to receive school mailings at this address: Y N
Circle one

Parent/Guardian Name: _____ Cell Phone: (____) ____ - ____ Pager: (____) ____ - ____
First Middle Last
 Household: Primary Secondary Relationship: _____ E-Mail 1: _____
Circle one
 Address: _____ APT: _____ E-Mail 2: _____
 City, State, and Zip: _____ Home Telephone: (____) ____ - ____
 Subdivision: _____ Work Phone: (____) ____ - ____ EXT: _____
 Employer Name: _____ Alternate Telephone: (____) ____ - ____
 Do you wish the address to be kept private: Y N Do you wish the phone to be kept private: Y N
Circle one Circle one
 Do you wish to receive school mailings at this address: Y N
Circle one

OFFICE USE ONLY

Birth Certificate [] Residency [] Medical [] IPEF [] Handbook [] Fees [] Internet [] Home Language Survey []
 Milk [] Technology [] SSN [] ISBE [] Permission []

Records Request Sent _____, Received _____, District ID _____ State ID _____

2008-2009 New Student Registration

- continued -

EMERGENCY CONTACT INFORMATION

Please list at least 2 (two) contacts in the immediate area to call if you are unavailable.

Contact Name: _____
 First Last

Contact Type: _____

Telephone: (____) _____ - _____

Alternate Telephone: (____) _____ - _____

Contact Name: _____
 First Last

Contact Type: _____

Telephone: (____) _____ - _____

Alternate Telephone: (____) _____ - _____

CHILD CARE/DAY CARE PROVIDER

Circle Days Attending: **M** **T** **W** **TH** **F**

Provider Name: _____ Telephone: (____) _____ - _____

Address: _____ Suite/APT: _____

City, State, and Zip: _____ Alternate Telephone: (____) _____ - _____

BROTHERS & SISTERS

(Include Pre-School)

Name: _____ Birthday: __/__/____ School: _____ Grade: ____

Name: _____ Birthday: __/__/____ School: _____ Grade: ____

Name: _____ Birthday: __/__/____ School: _____ Grade: ____

ADDITIONAL INFORMATION

Use this space to add any Student, Household, Guardian or Emergency Contact information.

Home Language Survey

Dear Parent/Guardian,

The Federal NCLB-Title III Act and the Illinois School Code require that each school district administer a Home Language Survey to every student entering the district's schools for the first time. This information is used to report to the state the number of students whose families speak a language other than English. It also helps to identify the need for English Language Learning services in the schools. Your cooperation in helping us meet this important legal requirement is appreciated.

Student Name _____ Grade _____

School _____ Birthdate _____ Gender _____

Country of Birth _____ Home Phone Number _____

1. Is a language other than English spoken in your home? YES NO

If yes, what language? _____

2. Does this student speak a language other than English? YES NO

Note: Foreign languages the student has learned in school do not count.

What language, other than English, does this student speak? _____

Can the student read this language? YES NO

Can the student write this language? YES NO

****** If the answers to question #1 AND # 2 are both NO, you may stop here. If the answer to EITHER question is YES, please continue. ******

3. Which language is spoken most often in your home? _____

Please be specific. (example: Mandarin, not Chinese)

4. Does this student

...understand English? YES NO ... speak English? YES NO

...read English? YES NO ... write in English? YES NO

5. Which language does this student speak most often with his/her parents? _____

6. Which language does this student speak most often with his/her friends? _____

7. Where did this student attend school last year? _____

8. Was this student in a bilingual or ELL/ESL program during the last school year? YES NO

9. Was this student ever in a Bilingual or ELL/ESL program? YES NO

If yes, what grade(s)? _____ where (school/city)? _____

10. If you speak a language other than English, would you be willing to occasionally translate at school if needed? YES NO

Parent/Guardian Signature

Date

Revised August 2007

O F F I C E U S E O N L Y

HOME LANGUAGE on student's language record will match language listed in question 3.
OTHER LANGUAGE on the student's language record will match language listed in question 1.

Permissions

Student Name _____ School _____

ATTENTION PARENTS

From time to time, your student's photograph/picture may appear in various in-district and out-of-district publications such as newsletters, school newspapers, and yearbooks, web pages, communications to parents or guardians, textbooks, newspapers, and/or videos. This also applies to PTA and Indian Prairie Educational Foundation publications.

