
# Lincolnwood School District 74
# Registration Packet 2013-2014

*Revised 02/2013*

# ENROLLMENT DIRECTIONS & CHECKLIST

The following documents must be presented by the parent for verification at the time of registration.

☐ **ORIGINAL (CERTIFIED COPY) BIRTH CERTIFICATE** – If your child was born in Cook County, you may obtain the birth certificate at the Skokie Mini Civic Center (court house), 5600 Old Orchard Road, Skokie (telephone 847-818-2850), or at participating currency exchanges. If your child was born outside of Cook County, you will need to contact the county or village hall for information on how to obtain the birth certificate. (A CERTIFIED COPY WILL HAVE A SEAL OF THE COUNTY ON THE CERTIFICATE). Hospital and/or Baptismal Certificates will NOT be accepted.

## ACCEPTABLE PROOF OF RESIDENCY IN DISTRICT 74

**Category A** (Check and attach at least ONE of the following documents)

☐ A closing statement for the purchase of your residence

☐ Signed lease for your residence

☐ The most recent real estate tax bill for the residence showing you as the taxpayer

**Category B** (Check and attach at least TWO of the following documents)

☐ Gas, electric, or telephone bill (or letter from utility company); only 1 needed

☐ Home/apartment insurance certificate

☐ Drivers license

☐ Voter registration card or application for voter registration card

☐ Automobile registration-State of Illinois

**Category C** (Each of the following forms MUST be completed and turned in)

☐ **ENROLLMENT FORM AND REGISTRATION PACKET**
Fill the packet out as completely as possible. We will go over it when you come in. ***Please Print Legibly.***

☐ **AFFIDAVIT OF RESIDENCE**
Fill out the Affidavit and have it NOTARIZED (this may be done at a bank, currency exchange, etc.)

☐ **HOME LANGUAGE SURVEY**

☐ **RACE AND ETHNICITY FORM**

☐ **PERMISSION FORM TO SEND FOR SCHOOL RECORDS**
You will need to know the **exact** name of the previous school, mailing address, and zip code.

☐ **SCHOOL FEES (If you think you are eligible for the Waiver Program, see information on our website listed under "Parents")**

☐ **GYM UNIFORM ORDER FORM if the child is in grades 6 through 8**

☐ **SPORTS FORMS (Interscholastic Sports and Sports Physical)**
**ONLY** needs to be completed for Lincoln Hall 6th, 7th, and 8th grade.

**PLEASE NOTE: THE ABOVE REQUIREMENTS MUST BE MET BEFORE STUDENT CAN START SCHOOL**

**Please do not remove pages from this packet. Only complete pages that apply to your needs. All forms must be submitted.**

# INSTRUCTIONS REGARDING PROOF OF RESIDENCY

In order to attend a Lincolnwood School District 74 school, a student is required to reside within the boundaries of Lincolnwood. Proof of residency is being required as part of the registration process for all students.

**PLEASE NOTE: STUDENTS WILL NOT BE PERMITTED TO ATTEND SCHOOL UNTIL THEIR RESIDENCY HAS BEEN VERIFIED.**

The issue of students illegally attending schools outside of their home district has surfaced during the last several years. In Spring, Representative O'Connor sponsored HB1459 which allows a district to impose a tuition charge if the school board determines that a non-resident pupil is improperly attending a district's school on a tuition-free basis. The bill makes it a Class C misdemeanor to knowingly enroll a non-resident in a school without paying tuition. A hearing process also is included in this measure as are other provisions.

NOTE: Original documents requested will be inspected, photocopied, and returned.

## AFFIRMATION OF RESIDENCY DOCUMENTS

### HOMEOWNERS

A **photocopy** of the following will be accepted:

1. Most recent property tax bill **AND**
2. Proof of payment (canceled check or form 1098) **AND**
3. **One** (1) of the items below:
    a. Current homeowner's insurance policy
    b. Current village/county vehicle registration
    c. Mortgage coupon
    d. Current vehicle insurance policy
    e. Closing statement & homeowner's insurance if moved in within 2 months of registration

### RENTERS

**Only Originals** of the following will be accepted

1. Valid original lease (signed and dated) **AND**
2. Proof of last two months payment (canceled checks (originals) or receipts required) **AND**
3. The items below:
    a. Current renter's insurance policy
    b. Current village/county vehicle registration
    c. Current vehicle insurance policy
    d. Driver's license
    e. Voter's card

****Landlord's phone number is required**

### LIVING WITH RELATIVES

**Only Originals** of the following will be accepted

1. Previous two (2) months of bills
2. Current village vehicle registration
3. Automobile insurance policy
4. Tax returns (current year only)
5. Checking and/or savings statements for the previous 2 months
6. Statement from parents, homeowners and neighbors of verification of residence
7. **Homeowner and parent or guardian must sign the Financial Responsibility Form**
8. Driver's license
9. Voter's card

# REGISTRATION INFORMATION

Last Name: _____ First Name: _____ Initial: _____

Address: _____ Lincolnwood, IL 60712

Home Phone: _____ Birth Date: _____ Grade: _____

☐ Male ☐ Female Child's Place of Birth_____

FATHER'S INFORMATION

Last Name: _____ First Name: _____ Initial: _____

Address: If different than Child: _____City/State/Zip: _____

Occupation: _____ Work Phone Number: _____

Cell Number: _____ Email: _____

MOTHER'S INFORMATION

Last Name: _____ First Name: _____ Initial: _____

Maiden Name: _____

Address: If different than Child: _____City/State/Zip: _____

Occupation: _____ Work Phone Number: _____

Cell Number: _____ Email: _____

**RESIDENCY:** ☐ **Owner** ☐ **Living with Others** ☐ **Renting** (*Must complete Affidavit of Residence*)

RENTER INFORMATION

Landlord Name: _____ Phone Number: _____

Address: _____City/State/Zip: _____

Current lease valid for: (date) _____ to _____

**Renters please understand that School District 74 can/will contact the above landlord to verify the student's residency.**

## REGISTRATION INFORMATION – *PAGE 2*

Name and age of all student/s in District 74:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name/s and relationship of others living in household: (*if adults, please list work phone number)*

