LEMONT HIGH SCHOOL ENROLLMENT CHECKLIST
* TRANSFER STUDENTS *

New student enrollment for transfer students is completed **by appointment only**. Once you have collected all **required** documents, please contact Registrar Heather Richa at (630) 243-3218 to schedule an appointment.

REQUIRED STUDENT INFORMATION

Please bring this enrollment checklist and all required documents with you to your appointment.
*Students may not enroll at Lemont High School until they have been withdrawn from their current school. Biological, adoptive or foster parents may enroll a student. Guardians must have proper court authorization. Custody documentation is required when applicable.**

_____ **Student Enrollment Information Form**
_____ **Parent/Guardian Photo ID** ***(driver's license or any photo ID is acceptable)***
_____ **Student's Certified Original Birth Certificate or Passport** ***(passport only may be used for international students)***
_____ **Illinois Child Health Examination Form, completed by an Illinois physician** ***(w/ up-to-date immunization record)***
_____ **State of Illinois Eye Examination Form, completed by an Illinois physician** ***(if transferring from out-of-state)***
_____ **ISBE Student Transfer Form** ***(required if transferring from an Illinois public high school)***
_____ **Discipline Records/"Good Standing" Letter** ***(required if transferring from out-of-state or a parochial school)***
_____ **Withdrawal Form from Previous School, including Withdrawal Grades/Grades in Progress** ***(for in-year transfers)***
_____ **Transcript** ***(required for upperclassmen and second-semester freshmen)***
_____ **Authorization for Release/Exchange of Information Form**
_____ **Current/Future Schedule**
_____ **Required Proofs of Residency** ***(see below)***
_____ **IEP/Special Education Records/Section 504 Plan** ***(if applicable)***
_____ **Divorce/Custody/Guardianship Papers/906 Placement Form** ***(if applicable)*** **– *NOTE:** If a non-custodial parent/guardian is enrolling the student, the Registrar may require that individual to complete the Non-Parent Custodial Form at the time of enrollment.

REQUIRED PROOF OF RESIDENCY FROM PARENT/HOMEOWNER

To enroll, a student's parent/legal guardian AND the student must be full-time residents within the district's attendance boundaries.

IF YOU OWN YOUR HOME:	***IF YOU RENT OR LEASE:***	***IF YOU LIVE WITH ANOTHER FAMILY:***
• One proof of residency from Category A • Two proofs of residency from Category B	• Current signed lease/rental agreement • Two proofs of residency from Category B	• Owner's Affidavit of Residence Form • One proof of residency from Category A and one proof of residency from Category B **by the owner/renter of the residence** • One proof of residency from Category C **by the parent/guardian**

CATEGORY A ***(only originals will be accepted)***

_____ **Most recent property tax bill, deed of ownership, or current signed lease/rental agreement**
_____ **Signed and dated real estate papers indicating purchase/ownership of property within District 210's boundaries**
_____ **Mortgage statement or mortgage payoff letter**

CATEGORY B ***(only originals will be accepted)***

_____ **Current utility bill** ***(i.e., gas, electric, water, telephone, cell phone, Internet)***
_____ **Homeowner's/Renter's insurance statement**
_____ **Vehicle registration**
_____ **Driver's license**
_____ **Voter registration card**
_____ **Income tax bill**

CATEGORY C – must provide proof of residence at the address listed ***(only originals will be accepted)***

_____ **Current bill** ***(i.e., cell phone)*** **with your name and address clearly listed**
_____ **Insurance statement**
_____ **U.S. Postal Service change of address form**
_____ **Bank statement**
_____ **New Illinois driver's license receipt**

LEMONT HIGH SCHOOL ENROLLMENT INFORMATION FORM

Please complete this form fully and return it in person to Heather Richa in the school's Main Office or via:
Mail – *Lemont High School Counseling Department, 800 Porter Street, Lemont, IL 60439*
FAX – *(630) 243-7904 (Attn: Registrar)* • ***E-Mail –*** *hricha@lhs210.net*

STUDENT'S LEGAL NAME: _____
(as listed on the birth certificate) **(Last)** **(First)** **(Middle)** **(Suffix)**

STUDENT'S BIRTH DATE: ____ /____/_____ **GENDER:** **Male** **Female** *(please circle)* **CURRENT GRADE:** **7** **8** **9** **10** **11** **12** *(please circle)*

STUDENT'S BIRTH PLACE: _____
(City) **(State)** **(Country)**

RACE AND ETHNICITY

These questions are required by the United States Department of Education (72 Fed. Reg. 59267). The first question asks about the student's ethnicity, and the second question asks about the student's race. If a parent/guardian or student age 18 or older declines to respond to either question, the school district is required to provide the missing information by observer identification.