If you do **NOT** wish to have your student's information/picture appear in such publications, **please mark** the appropriate boxes below.

Marking **YES**, gives permission to use the student's information. Marking **NO**, denies permission to use the student's information.

If all boxes remain unchecked for a statement, you will be giving permission to have your student's information appear in both in-district or out-of district publications and the school PTA directory.

PERMISSIONS

DISTRICT PRINT PUBLICATION:

My student's picture and/or name may appear in District print publications.

YES NO

My student's picture and/or name may appear on District 204 web pages.

YES NO

My student's work may appear on District 204 web pages.

YES NO

PERMISSIONS

SCHOOL PTA DIRECTORY:

PTA may use my student's name.

YES NO

PTA may use my student's address.

YES NO

PTA may use my student's telephone number.

YES NO

PTA may use my student's Parent or Guardian Name.

YES NO

INFORMATION RELEASE FOR MILITARY RECRUITMENT:

Federal Law requires the district to release directory information, including a student's name, address, and telephone number, to military recruiters unless the parent objects in writing. If you do **NOT** want this information released to military recruiters, check the **NO** box below.

My student's directory information may be released to military recruiters.

YES NO

SCHOOL NEWSLETTER AVAILABILITY:

Instead of mailing me a copy of the latest school newsletter, please notify me via E-mail that it is available to read on the school's website. If you check the "Yes" box, Please be sure to write your Email address on the "Registration" form.

YES NO



INDIAN PRAIRIE SCHOOL DISTRICT

Instructional Technology
Jeffrey L. Hunt, Ed.D, Director
jeff_hunt@ipspd.org

March 2008

Dear Parents,

The Internet is a valuable part of Indian Prairie School District's educational mission. On-line databases, on-line content from universities and governmental agencies, and on-line tutorials are just a few Internet sites that our students and faculty use in their daily learning activities. Even with these valuable resources, the district shares parents' concerns about Internet use by children. Having high parental expectations of proper use, adult supervision at school, and required electronic filtering, the Internet is not perfect. There is a rare possibility that a student could be exposed to material that is inappropriate in a school setting.

To address this parental concern, Indian Prairie School District 204 uses an opt-out policy from Internet activities. The Board of Education's Internet Policy (645) outlines Internet use at schools. If parents decide that their children should not participate in Internet activities, the parents should sign the opt-out form that is available from the school's office or on-line (http://board.ipspd.org/policy/sec6/645_e2.pdf). This exclusion needs to be signed only once when a student enters a school or changes levels, such as when advancing from elementary school to middle school. Please return the opt-out form to the school's office with the registration materials.

With a parental signature on the form, students will not participate in any Internet activity that is on the public Internet, although students will be able to use the district's web-based library circulation system, District 204's curricular resources, like *Blackboard*, and the district's subscriptions to on-line databases along with other district electronic resources.

We thank you for your continued support of technology activities. If you have any questions, please contact your school's principal or me at 375-3000.

Yours truly,

Jeffrey L. Hunt, Ed. D
Director, Instructional Technology

P R E P A R I N G A L L S T U D E N T S T O S U C C E E D

District Education Center

P.O. Box 3990, Naperville, IL 60567

phone: 630-375-3000 • fax: 630-375-3007 • web: it.ipspd.org

**ELECTION BY PARENT/GUARDIAN
TO EXCLUDE STUDENT FROM INTERNET USE
AND PARTICIPATION IN INTERNET BASED ACTIVITIES**

TO: Indian Prairie Community Unit
School District No. 204
P.O. Box 3990
Naperville, Illinois 60567

Student's Name: _____ Birth Date: _____
School Attended: _____ Grade: _____

To Whom It May Concern:

The undersigned, being the parent or guardian of the above-named student, acknowledge that I am familiar with the policies and procedures of the Board of Education relating to Access to the Internet, and hereby request that such student be excluded from using the Internet as part of the educational program at his/her school and be excluded from participation in Internet based instructional activities. I recognize that it is not always practical or possible to monitor student activity at every moment of the school day, and acknowledge that this exclusion is intended to restrict Internet use that is part of the supervised instructional program at the school, and is not intended to guarantee that my child will not seek or gain unapproved access to the Internet at other times during the school day. I further understand that this exclusion will not prohibit the student from using the web-based electronic card catalog and other curriculum resources that are under the domains of School District 204 (ipspd.org and ipspd.net). This election shall remain in effect so long as the referenced student remains at the school that he/she currently attends.