Name: _____ Relationship: _____ Work #: _____

Name: _____ Relationship: _____ Work #: _____

Name: _____ Relationship: _____ Work #: _____

Who is the custodial Parent? _____

With whom does the child live? _____

Do you own another residence? ☐ Yes ☐ No If yes, please state the address: _____

Who is responsible for the discipline and control of the student? _____

Who is financially responsible for any damages caused by the student? _____

In the event of an accident or other emergency, who may direct and consent to medical treatment and sign the required release form? _____

If custody of the student has been transferred by the parents to another party who is a resident of the school district, what was the reason for the transfer? _____

Please provide any additional information which may help establish the student's residence or which is otherwise relevant to the question of the student's residency. _____

Public Aid Identification Number (if applicable): _____

Who claims the child/ren for income tax purpose? _____

(Attach copies of any agreements, judgments, decrees, or other documents awarding or giving custody of the student To any person)

## EMERGENCY CONTACT INFORMATION – other than parent

(Please list additional emergency information in the event we cannot contact a parent.)

#1 Last Name: _____ First Name: _____

Relation: _____

Home/Work Phone: _____ Cell Phone: _____

#2 Last Name: _____ First Name: _____

Relation: _____

Home/Work Phone: _____ Cell Phone: _____

#3 Last Name: _____ First Name: _____

Relation: _____

Home/Work Phone: _____ Cell Phone: _____

## Medical Contact Information

Doctor's Name: _____ Phone: _____

Doctor's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

# HOME LANGUAGE SURVEY

Date: _____ School: _____ Grade: _____

The Illinois School Code and the Emergency Immigration Act, Title IV of the Education Amendment of 1984 (PL 98-511), states that each school district shall administer a home language survey to every student entering the district's schools for the first time. If a second language is indicated the student will be screened for possible English Language Learner (ELL) services.

Student's First Name: _____ Last Name: _____

Student's Date of Birth: _____ Male: _____ Female: _____

Father's First Name: _____ Last Name: _____

Mother's First Name: _____ Last Name: _____

1. In what country was your child born? _____
2. How long has your child lived in the United States? _____
3. **Is a language other than English spoken in your home? Yes _____ No _____
4. What other languages are spoken in your home?

   Father: _____ Mother: _____

   Other: (grandparents, caretaker, siblings, etc.) _____
5. **Does your child speak a language other than English? Yes _____ No _____

   What language? _____
6. Is your child able to read this/these languages? Yes _____ No _____ Some _____
7. Is your child able to write in this/these languages? Yes _____ No _____ Some _____
8. What language is used most often in your home? _____
9. How many years of formal schooling has your child completed? _____
10. How many years of ELL/Bilingual programming has your child completed? _____
11. What was the language of instruction at your child's previous school? _____

_____ _____

*Parent/Guardian Signature* *Signature of Translator (if applicable)*

***If yes is answered in either question #3 or #5: a copy of this form along with the registration form should be given to the ELL Specialist in your building. This form should be placed in the student's temporary file.*

Illinois State Board of Education

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

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

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

**INSTRUCTIONS:** This form is to be filled out by the student's parents or guardians, and both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

**Part A. Is this student Hispanic/Latino?** (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) **Choose only one.**

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

*The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.*

**Part B. What is the student's race? Choose one or more.**

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

**Note:** Data collected on this form must be maintained by the school district for three years. However, when there is litigation, a claim, an audit, or another action involving this record, the original responses must be retained until the completion of the action.

# AFFIDAVIT OF RESIDENCE

STATE OF ILLINOIS )
)SS
COUNTY OF COOK)

I, _____ having first been sworn upon my oath depose and say as follows: That I am

the parent, foster parent, guardian, or _____ of _____ age_____

and that his/her residence is _____ address,

Village of Lincolnwood, Illinois, Cook County, within the territorial boundaries of Lincolnwood School District 74, Cook County, Illinois. That the said child's residence within the said school district has not been established solely for the purpose of attending the schools thereof. That the following facts are sworn to in order to permit the said school district to enroll the said student as a resident:

| | | |
|---|---|---|
| The said child eats his/her meals regularly at the said residence. | ☐ Yes | ☐ No |
| The said child sleeps regularly at the said residence. | ☐ Yes | ☐ No |
| The said child spends his/her weekends regularly at the said residence. | ☐ Yes | ☐ No |
| The said child spends his/her summers regularly at the said residence. | ☐ Yes | ☐ No |

I acknowledge and agree that if my child(ren) enrolls in Lincolnwood School District 74 but is not a resident of the Village of Lincolnwood, Illinois that I shall be liable for the cost to Lincolnwood School District 74 to educate my child(ren) during the time they are enrolled in the Lincolnwood Schools. That my child(ren) shall immediately upon determination that he/she is not entitled to enrollment be removed from Lincolnwood School District 74 and shall not be permitted to attend such schools.

_____
Signature

Subscribed and Sworn to before me

this _____ day of _____, _____ (year)

_____ (SEAL)
Signature of Notary Public

# STATEMENT OF FINANCIAL RESPONSIBILITY FOR NON-RESIDENT OR FRAUDULENT ENROLLMENT OF A STUDENT

I, _____ agree to surrender payment to Lincolnwood School District 74 tuition fees (the per diem rate, based on per pupil cost, stated in the most current copy of the "School Report Card") for my child _____ should it be determined, by the Board of Education or its designees, that I have enrolled my child by falsifying information or documents. I am fully aware that this same practice will be In effect if I do not become a resident of Lincolnwood within the agreed upon time constraints so deemed by the Superintendent of Schools.

_____ _____

Signature of Parent or Guardian Date

_____ _____

Signature of Homeowner Date

Lincolnwood 74
*Lincolnwood School District 74*
Marvin Garlich Administration Building
6950 N. East Prairie Road
Lincolnwood, IL 60712
Main 847-675-8234 :: Fax 847-675-4207

# REQUEST FOR STUDENT INFORMATION

Date: _____

Name of Pupil: _____ Date of Birth: _____

Previous home address: _____

_____

The above-named student has transferred from:

School: _____

Address: _____

_____

and has enrolled at Lincolnwood School District 74 in grade: _____

1. Has your child been retained: _____

2. Has your child received special services: i.e., gifted program, special education, ESL, remedial reading?

*SPECIFY:* _____

3. Has your child failed a subject? *SPECIFY:* _____

Please send records to include student health and special service records.