IS THIS STUDENT HISPANIC OR LATINO? *(please circle)* **YES** **NO**

WHAT IS THE STUDENT'S RACE? *(please circle ALL that apply)*

American Indian/Native Alaskan **Asian** **Black/African-American** **Native Hawaiian/Pacific Islander** **White**

LANGUAGE SURVEY

Illinois Administrative Code (23 Ill. Admin. Code 228.15) requires that each school district administer a Home Language Survey to each student entering the district for the first time. The information is used to identify the need for English language support services.

DOES THIS STUDENT PRIMARILY SPEAK A LANGUAGE OTHER THAN ENGLISH? *(please circle)* **YES** **NO**

IF YES, PLEASE SPECIFY THE LANGUAGE: _____

IS A LANGUAGE OTHER THAN ENGLISH PRIMARILY SPOKEN IN YOUR HOME? *(please circle)* **YES** **NO**

IF YES, PLEASE SPECIFY THE LANGUAGE: _____

Please note: *If the answer to either question is* ***YES****, the school will assess your student's English language proficiency. As required by Illinois State law, the school will use the WIDA Model or W-APT test to measure the student's listening, speaking, reading and writing skills to determine if he/she needs additional language supports.*

CURRENT/LAST ATTENDED SCHOOL

STUDENT'S MOST RECENT SCHOOL: _____
(Name) **(City)** **(State/Country)**

DOES THIS STUDENT HAVE AN INDIVIDUALIZED EDUCATION PLAN (IEP)? *(please circle)* **YES** **NO**

DOES THIS STUDENT HAVE A 504 PLAN? *(please circle)* **YES** **NO**

HAS THIS STUDENT EVER BEEN ELIGIBLE FOR SPECIAL EDUCATION SERVICES? *(please circle)* **YES** **NO**

DOES THIS STUDENT CURRENTLY RECEIVE ENGLISH LANGUAGE LEARNER SERVICES? *(please circle)* **YES** **NO**

PLEASE ANSWER BELOW ONLY IF THE STUDENT WAS NOT BORN IN EITHER THE UNITED STATES OR PUERTO RICO.
(The Illinois State Board of Education requires this information to be collected for students not born in the U.S. or Puerto Rico in order to identify students who are eligible for the Immigrant Student Program)

PLEASE PROVIDE THE DATE THE STUDENT FIRST ENROLLED IN A U.S. SCHOOL: _____ /_____ / _____

All sections on this page are mandatory.

STUDENT'S NAME: _____ **TODAY'S DATE:** _____ / _____ / _____

DOES THIS STUDENT HAVE A SIBLING WHO HAS ATTENDED LEMONT HIGH SCHOOL? *(please circle)* **YES NO**

PRIMARY FAMILY INFORMATION

This section is mandatory. *Please include parents/guardians who reside with the student on a permanent basis.*

PARENT/GUARDIAN: _____ **RELATIONSHIP TO STUDENT:** _____

MAILING ADDRESS: _____
(Street - w/ PO Box or Apartment Number) (City) (State) (Zip)

PRIMARY PHONE ( ) _____ **CELL** ( ) _____ **WORK** ( ) _____

E-Mail Address _____

SPOUSE/PARTNER: _____ **RELATIONSHIP TO STUDENT:** _____

CELL ( ) _____ **WORK** ( ) _____

E-Mail Address _____

SECONDARY FAMILY INFORMATION

This section is optional. *Please complete* ***ONLY*** *if the student has a parent/guardian with whom he/she does not reside on a permanent basis. The most common circumstances are when the student's parents are divorced; the student's parents are separated and living at different addresses; or the student has a non-custodial/non-residential parent/guardian living at a different address than his/her own.*

Parents/guardians of students with these circumstances should complete this section and, if necessary, provide a copy of the proper legal documentation to the Registrar. Depending on the circumstances, these legal documents may include custody papers, a divorce decree, or a notarized letter from the Residential Custodial Parent (i.e., the parent with whom the student lives within the district boundaries).

The secondary family will receive all mailings that the Residential Custodial Parent receives. In order for the secondary family not to receive mailings or have access to student records based on a custodial agreement, the appropriate legal documentation must be on file with the school.

DO THE DIVORCED PARENTS HAVE: *(please circle)* **JOINT CUSTODY SOLE CUSTODY NOT APPLICABLE**

IF APPLICABLE, ARE THE APPROPRIATE LEGAL DOCUMENTS ON FILE WITH THE SCHOOL? *(please circle)* **YES NO**

SHOULD THE SECONDARY FAMILY RECEIVE MAILINGS (including report cards) FROM THE SCHOOL? *(please circle)* **YES NO**

PARENT/GUARDIAN: _____ **RELATIONSHIP TO STUDENT:** _____

MAILING ADDRESS: _____
(Street - w/ PO Box or Apartment Number) (City) (State) (Zip)

PRIMARY PHONE ( ) _____ **CELL** ( ) _____ **WORK** ( ) _____

E-Mail Address _____

SPOUSE/PARTNER: _____ **RELATIONSHIP TO STUDENT:** _____

CELL ( ) _____ **WORK** ( ) _____

E-Mail Address _____

STUDENT'S NAME: _____ **TODAY'S DATE:** _____ / _____ / _____

STUDENT RESIDENCY

All parts of this section are mandatory. *A student's residence for school purposes is the residence of the person who has* ***legal custody*** *of the student. According to Illinois School Code (105 ILCS 5/10-20.12b), legal custody and residency must be proven for the student to enroll.*