Signature of Parent/Guardian Date

Name of Parent/Guardian (Please Print)

Street Address

City/State ZIP Code

Phone No. During School Hours

Adopted: 05/03/2004



INDIAN PRAIRIE SCHOOL DISTRICT

Elementary School Fee Statement 2008-09 School Year

School _____

Student Name:	Grade:	Parent/Guardian Name:	
Address:		City:	Zip:

Instructions:

1. Place a check mark after the applicable Required Fees and after Optional Fees you select.
2. Total the fees.
3. Make payment by check or money order to **IPSD 204**, or **set up an online Café Prepay Account – see attached sheet for instructions!** (*on-line is only available to returning IPSD students*)
4. Sign your name and date this statement.
5. Return statement and payment to the elementary school. **If you have made your payment through Café Prepay please attach a copy of the confirmation. (Transaction ID# _____)**
6. Insurance fees are separate. See the insurance packet for further instructions.

REQUIRED FEES*:	(✓)	
Kindergarten – <u>Half Day</u> (Includes \$10 technology fee.)		\$45.00
Kindergarten – <u>Full Day & Grades 1 – 5</u> (Includes \$10 technology fee.)		\$80.00
OPTIONAL FEES:		
Milk (Kindergarten – Full Day & Grades 1 – 5 per year)		\$15.00
✓ Indian Prairie Educational Foundation		\$15.00
TOTAL:		

Parent/Guardian Signature: _____ Date: _____

*If you believe that you are eligible for a fee waiver, please complete the Application for Free Milk and/or Illinois Free Lunch Form. These applications are available after July 1st in the school office or in the back of the Parent-Student Handbook when published.

✓The *Indian Prairie Educational Foundation* fee is a tax-deductible donation to support educational enrichments such as the science fair, artist-in-residence programs, teacher mini-grants, and the Fine Arts Festival.



INDIAN PRAIRIE SCHOOL DISTRICT

Middle School Fee Statement 2008-09 School Year

<i>Select Middle School</i>		
<input type="radio"/> Crone	<input type="radio"/> Granger	<input type="radio"/> Gregory
<input type="radio"/> Hill	<input type="radio"/> Scullen	<input type="radio"/> Still

Student Name:	Grade:	Parent/Guardian Name:	
Address:		City:	Zip:

Instructions:

- Place a check mark after the applicable Required Fees and after the Optional Fees you select.
- Total the fees.
- Make payment by check or money order to **IPSD 204**, or **set up an online Café Prepay Account – see attached sheet for instructions!** (*on-line is only available to returning IPSD students*)
- Sign your name and date this statement.
- Return statement and payment to the middle school.
If you have made your payment through Café Prepay please attach a copy of the confirmation. (Transaction ID# _____)
- Insurance fees are separate. See the insurance packet for further instructions.

REQUIRED FEES*:	(✓)	
Grades 6-8 (Registration \$90 and Technology \$25)		\$115.00
OTHER:		
✓Indian Prairie Educational Foundation		\$15.00
TOTAL: (check or money order payable to IPSD 204)		

Parent/Guardian Signature: _____ Date: _____

Note:

- **Fees for athletics / activities are collected by the appropriate coach or teacher.

*** Athletic & Activity fees are charged per sport or activity at \$50 each. The maximum charge is \$100, regardless of the number of sports or activities in which the student is involved. Fees for Athletic, Cheerleading, Band or Choral uniform cleaning/replacement, and Solo and Ensemble contest participants are collected by the appropriate coach or teacher. Additional fees will also apply to courses that use consumable materials, including workbooks and supplies, as part of the coursework for certain classes. Specific fee information will be available soon.*

*If you believe that you are eligible for a fee waiver, please indicate on the above statement and return it with your registration information. The 2008-09 *Application for Free Milk* and/or *Illinois Free Lunch Form* will be available in the school office beginning mid-July, 2008.

✓The *Indian Prairie Educational Foundation* fee is a tax-deductible donation to support educational enrichments such as the science fair, artist-in-residence programs, teacher mini-grants, and the Fine Arts Festival.