_____

Parent Signature

## SEND RECORDS TO:

**Grade K-2**
Todd Hall School
3925 W. Lunt Avenue
Lincolnwood, IL 60712
Attn: School Records

**Grade 3-5**
Rutledge Hall School
6850 N. East Prairie Road
Lincolnwood, IL 60712
Attn: School Records

**Grade 6-8**
Lincoln Hall Middle School
6855 N. Crawford Avenue
Lincolnwood, IL 60712
Attn: School Records

Lincolnwood 74
Lincolnwood School District 74
Marvin Garlich Administration Building
6950 N. East Prairie Road
Lincolnwood, IL 60712
Main 847-675-8234 :: Fax 847-675-4207

2013-2014 School Year

Dear Parents and Physicians:

The Lincolnwood Schools operate in accordance with the State Law and Lincolnwood Board of Education Policy. Physical examinations and proof of adequate immunizations are required of all new students to District 74, all children entering Pre-Kindergarten, Kindergarten or students starting First Grade without Kindergarten experience, and students entering Sixth Grade. Because there are a myriad of required medical forms (depending on what grade your child will be entering) or varied medical conditions your child may have, we have developed a checklist below. Please look at the grade your child will be entering and submit all required forms.

**ALL FORMS** listed below are included in this packet and are also available on the Lincolnwood School District 74 website. Physical examinations cannot be more than twelve (12) months in advance of the first day of school. ALL REQUIRED MEDICAL FORMS SHOULD BE FILLED OUT AND SENT IN BEFORE THE FIRST DAY OF THE SCHOOL YEAR. Any child not in compliance with the above requirements by October 15th will be excluded from school that day and until proof of compliance is presented to the school. All new students who are first-time registrants, entering after October 14th, shall have 30 days following registration to comply with the health examination and immunization regulations.

**For students new to Lincolnwood Schools:**

- ☐ **Certificate of Child Health Examination** – You will need a doctor's physical and up-to-date immunizations.
- ☐ **Eye Examination Report** – Any students new to Illinois public schools will need an eye exam. Illinois law requires that an optometrist or ophthalmologist perform an eye exam and complete the State of Illinois Eye Examination Report.
- ☐ **Proof of School Dental Examination Form** – Please have dentist complete this form.

**For new Pre-Kindergarten Students:**

- ☐ **Certificate of Child Health Examination** – You will need a doctor's physical and up-to-date immunizations. *A lead screening or blood test and a diabetes screening must be indicated on this form.*
- ☐ **Childhood Lead Risk Assessment Questionnaire** – If you respond "Yes" or "Don't know" on this form, your child's doctor must perform a blood lead test.

**For Kindergarteners or students starting First Grade without a Kindergarten experience:**

- ☐ **Certificate of Child Health Examination** – You will need a doctor's physical and up-to-date immunizations. *A lead screening or blood test and a diabetes screening must be indicated on this form.*
- ☐ **Childhood Lead Risk Assessment Questionnaire** – If you respond "Yes" or "Don't know" on this form, your child's doctor must perform a blood lead test.
- ☐ **Proof of School Dental Examination Form** – Please have dentist complete this form.
- ☐ **Eye Examination Report** – Please have an optometrist or ophthalmologist complete this form.

**For Second Graders:**

- ☐ **Proof of School Dental Examination Form** – Please have dentist complete this form.

**For Sixth Graders:**

- ☐ **Certificate of Child Health Examination** – You will need a doctor's physical and up-to-date immunizations. ***REQUIREMENT!!*** – Any child entering sixth grade shall show proof of receiving one dose of Tdap. (See letter from IL Dept. of Public Health in this packet)
- ☐ **Proof of School Dental Examination Form** – Please have dentist complete this form.

**For Sixth, Seventh, and Eighth Graders:**

- ☐ **ALL 6th, 7th, and 8th Graders** – Beginning in the Fall of 2013, ALL students entering, advancing, or transferring into 6th, 7th, and 8th grades will be required to show proof of one dose of Tdap vaccine regardless of the interval since the last Dtap, DT or Td dose.
  (See letter from IL Dept. of Public Health in this packet)
- ☐ **Interscholastic Sports Pre-Participation Examination** – Please fill out form.
- ☐ **Sports Physical – Examination** – Please fill out with your doctor.

**ALL STUDENTS:**

- ☐ **Medical History Update Form** – Please fill out this form.

It is most helpful to your child, and to us, if we are made aware of important problems, such as severe allergies to food or bee stings, diabetes, convulsions, asthma, drug allergies, or any other problems. This will help us in attending to the health of your child.

Any information that you provide to the school will be confidential. Our request for this information is ONLY to be of greater service to you and your child.

If you have any questions regarding any of the above instructions, please contact the school nurse in your child's building.

**Other Medical Forms in this Packet that you may need to fill out:**

- ☐ **Food Allergy Action Plan Form** – If your child has a severe allergy to food, bees, or other allergy that requires an Epi-pen, please fill out this form with your doctor.
- ☐ **Student Asthma Action Card** – If your child has asthma, please fill out this form with your doctor.
- ☐ **Order/Authorization for Administration of Medication at School Form** – To receive any over-the-counter or prescription medications at school (including any pain relievers), please fill out this form and have your doctor sign.

*Please bring in all medications, including inhalers and Epi-pens, to the Health Office by the first day of school.*

**Vision and Hearing Screening:**
Vision screening will begin, as mandated, for the following students: Pre-Kindergarten, Second Grade, Eighth Grade, Transfer Students, Special Needs, and Teacher Referrals in the month of September. Hearing screenings will also be done for Pre-Kindergarten, Kindergarten, First Grade, Second Grade, Third Grade, Special Needs, Transfer Students, and Teacher Referrals.

