*Dear Parents,*

*Please review the following chart. This outlines what medical/dental forms are needed by grade. If your child has seen the pediatrician, dentist or eye doctor in the current year that appointment may count for the upcoming school year.*

| | ***Medical Examination*** *Including immunization documentation* | ***Dental Examination*** | ***Vision Examination*** | ****Tdap Vaccine & *MCV4 (MPSV4)*** | ***Athletic Physical*** *Including emergency information, Bishop Waiver, SMAA Waiver* | ***Varicella Vaccine*** | ***Pneumococcal Vaccine*** |
|---|---|---|---|---|---|---|---|
| ***Pre-School*** | X | | | | | | X |
| ***KDG.*** | X | X | X | | ***3rd-8th ALL*** | X | |
| ***Second Grade*** | | X | | | ***STUDENTS*** | | |
| | | | | | ***WHO*** | | |
| ***Sixth Grade*** | X | X | | X | ***PARTICIPATE*** | X | |
| ***New Students*** | X | X | X | | ***IN*** | X | X |
| | | | | | ***ATHLETICS*** | | |

*SMAA Physicals are separate and distinct. Students who participate in athletics through SMAA must have a physical form and all athletic forms completed. The athletic physical is good for 365 days from date of physical. If you need SMAA forms, please contact the school office.*

*All necessary forms are included with this letter. Some you may not need this year, you may keep them for future use however forms will be sent home annually.*

*If you have any questions please contact Mary Lynn Kempf at the school office.*
*847-459-6270*

**Tdap*=Combination vaccine: tetanus, diphtheria, acellular pertussis (improved booster vaccine containing pertussis)
*Menactra (MCV4) Menomune (MPSV4)= Meningococcal meningitis vaccine

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

Please Print

| Student's Name (Last / First / Middle) | Birth Date (Month/Day/Year) | Sex | 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 MO DA YR | 2 MO DA YR | 3 MO DA YR | 4 MO DA YR | 5 MO DA YR | 6 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) | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 | ☐PCV7 ☐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 | 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 (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 the night coughing | Yes<br>Yes | No<br>No | Indicate Severity | 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<br>Other concerns? | | | |
| 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 | | | | | |

**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 ☐ 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 Indicated?** Yes ☐ No ☐ **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☐ No☐ Objective screening Yes☐ No☐ Result_____<br>Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐ | | | Genito-Urinary | | LMP |
| | | | Neurological | | |
| Nose | | | Musculoskeletal | | |
| Throat | | | Spinal examination | | |
| Mouth/Dental | | | Nutritional status | | |
| Cardiovascular/HTN | | | Mental Health | | |
| Respiratory | | | | | |

**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** (for one year) Yes ☐ No ☐ Limited ☐

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: ☐ 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 _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health, 535 W. Jefferson St., Springfield, IL 62761
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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P.O.#346085 5M 10/05

# 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 15th 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 child beginning school

Student Name: _____ Birth Date: _____ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: _____ Phone: _____
(Last) (First) (Area Code)

Address: _____ County: _____
(Number) (Street) (City) (Zip Code)

## To Be Completed By Examining Doctor

Date of Exam: _____

### Case History

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) | ❑ | ❑ | ❑ | _____ |
| Internal Exam (media, lens, fundus, etc.) | ❑ | ❑ | ❑ | _____ |
| Neurological Integrity (pupils) | ❑ | ❑ | ❑ | _____ |
| Binocular Function (stereopsis) | ❑ | ❑ | ❑ | _____ |
| Accommodation and Vergence | ❑ | ❑ | ❑ | _____ |
| Color Vision | ❑ | ❑ | ❑ | _____ |
| IOP (glaucoma) | ❑ | ❑ | ❑ | _____ |
| Oculomotor Assessment | ❑ | ❑ | ❑ | _____ |
| Other: _____ | ❑ | ❑ | ❑ | _____ |

### Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other: _____

### 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. _____

**Consent of Parent or Guardian**
I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

Print Name: _____
Optometrist or Physician Who Provides Eye Examinations

Address: _____

_____

Signature: _____ Phone: _____
Optometrist or Physician Who Provides Eye Examinations