INDIAN PRAIRIE SCHOOL DISTRICT

High School Fee Statement 2008-09 School Year

Select High School

- Neuqua Valley
- Waubonsie Valley

Student Name:	Grade:	Parent/Guardian Name:	
Address:		City:	Zip:

Instructions:

- Place a check mark after the applicable Required Fees and after the Optional Fees you select.
- Total the fees.
- Make payment by check or money order to **IPSD 204**, or **set up an online Café Prepay Account – see attached sheet for instructions!** (*on-line is only available to returning IPSD students*)
- Sign your name and date this statement.
- Return statement and payment to the appropriate high school.
If you have made your payment through Café Prepay please attach a copy of the confirmation. (Transaction ID# _____)
- Insurance fees are separate. See the insurance packet for further instructions.

REQUIRED FEES*:	(✓)	
Grades 9-12 (Registration \$100 and Technology \$30)		\$130.00
OTHER:		
Athletic Activity Ticket (provides entrance to all home athletic events excluding regional, sectional, state contests and tournaments.)		\$15.00
✓Indian Prairie Educational Foundation		\$15.00
TOTAL: (check or money order payable to IPSD 204)		

Parent/Guardian Signature: _____ Date: _____

I have received the 2008-2009 Attendance/Discipline Code and Athletic Code:

Parent Signature _____ Date _____ Student Signature _____ Date _____

Note:

- Athletics / Activities (\$80 / \$160 maximum) are collected by the appropriate coach or teacher.
- Fees associated with specific courses are collected by the course teacher.

* If you believe that you are eligible for a fee waiver, please complete the *Application for Free Milk and/or Illinois Free Lunch Form*. These applications will be available in the school office in mid-July, 2008.

✓ The *Indian Prairie Educational Foundation* fee is a tax-deductible donation to support educational enrichments such as the science fair, artist-in-residence programs, teacher mini-grants, and the Fine Arts Festival.

OFFICE USE: Check/Café Prepay _____ Amount _____ Dated _____ Received _____



INDIAN PRAIRIE SCHOOL DISTRICT

2008 – 2009 On-Line Report Card Letter

Beginning with the 2008 – 2009 school year, Academic Report Cards will not be mailed to parents with 6th - 12th grade students who have Internet access.

If you have Internet access, you may view your student's report card at:

<http://gradebook.ipSD.org>

Progress Reports will continue to be viewed on-line.

Please check the box below if you do not have Internet Access. If you do not have Internet access, your student's Academic Report card will be mailed to you.

I do not have Internet access.

Parent Signature: _____

School Name: _____

Student Name: _____ Student ID: _____

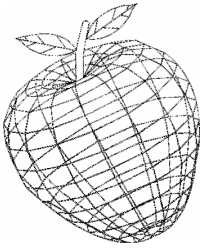
Please return this form to the Guidance Office at your student's school.

P R E P A R I N G A L L S T U D E N T S T O S U C C E E D

Crouse Education Center

P.O. Box 3990, Naperville, IL 60567

phone: 630-375-3000 • fax: 630-375-3001 • web: www.ipSD.org



Indian Prairie Educational Foundation

P.O. Box 3990
Naperville, IL 60567-3990

Dear Parents,

Since 1988, the Indian Prairie Educational Foundation has complimented and enhanced the educational experience of students attending District 204 schools. Through private donations, the Foundation provides support for program enrichments not normally financed with tax dollars. To date, the Foundation has contributed more than \$2 million to support "educational extras" that make the difference between a good school system and an excellent one.

Some of the Foundation's programs include:

- The Fine Arts Festival, a showcase featuring the artistic and musical talents of our students throughout the district.
- The Artist-in-Residence program, which brings artists in the areas of art, literature, and music into classrooms to work directly with students.
- Mini-grants for teachers, which provide enrichments in all areas of the curriculum and at all grade levels.
- Funding for high school lab equipment to support student work on the Human Genome Project.
- Sound and lighting enhancements to the auditorium/gymnasium spaces at each school.

I am grateful to our parents for the past contributions that have helped support the Foundation. Your support has enabled us to provide wonderful opportunities to students throughout our district. With your ongoing assistance, we can continue to fund programs that enrich our students' educational experience. On your registration form, please consider making a \$15 contribution to the Indian Prairie Educational Foundation.

If you would like more information on the Foundation, you can visit our web site at <http://ipef.ipisd.org> or call me at 630-904-4006. Thank you and have a wonderful year.