Vision screening is not a substitute for a complete eye and vision evaluation by an eye doctor. Your child is not required to undergo this vision screening if an optometrist or ophthalmologist has completed and signed a report form indicating that an eye examination has been administered within the previous 12 months. A copy of the eye examination needs to be on file in the school's health office.

If a vision examination report is **not** on file in the health office, your child will be screened if they are required by the State of Illinois.

**The Following Immunizations Are Required For All Children Entering Elementary School:**

**Diphtheria, Pertussis, Tetanus, and Polio**
Must receive the basic series, plus a booster given on or after the 4th birthday.

**Tetanus, Diphtheria, Acellular Pertussis (Tdap):**
Beginning in the Fall of 2013, ALL students entering, advancing, or transferring into 6th, 7th, and 8th grades will be required to show proof of one dose of Tdap vaccine regardless of the interval since the last Dtap, DT or Td dose. (See letter from IL Dept. of Public Health in this packet)

**Measles Vaccine**
All children must show proof of having received two measles immunizations, the first dose being at 12 months of age or older and the second dose no less than one (1) month later.

**Rubella Vaccine**
Given after twelve (12) months of age.

**Mumps Vaccine**
Given after twelve (12) months of age or have had the disease.

**Chicken Pox Vaccine**
All children must show proof of having received the chicken pox vaccine or have the doctor complete sections 1, 2, or 3 under "Alternative proof of immunity".

**Tuberculosis**
All children enrolling from a school outside of the United States must present proof that he/she is tuberculosis free prior to enrollment.

**HIB – Haemophilus Influenza Type B**
This is required for all Pre-Kindergarten Students.

**Hepatitis B**
Due to a new law from the Illinois Department of Public Health, all children entering preschool or fifth grade, starting in the fall of 1997 and thereafter, are required to have received three (3) Hepatitis B immunizations before entering school. This series takes six (6) months to complete.

**Diabetic Screening**
All students.

**PLEASE LIST ALL IMMUNIZATIONS BY MONTH, DAY, AND YEAR**.

Approval or disapproval of child's participation in physical education must be checked on the form. The health examination form must be completed, signed, and dated by the physician in two places: at the bottom of the immunization portion and at the bottom of the physical examination portion.

Parents: it is very important that you fill out the Health History portion of the physical and have it verified by your physician. ***Your signature is necessary.***

Thank you for your cooperation.

Sincerely,

Lincolnwood School District 74

Illinois Department of
PUBLIC HEALTH

Pat Quinn, Governor
LaMar Hasbrouck, MD, MPH, Director

525-535 West Jefferson Street • Springfield, Illinois 62761-0001 • www.idph.state.il.us

January 3, 2013

Dear Parent,

This is to inform you that beginning next school year (Fall of 2013) all students entering, advancing, or transferring into 6th, 7th, 8th, 9th, 10th, 11th, or 12th grades will be required to show proof of receipt of one dose of Tdap vaccine (combined tetanus, diphtheria, acellular pertussis) vaccine regardless of the interval since the last *DTaP, DT or Td* dose[1].

This requirement is important because pertussis (whooping cough) disease continues to occur throughout many Illinois communities and vaccination of children and adolescents reduces illness and absenteeism among school-age students. In addition, pertussis infections in infants can be fatal, and reducing the spread of pertussis through vaccination of community members helps to protect infants, especially those who are too young to be fully vaccinated.

Most students may have already received the vaccine and simply need to provide the school with verifying documentation from the family health care provider. Documentation accepted as complying with the requirement for students entering 6th through 12th grades for the 2013-14 school year includes the following information:

- Note or letter, signed by health care provider and identifying the vaccine (Tdap) and date (month, day, and year) administered.
- Print-out from provider's electronic medical record system that identifies Tdap vaccination(s) and date administered for student in question.
- Current Certificate of Child Health Examination (see link below), specifying Tdap and date (month, day, year) administered.
  *http://www.idph.state.il.us/health/vaccine/child_hlth_forms/Child_Hlth_Exam_Cert.pdf*

In addition to health care providers, many local health departments, and pharmacies offer the vaccine. The Illinois Department of Public Health recommends that parents get their adolescents immunized now to avoid a last-minute rush during the summer. Students without adequate proof of vaccination will be subject to exclusion as described in the School Code of Illinois *http://www.ilga.gov/legislation/ilcs/documents/010500050K27-8.1.htm*[2].

LaMar Hasbrouck, MD, MPH
Director

[1] There are four combination vaccines used to prevent diphtheria, tetanus and pertussis: DTaP, Tdap, DT, and Td. Two of these (DTaP and DT) are given to children younger than 7 years of age, and two (Tdap and Td) are given to older children and adults. Several other combination vaccines contain DTaP along with other childhood vaccines.

[2] 105 ILCS 5/27-8.1

# Lincolnwood School District 74
## Medical History Update
(To be completed by Parents/Guardian)

Student's Name _____ Birth Date _____

Current Grade _____ School _____

**Please complete the following checklist and give details below (attach any additional pertinent information):** Does your child have any past or present medical conditions (including allergic reactions) that might need special attention by the school personnel?

**If yes, please mark and describe below:**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **Allergies (Please Select):** ☐ Food ☐ Seasonal ☐ Medication Other: _____ | ☐ | ☐ | Speech | ☐ | ☐ |
| | | | Headaches (i.e. migraines) | ☐ | ☐ |
| Asthma | ☐ | ☐ | Stomach Problems/Ulcer | ☐ | ☐ |
| ADHD / ADD | ☐ | ☐ | Diabetes | ☐ | ☐ |
| Epilepsy / Seizures | ☐ | ☐ | Serious injury or illness | ☐ | ☐ |
| Heart Condition / Murmur | ☐ | ☐ | Surgery | ☐ | ☐ |
| Orthopedic/Bone/Knee | ☐ | ☐ | Hospitalizations/ When? What for? | ☐ | ☐ |

Please give details and dates to any of the above marked YES. Please list ALL Allergies and any other health concerns.

_____

_____

Dr. ordered special needs (Please check): ☐ Glasses/Contacts ☐ Seat close to instruction ☐ Hearing Aids ☐ Physical Education Limits

List any social, emotional conditions that may affect your child's school performance.

_____

_____

Is the student currently under any kind of medical care or treatment? ☐ Yes ☐ No

If Yes, please describe care or treatment: _____

_____

Is the student taking any medications on a regular basis (prescription or non prescription)? ☐ Yes ☐ No

List the medication, dose, times and reasons for taking: _____

_____

If your child must take any medication in school, you must complete the Lincolnwood School District 74 Authorization of Medication at School Form, completed and signed by your physician.

Is there any other information that you feel would be helpful for us to know regarding your child?

_____

_____

_____

_____

_____

***Information may be shared with all School District 74 personnel for health and educational purposes.

Parent/Guardian Signature _____ Date _____

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

DCFS

# State of Illinois
# Certificate of Child Health Examination

| Student's Name<br>Last First Middle | Birth Date<br>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. 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<br>MO DA YR | 2<br>MO DA YR | 3<br>MO DA YR | 4<br>MO DA YR | 5<br>MO DA YR | 6<br>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 | | | | | | |
| **Hepatitis B** (HB) | | | | | | |
| **Varicella** (Chickenpox) | | | | COMMENTS: | | |
| **MMR** Combined Measles Mumps. Rubella | | | | | | |
| **Single Antigen** Vaccines | **Measles** | **Rubella** | **Mumps** | | | |
| **Pneumococcal Conjugate** | | | | | | |
| **Other**/Specify Meningococcal, Hepatitis A, HPV, Influenza | | | | | | |

**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 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 result)**

## VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

| | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Date** | | | | | | | | | | | | | | | | | | | | |
| **Age/ Grade** | | | | | | | | | | | | | | | | | | | | |
| | R | L | R | L | R | L | 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**

IL444-4737 (R-01-12) **(COMPLETE BOTH SIDES)** **Printed by Authority of the State of Illinois**

| 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) | | | | **MEDICATION** (List all prescribed or taken on a regular basis.) | | | |
|---|---|---|---|---|---|---|---|
| Diagnosis of asthma?<br>Child wakes during night coughing? | Yes<br>Yes | No<br>No | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes | No | |
| Birth defects? | Yes | No | | Hospitalizations?<br>When? What for? | Yes | No | |
| Developmental delay? | Yes | No | | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes | No | | Surgery? (List all.)<br>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 _____<br>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.<br>**Parent/Guardian Signature** **Date** | | | |
| Bone/Joint problem/injury/scoliosis? | Yes | No | | | | | |

**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. **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** | | | **Gastrointestinal** | | |
| **Eyes** | | Amblyopia Yes☐ No☐ | **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:<br>☐ Quick-relief medication (e.g. Short Acting Beta Agonist)<br>☐ 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** ☐ **Limited** ☐

**Print Name** (MD,DO, APN, PA) **Signature** **Date**

**Address** **Phone**

**(Complete Both Sides)**

## 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: _____
(Mo.) (Day) (Yr.)

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: _____

**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/Recess
2. Preferential Seating Recommended: ❑ No ❑ Yes Comments: _____
3. Recommend Re-examination: ❑ 3 months ❑ 6 months ❑ 12 months
   ❑ Other _____
4. _____
5. _____

Print Name: _____ Lic. No.: _____

Optometrist or Physician (such as an ophthalmologist) Who Provided the Eye Examination
❑MD ❑OD ❑DO

Address: _____

_____

Phone: _____

Signature: _____

Optometrist or Physician (such as an ophthalmologist) Who Provided the Eye Examination
❑MD ❑OD ❑DO

Date: _____

**Consent of Parent or Guardian**

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent's or Guardian's Signature)

Date _____

**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

**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.** | **R E S P O N S E** |
|---|---|

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**

**Illinois Department of Public Health**
**Guidelines for Blood Lead Screening and Lead Risk Assessment**

- **Blood lead screening** is defined as obtaining a blood lead test. **Lead risk assessment** is defined as evaluation of potential for exposures to lead based on questionnaire responses.

- **It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or potential exposure to lead has been identified, regardless of child's age.**

- Federal mandates and the Illinois Department of Healthcare and Family Services' (HFS) policy require that all children enrolled in HFS medical programs be considered at risk for lead poisoning and receive a screening blood lead test prior to age **12 months and 24 months**. Children older than the age of 24 months, up to 72 months of age, for whom no record of a previous screening blood lead test exists, also should receive a screening blood lead test. **All children enrolled in HFS medical programs are expected to receive a blood lead test regardless of where they live.** (Consult *Handbook for Providers of Healthy Kids Services,* Chapter HK-203.3.1, for more blood lead screening and reporting information.)

- Illinois has defined ZIP code areas at high risk and low risk for lead exposure based on housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.

**Childhood Lead Risk Assessment Questionnaire**

- Complete the Childhood Lead Risk Assessment Questionnaire during a health care visit at ages 12 months and 24 months.
  - If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.
  - If any response is "YES" or "DON'T KNOW," obtain a blood lead test.

- Consider evaluating children before 12 months of age, depending on the area.

- If the child is age 3 years to 6 years ***and***
  1) there are any "YES" or "DON"T KNOW" answers ***and***
  2) has had two successive blood lead test results that were each less than < 10 mcg/dL with one of these tests at age 2 years or older ***and***
  3) risks of exposure to lead have not changed, **further blood lead tests are not necessary.**

- If the child is 3 years to 6 years of age, ***and***
  1) all answers to the Childhood Lead Risk Assessment Questionnaire are "NO," ***and***
  2) risks of exposure to lead have not changed, a blood lead test is not necessary.

- If the child is 3 years to 6 years of age and risks of exposures to lead have increased, obtain a blood lead test.

- Continue to use the Childhood Lead Risk Assessment Questionnaire through age 6.

**For children living in Chicago:**

- A blood lead test for children age 3 and younger should be obtained at 6, 12, 18, 24 and 36 months **OR** at 9, 15, 24 and 36 months.

- Children 4 years through 6 years of age with prior blood lead levels of <10 mcg/dL should have an annual risk assessment. A blood lead test should be performed if risk increases or if the child exhibits persistent oral behaviors.