Sincerely,

Alan Fry
Chairman
Indian Prairie Educational Foundation



INDIAN PRAIRIE SCHOOL DISTRICT

Dear Parent/Guardian:

Welcome to Indian Prairie School District. The purpose of this letter is to inform you of the health examination and immunization requirements in Illinois and the policy of the school district. Indian Prairie School District will follow the mandates of the Illinois Department of Public Health with regards to required immunizations for our students.

- Students entering preschool, kindergarten, sixth, and ninth grades, and new students to the district, must present proof of the required state of Illinois physical examination and immunizations. If this is not completed, the student will be excluded on the seventh (7th) calendar day after the first day of attendance.
- All students entering kindergarten, second, and sixth grades are required to present proof of an oral health examination completed by a licensed dentist. This will be due prior to May 15th of that academic year.
- A vision examination is required of all students entering kindergarten or enrolling in a public school for the first time. Written proof of having been examined by a physician licensed to practice medicine in all of its branches or a licensed optometrist will be required.
- Students enrolled last school year in District 204 should not need a new physical exam unless he/she is entering grade six or nine. Returning students who need immunization will receive individual letters notifying the parent of the immunization needed. The DuPage (682-7560) and Will (815-727-8480) County Health Departments offer immunization clinics for a nominal fee. Please contact them directly to schedule an appointment.
- Please note that a current physical is required **to try out** for any interscholastic sport (grades 7-12). A physical is not required for intramural sports (grades 6-12).

If a physical or dental exam is needed, check with your health care provider to see if he/she has the mandated Illinois physical form. If he/she does not have the Illinois form, it will be available on the District Web site.

The District's Medication Policy is found in the district Parent/Student Handbook and on the district web site at www.ipsd.org. Please reference the section on School Board Policy. A student, who has asthma or allergies, is allowed to carry necessary medication while at school. Physician orders for the medication must be on file with the nurse.

Enclosed in the registration packet you will find an emergency medical card, which must be filled out, **signed**, and **returned to your child's school**. This card is kept in the nurse's office and used in the event of an emergency. This card is needed in the nurse's office prior to your child starting school. If you have any questions, please do not hesitate to call your school health office.

Sincerely,
Linda Herwaldt RN, BSN, MS, IL-CSN
Coordinator of Health Services

P R E P A R I N G A L L S T U D E N T S T O S U C C E E D

Crouse Education Center

P.O. Box 3990, Naperville, IL 60567

phone: 630-375-3000 • fax: 630-375-3001 • web: www.ipsd.org



**STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

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

Address			Parent/ Guardian	Telephone # Home	Work
Street	City	ZIP code			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		Comments
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. **Clinical diagnosis is acceptable if verified by physician.** *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below is verifying 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	Date
-----------------	-----------	-------	------

3. **Laboratory confirmation (check one)** Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels														
Date														
Age/Grade														
	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision														
Hearing														

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Printed by Authority of the State of Illinois
(Complete Both Sides)

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

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during the night coughing	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	No No
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No
Developmental delay?	Yes	No		Surgery? (List all.) When? What for?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes	No
Diabetes?	Yes	No		TB skin test positive (past/present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No		TB disease (past or present)?	Yes*	No
Seizures? What are they like?	Yes	No		Tobacco use (type, frequency)?	Yes	No
Heart problem/Shortness of breath?	Yes	No		Alcohol/Drug use?	Yes	No
Heart murmur/High blood pressure?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No
Dizziness or chest pain with exercise?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Other concerns?			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Information to be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?	Yes	No		Parent/Guardian Signature	Date	
Bone/Joint problem/injury/scoliosis?	Yes	No				

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS		HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>					
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 Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (Blood test required in Chicago and other high risk zip codes.)					
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read / / Result _____ mm					
LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES		Date	Results	Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin				Endocrine	
Ears				Gastrointestinal	
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/>	Result _____	Genito-Urinary	LMP
Nose				Neurological	
Throat				Musculoskeletal	
Mouth/Dental				Spinal examination	
Cardiovascular/HTN				Nutritional status	
Respiratory				Mental Health	
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>			
Physician/Advanced Practice Nurse/Physician Assistant performing examination					
Print Name		Signature		Date	
Address			Phone		

(Complete both sides)

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: <input type="checkbox"/> Male <input type="checkbox"/> 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 _____

Address _____
Street City ZIP Code

Telephone _____



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete 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 October 15 of the year the child enters an Illinois school.