**Illinois Lead Program**
**866-909-3572 or 217-782-3517**
**TTY (**For Deaf, Hard of Hearing Use Only**) 800-547-0466**
Printed by Authority of the State of Illinois
P.O. #5511502 2M 10/10

# HEALTH POLICIES

The health of children is very important to their total education and development. The following is a brief summary of the school health rules, which are designed to assist you in protecting your child's health.

**GENERAL**

It is required that parents call the school each morning that a child will be absent:

1. Todd Hall 847-745-3732
2. Rutledge Hall 847-675-8236
3. Lincoln Hall 847-675-8240

Students are encouraged to practice good hygiene by frequently washing their hands and covering their mouths and noses when coughing or sneezing, and to cough or sneeze into their sleeve at the elbow.

***Students should not attend school if any of the following conditions are present:***

Temperature of 99.7 degrees or higher
Vomiting
Diarrhea
Incessant or deep cough
Conjunctivitis (pink eye)
Strep throat
Unidentified rash

Symptoms should be absent for twenty-four (24) hours before the student returns to school (fever-free without medication), and a physician's note may be required. Children with communicable diseases will be excluded from school. Please contact your physician in these cases, and notify the nurse or specialist when a diagnosis is established.

When a child is to be out of gym class, a doctor's note will be required. If a child has been seriously ill or injured and is under the care of a physician, please obtain a doctor's note stating whether the child is to be on limited or full activity, and any other pertinent information.

**COMMUNICABLE DISEASE**

Children with communicable diseases including strep throat, conjunctivitis and undiagnosed rashes are to be excluded from school. Contact your doctor. When diagnosis has been made, notify the school nurse. A written diagnosis may be necessary.

# MEDICATION GUIDELINES

Medications should be limited to those required during school hours which are necessary to maintain the student in school, and to those needed in case of an emergency. In these cases, the administration of long- and short-term prescription and non-prescription (over the counter) medication will be subject to the following guidelines:

An authorization form to administer medication in school must be submitted to school staff on an annual basis. This form will be on file in the medication log in the health office. This authorization includes the following:

- Written physician order including the name of medication, dosage, time for administration, indication, and potential side effects.
- Written permission from the parent or guardian for the student to receive the medication as ordered by the physician.
- Any change in the prescription requires a new physician's order and parent permission.

If your child has a severe allergy that requires the use of an epi-pen, please fill out the Food Allergy Action Plan form with your doctor.

If your child has asthma and/or requires the use of an inhaler at school, please fill out the Student Asthma Action Card with your doctor.

The medication must be provided by the parent/guardian in a container properly labeled by the pharmacy. Medications will be stored in a locked cabinet in the health office. At the end of the school year or the conclusion of the administration of the medication, any remaining medication will be returned personally to the parent/guardian.

Medication will be administered by health office staff or other designated school personnel. During field trips, the classroom teacher will administer the medication.

The school district reserves the right to refuse any request for administration of medication at school.

# Food Allergy Action Plan

*Emergency Care Plan*

**Place Student's Picture Here**

**Name:** _____ **D.O.B.:** ___/___/___

**Allergy to:** _____

**Weight:** _____ lbs. **Asthma:** ☐ Yes (higher risk for a severe reaction) ☐ No

**Extremely reactive to the following foods:** _____

**THEREFORE:**

☐ If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.

☐ If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

**Any SEVERE SYMPTOMS after suspected or known ingestion:**

**One or more** of the following:

| | |
|---|---|
| LUNG: | Short of breath, wheeze, repetitive cough |
| HEART: | Pale, blue, faint, weak pulse, dizzy, confused |
| THROAT: | Tight, hoarse, trouble breathing/swallowing |
| MOUTH: | Obstructive swelling (tongue and/or lips) |
| SKIN: | Many hives over body |

Or **combination** of symptoms from different body areas:

| | |
|---|---|
| SKIN: | Hives, itchy rashes, swelling (e.g., eyes, lips) |
| GUT: | Vomiting, diarrhea, crampy pain |

1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications:*
   -Antihistamine
   -Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

**MILD SYMPTOMS ONLY:**

| | |
|---|---|
| MOUTH: | Itchy mouth |
| SKIN: | A few hives around mouth/face, mild itch |
| GUT: | Mild nausea/discomfort |

1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

## Medications/Doses

Epinephrine (brand and dose): _____

Antihistamine (brand and dose): _____

Other (e.g., inhaler-bronchodilator if asthmatic): _____

## Monitoring

***Stay with student; alert healthcare professionals and parent***. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

_____ _____ _____ _____

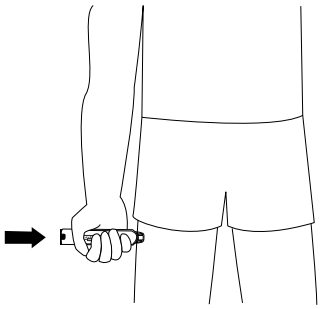
**Parent/Guardian Signature** **Date** **Physician/Healthcare Provider Signature** **Date**

**TURN FORM OVER** **Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011**

## EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- **First, remove the EPIPEN Auto-Injector from the plastic carrying case**
- **Pull off the blue safety release cap**

- **Hold orange tip near outer thigh (always apply to thigh)**

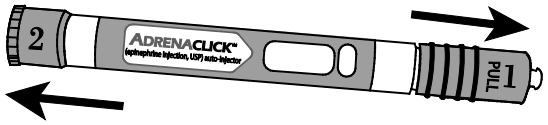


- **Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds**

EPIPEN 2-PAK® | EPIPEN Jr 2-PAK®
(Epinephrine) Auto-Injectors 0.3/0.15mg



## Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions




**Remove GREY caps labeled "1" and "2."**

**Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.**

**A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.**

**A kit must accompany the student if he/she is off school grounds (i.e., field trip).**

## Contacts

Call 911 (Rescue squad: (___) _____-_____) Doctor: _____ Phone: (___) _____-_____

Parent/Guardian: _____ Phone: (___) _____-_____

**Other Emergency Contacts**

Name/Relationship: _____ Phone: (___) _____-_____

Name/Relationship: _____ Phone: (___) _____-_____



**Form provided courtesy of the Food Allergy & Anaphylaxis Network (www.foodallergy.org) 9/2011**

Asthma and Allergy Foundation of America

# STUDENT ASTHMA ACTION CARD

National Asthma Education and Prevention Program

Name: _____ Grade: _____ Age: _____

Homeroom Teacher: _____ Room: _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

Parent/Guardian Name: _____ Ph: (h): _____

Address: _____ Ph: (w): _____

*ID Photo*

Emergency Phone Contact #1 _____
Name Relationship Phone

Emergency Phone Contact #2 _____
Name Relationship Phone

Physician Treating Student for Asthma: _____ Ph: _____

Other Physician: _____ Ph: _____

## *EMERGENCY PLAN*

Emergency action is necessary when the student has symptoms such as, _____ , _____,
_____ , _____or has a peak flow reading of _____.

**• Steps to take during an asthma episode**:

1. Check peak flow.
2. Give medications as listed below. Student should respond to treatment in 15-20 minutes.
3. Contact parent/guardian if _____
   _____
4. Re-check peak flow.
5. Seek emergency medical care if the student has any of the following:
   - ✔ Coughs constantly
   - ✔ No improvement 15-20 minutes after initial treatment with medication and a relative cannot be reached.
   - ✔ Peak flow of _____
   - ✔ Hard time breathing with:
     - Chest and neck pulled in with breathing
     - Stooped body posture
     - Struggling or gasping
   - ✔ Trouble walking or talking
   - ✔ Stops playing and can't start activity again
   - ✔ Lips or fingernails are grey or blue

**IF THIS HAPPENS, GET EMERGENCY HELP NOW!**

**• Emergency Asthma Medications**

| | Name | Amount | When to Use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

*See reverse for more instructions*

## Daily Asthma Management Plan

### • Identify the things which start an asthma episode (Check each that applies to the student.)

☐ Exercise
☐ Respiratory infections
☐ Change in temperature
☐ Animals
☐ Food _____
☐ Strong odors or fumes
☐ Chalk dust / dust
☐ Carpets in the room
☐ Pollens
☐ Molds
☐ Other _____

Comments _____

### • Control of School Environment

(List any environmental control measures, pre-medications, and/or dietary restrictions that the student needs to prevent an asthma episode.) _____

### • Peak Flow Monitoring

Personal Best Peak Flow number: _____

Monitoring Times: _____ _____ _____ _____

### • Daily Medication Plan

| | Name | Amount | When to Use |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |

## Comments / Special Instructions

_____

_____

_____

## For Inhaled Medications

☐ I have instructed _____ in the proper way to use his/her medications. It is my professional opinion that _____ should be allowed to carry and use that medication by him/herself.

☐ It is my professional opinion that _____ should not carry his/her inhaled medication by him/herself.

_____ _____
Physician Signature Date

_____ _____
Parent/Guardian Signature Date

Lincolnwood 74
Lincolnwood School District 74

**MEDICAL**

# Order/Authorization for Administration of Medication at School

**This form shall be effective for the 20____ – 20____ School Year ONLY and MUST be renewed each school year**

**TO BE COMPLETED BY THE STUDENT'S PARENT(S)/GUARDIAN(S)**

Student Name: _____ Birthdate: _____

Address: _____ Home Phone: _____

Emergency Contact Name: _____ Phone: _____

School: _____ Grade: _____ Teacher: _____

**TO BE COMPLETED BY THE STUDENT'S PHYSICIAN, PHYSICIAN ASST., OR ADVANCED PRACTICE RN**

Diagnosis: _____

Medication Name (1): _____

Route of Administration: _____ Dosage: _____ Frequency: _____

Prescription Date: _____ Discontinuation Date: _____

Side Effects/Comments: _____

Medication Name (2): _____

Route of Administration: _____ Dosage: _____ Frequency: _____

Prescription Date: _____ Discontinuation Date: _____

Side Effects/Comments: _____

Other Medication student is receiving: _____

Physician's Printed Name or Office Stamp: _____ Phone: _____

Office Address: _____

Physician's Signature: _____ Date: _____

**ASTHMA INHALERS ONLY – PLEASE ATTACH PRESCRIPTION LABEL BELOW:**

| | |
|---|---|
| | |

*Please see other side -* Rev. 02/13

**This section ONLY for parents/guardians of students who need to carry asthma medication or an epinephrine auto-injector**

I authorize Lincolnwood School District 74 and its employees and agents, to allow my child or ward to carry and self-administer his or her asthma inhaler and/or use his or her epinephrine auto-injector: (1) While in school; (2) While at a school-sponsored activity; (3) While under the supervision of school personnel; or (4) Before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires Lincolnwood School District 74 to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector (105 ILCS 5/22-30).

If you agree, please sign: _____ Date: _____
Parent/Guardian

**This section must be completed by the STUDENT**

For students with asthma - I agree: (1) To safely store my inhaler; (2) To never share the inhaler with another person; and (3) To notify a teacher or other responsible adult if there is not a marked improvement in my breathing after two puffs of the inhaler.

For student with severe allergies - I agree: (1) To safely store my Epipen; (2) To not trade food with others; (3) To not eat anything with unknown ingredients or known to contain any allergens; and (4) To notify a teacher or other responsible adult immediately if I eat something I believe may contain a food I am allergic to.

Student Signature: _____ Date: _____

**This section must be completed by ALL Parents/Guardians**

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize Lincolnwood School District 74 and its employees and agents, in my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of Lincolnwood School District 74), lawfully prescribed medication in the manner described above.