Student Name _____ (Last) _____ (First) _____ (Middle Initial)

Birth Date _____ Sex _____ 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

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity	20/	20/	20/	20/
Best Corrected Visual Acuity	20/	20/	20/	20/

Was refraction performed with cycloplegic agents? Yes No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (media, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Integrity (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and Vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IOP (glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other _____



State of Illinois Eye Examination Report

Recommendations

1. Corrective Lenses: No Yes, glasses 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 who provides eye examinations

Address _____

Phone _____

Signature _____
Optometrist or Physician who provides eye examinations

Date _____

<p>Consent of Parent or Guardian</p> <p>I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p>_____</p> <p style="text-align: center;">(Parent or Guardian's Signature)</p> <p>_____</p> <p style="text-align: center;">(Date)</p>

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

STUDENT MEDICATION FORM
(PHYSICIAN, PHYSICIAN ASSISTANT OR ADVANCED PRACTICE R.N.)

TO: Building Nurse
Indian Prairie Community Unit
School District No. 204
P.O. Box 3990
Naperville, Illinois 60567

The following student is presently under my care for asthma or other illness. I believe that the failure of the student to receive the medication referenced herein, which I have prescribed, during the school day would jeopardize the student's health and education. Where applicable, information relating to the student's self-administration of the medication referenced herein, which I have prescribed, is set forth below.

Student's Name: _____ Birth Date: _____

Student's Address: _____ Phone No.: _____

School Attended: _____ Grade: _____
* * *

Name of Medication:

Dosage of Medication:

Purpose of Medication:

Illness or Disease Identified (or Diagnosed):

Possible Side Effects:

Time or times at which, or special circumstances under which, the medication is to be administered:

Signature of Physician/Provider Date

Name of Physician/Provider

Street Address

City/State Zip Code

Office Phone No.

Emergency Phone No.

STUDENT MEDICATION FORM (PARENT OR GUARDIAN)

TO: Indian Prairie Community Unit School District 204
P.O. Box 3990
Naperville, Illinois 60567

To Whom It May Concern:

Student's Name:

Student's Address:

School Attended:

PLEASE CHECK APPLICABLE SECTION:

◀◀ ADMINISTRATION OF MEDICATION BY DISTRICT PERSONNEL

The undersigned, being the parent or guardian of the above-named student, hereby requests that School District 204 administrative personnel administer prescription medication ordered by the student's physician or licensed prescriber in accordance with the letter that accompanies this form.

I recognize that it is not always practical or possible for medication to be administered by a school nurse and, therefore, consent to administration of medication to the student by administrative personnel in addition to the school nurse.

I understand that I am to bring the medication to the school office in a pharmaceutical container labeled with the student's name, name of medication, dosage and all pertinent instructions.

I hereby release School District 204, its officers, directors, agents, employees and assigns from any and all liability arising from the administration of medication to the above-named student.

◀◀ SELF-ADMINISTRATION OF MEDICATION BY STUDENTS

Pursuant to the *School Code*, Indian Prairie Community Unit School District No. 204 will permit the self-administration of medication by a student with asthma or other illness, if the following documents are provided by the student's parents or guardians:

1. Written authorization, signed by the parent or guardian; and
2. A written statement from the student's physician, physician assistant or advanced practice registered nurse, containing the following information:
 - A. The name and purpose of the medication;
 - B. The prescribed dosage; and
 - C. The time or times at which or the special circumstances under which the medication is to be administered.

STUDENT MEDICATION FORM (PARENT OR GUARDIAN)

By signing this document, a parent or guardian may authorize the School District to permit his or her child to self-administer asthma medication or other medication. The School District and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the student's self-administration of the medication.

The undersigned, being the parent or guardian of the student named above, authorizes the School District to permit the student to self-administer his or her asthma medication or other medication. I acknowledge that the School District and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the student's self-administration of the medication. I agree to indemnify and hold harmless the School District and its employees and agents against any and all claims, except claims based on willful and wanton conduct, arising out of the self-administration of medication by the student.

Signature of Parent/Guardian

Date

Name of Parent/Guardian (Please Print)

Street Address

City/State

ZIP Code

Phone No. During School Hours

Emergency Phone No.