I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices; and I agree to indemnify and hold harmless Lincolnwood School District 74 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

_____ _____
Parent/Guardian (printed name) Address (if different from Student)

Phone: _____ Emergency Phone: _____

Parent/Guardian Signature: _____ Date: _____

*Please see other side -* Rev. 02/13

# INTERSCHOLASTIC SPORTS

*Pre-Participation Examination – page 1 of 3*

To be completed by athlete or parent:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Last Name: | | First Name: | | Initial: | | | |
| Address: | | | | *Lincolnwood, IL 60712* | | | |
| Birthdate: | | Age: | | Grade: | | Student ID No.: | |
| Parent's Name: | | | | | | | |
| Address: | | | | | | | |
| Phone Number: | | | | | | | |
| Person to contact in case of emergency: | | | | Phone Number: | | | |
| Family Doctor: | | | | City/State: | | | |
| Phone Number: | | | | | | | |

PAST MEDICAL HISTORY (for student listed above):

| INFORMATION | YES | NO | If YES, please explain (what, where, when) |
|---|---|---|---|
| 1. Taking Medication (incl. birth control pills) | | | |
| 2. Ever been diagnosed with asthma? | | | |
| 3. Ever been prescribed by a physician to use any asthma medication? | | | |
| 4. Does student currently have a consent form to self-administer to asthma medication on file with your school? | | | |
| 5. Allergic to medicine, foods, bee stings? | | | |
| 6. Wears any appliances, glasses, contact lenses? | | | |
| 7. History of braces, chipped teeth, bridges? | | | |
| 8. Has ongoing medical problem? | | | |
| 9. Had serious or significant illness in the past? | | | |
| 10. Any past surgical operations, accidents, non-sports or related injuries? | | | |
| 11. Any past injuries directly related to sports? | | | |
| 12. Any hospitalization not explained above? | | | |
| 13. Any known deformities (such as curvature of back, heart problems, one kidney, blindness in one year, one testicle, etc.)? | | | |
| 14. Any serious family illness (such as diabetes, bleeding disorders, etc.)? | | | |

| **INFORMATION** *(continued)* | **YES** | **NO** | **If YES, please explain (what, where, when)** |
|---|---|---|---|
| 1. Heart | | | |
| - Ever passed out during or after exercise? | | | |
| - Ever been dizzy during or after exercise? | | | |
| - Ever had chest pain during or after exercise? | | | |
| - Tired more quickly than your friends do during exercise? | | | |
| - Ever had racing of your heart or skipped heartbeats? | | | |
| - Ever had high blood pressure or high cholesterol? | | | |
| - Ever been told you have a heart murmur? | | | |
| - Has any family member or relative died of heart problems or of sudden death before age 50? | | | |
| - Ever had a severe viral infection (for ex. myocarditis or mononucleosis) within the last month? | | | |
| - Has a physician ever denied or restricted your participation in sports for any heart problems? | | | |
| - Has anyone in your family had a heart attack before the age of 50? | | | |
| 2. Head and Nerve | | | |
| - Ever had a head injury or concussion? | | | |
| - Ever been knocked out, become unconscious, or lost your memory? | | | |
| - Ever had a seizure? | | | |
| - Frequent or severe headaches? | | | |
| - Ever had numbness or tingling in your arms, hands, legs, or feet? | | | |
| - Ever had a stinger, burner, or pinched nerve? | | | |
| 3. Last tetanus shot? | Date: | | |
| 4. Last eye exam? | Date: | | |
| 5. Last menstrual period (if female) | Date: | | |

| **PERSONAL HABITS** | **YES** | **NO** |
|---|---|---|
| Smoking/smokeless tobacco | | |
| Alcohol/non-medical drugs: marijuana, cocaine, etc. | | |
| Steroids | | |
| Eating Disorders – weight loss or gain? | | |

| **REVIEW OF SYSTEMS (Please check if student has any problems with any of the following areas of the body.)** | | |
|---|---|---|
| ☐ Skin | ☐ Lungs | ☐ Shoulders, Arms, Hands |
| ☐ Head | ☐ Heart | ☐ Hips, Legs, Feet |
| ☐ Eyes | ☐ Abdomen | ☐ Muscles – strength, feeling |
| ☐ Ears | ☐ Back | ☐ Neck |
| ☐ Nose | ☐ Mental Emotional Fatigue | ☐ Nutrition, Weight Control |
| ☐ Mouth/Throat | ☐ Urination, Bowel Control (incl. menstrual for female) | |
| ☐ Other: What? | | |

I certify that the above information is correct to the best of my knowledge.

Parent/Guardian Signature

Student Signature

**Both Student and Parent/Guardian Signatures are Mandatory**

# SPORTS PHYSICAL — EXAMINATION

*To be completed by Physician – Page 1 of 2*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Last Name: | | First Name: | | | | Initial: | |
| Address: | | | | | | | |
| Phone Number: | | Grade: | | Allergies/Asthma: | | | |
| Height: | | Weight: | | Blood Pressure: | | | |
| Pulse recorded: | Resting: | | | 15 hops: | | After 2 minutes: | |
| Visual Acuity: | | Eyes (R) 20/ | | w/o glasses | | Eyes (L) 20/ | | w/o glasses | |

| **OTHER TESTING:** | **NORMAL** | **ABNORMAL FINDINGS** |
|---|---|---|
| 1. General | | |
| 2. Skin | | |
| 3. HEENT | | |
| 4. Teeth (Dental Exam) | | |
| 5. Neck | | |
| 6. Lungs | | |
| 7. Heart (Sit and Stand) | | |
| 8. Abdomen | | |
| 9. Genitalia | | |
| 10. Musculoskeletal | | |
| - Neck | | |
| - Shoulder/Arm | | |
| - Elbow/Forearm | | |
| - Wrist/Hand | | |
| - Back | | |
| - Hip/Thigh | | |
| - Knee | | |
| - Shin/Calf | | |
| - Ankle/Leg | | |
| - Foot | | |
| 11. Peripheral Pulses | | |
| 12. Neurologic | | |
| 13. Mental Status | | |
| 14. Marfan Screen | | |

| **Other Tests: (optional)** | | | |
|---|---|---|---|
| Auditory: | | U/V: | |
| Chest X-Ray: | | % Body Fat: | |
| Drug Screen: | | Tanner Stage: | |
| Hgb/Hct: | | SMAC | |

| **Comments or Notes:** |
|---|
| |
| |
| |
| |
| |

On the basis of the examination of this day, I approve this child's participation in interscholastic sports for one year:

| ☐ YES | ☐ NO | ☐ LIMITED: | |
|---|---|---|---|
| Examination Date: | | | |
| Physician's Printed Name Or Office Stamp: | | | |
| Physician's Telephone Number: | | | |
| Physician's Signature: | | | |