NAME OF PARENT/GUARDIAN COMPLETING THIS FORM: _____

RELATIONSHIP TO STUDENT: _____

DO YOU HAVE LEGAL CUSTODY OF THE STUDENT? *(please circle)* **YES NO**

DO YOU: *(please circle)* **OWN YOUR HOME** **RENT** **OTHER:** _____

HOME ADDRESS: _____

(Street - w/ PO Box or Apartment Number) **(City)** **(State)** **(Zip)**

Please INITIAL ONE that best describes your custody of the student. ***(If none applies, you must select one from the list of "Exceptions.")***

_____ **Custody is exercised by a natural or an adoptive parent with whom the student resides.**

_____ **Custody has been granted by court order to a person with whom the student resides for reasons other than to have access to the district's educational programs.** ***(Please provide a copy of the court order.)***

_____ **Custody is exercised under a court-approved short-term guardianship.** ***(Please provide a copy of the court order.)***

_____ **Custody is exercised by a caretaker adult relative who is receiving aid under the Illinois Public Aid Code, and with whom the student resides for reasons other than to have access to the district's educational programs.** ***(Please provide a copy of the Public Aid documents.)***

_____ **Custody is exercised by an adult who demonstrates that he/she has assumed, and exercises, legal responsibility for the student and provides a regular fixed nighttime dwelling for reasons other than to have access to the district's educational programs.**

EXCEPTIONS

_____ **The student is homeless.** ***(This will involve a meeting with the district's homeless liaison.)***

_____ **The student is a foreign exchange student.**

_____ **The student has been placed with a foster parent or child care facility by the Department of Children and Family Services outside the district's boundaries, but DCFS has determined it is in the best interests of the student to maintain attendance in the district.** ***(Please attach a copy of the DCFS determination.)***

_____ **The student is under the age of 18, but has been emancipated by court order or marriage and lives within the district's boundaries on a full-time basis and for an indefinite length of time.** ***(Please attach a copy of the court order or marriage license.)***

Please INITIAL EACH of the following statements and sign and date below.

_____ **I am the custodial parent/guardian of the student named at the top of this form.**

_____ **This student is under my custody and control, and has established permanent residence with me at the address listed above.**

_____ **I affirm that information presented as part of my residency verification, in connection with any investigation of my residency and custody of the student, is true, complete and accurate.**

_____ **I understand that knowingly or willfully providing false information to a school district regarding the residency of a student for the purpose of enabling him/her to attend any school in that district is a Class C misdemeanor.**

_____ **I understand that knowingly enrolling or attempting to enroll a student in the school district when I know the student to be a non-resident of the school district – unless the non-resident student has a lawful right to attend – is a Class C misdemeanor and I will be liable for payment of any applicable fees and fines.**

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** ____ / ____ / ____

STUDENT'S NAME: _____ **TODAY'S DATE:** _____ / _____/_____

NOTIFICATIONS

STUDENT HANDBOOK

Lemont High School's Student Handbook is available under the "Student Services" tab on the school's website – **www.lhs210.net**. Students are expected to abide by the policies, procedures and codes set forth in the book. These policies, procedures and codes – which may be amended during the school year as necessary – are related to policies established by the Lemont High School District 210 Board of Education and based on the Illinois School Code.

TECHNOLOGY USE EXPECTATIONS

Lemont High School's Technology Use Expectations are included within the Student Handbook on the school's website, and are available on the school's website (search "Technology Use Expectations"). These expectations pertain to all students, faculty and staff who utilize any of the school's technology resources. The district's network is designed for educational purposes. Users are expected to employ good judgment when accessing resources on the district's network. The district and/or its agents may access and monitor students' use of the Internet, including school-issued e-mail and downloaded material, without prior notice to a parent/guardian.

DIRECTORY INFORMATION

Lemont High School provides student directory information to various entities throughout the year. Though not an inclusive list, this information may be shared with trusted partners with whom the school contracts for services, as well as other institutions as required by state and/or federal law. Parents/guardians have rights to limit what information may be shared with external entities under the Family Educational Rights and Privacy Act (FERPA) and Illinois Student Records Act. These rights, as well as the correpsonding procedures to exercise these rights, are detailed within the Student Handbook that is available on the school's website – **www.lhs210.net**.

I acknowledge receipt of these notifications.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** ____/____ / ____

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

Lemont High School • 800 Porter Street • Lemont, IL 60439 • (630) 257-5838 • www.lhs210.net

I hereby authorize the exchange of communications and the release/exchange of the following records concerning

_____ between the agents and employees of **Lemont High School District 210** and:
(Student's name)

Name/Title: _____

Agency/Organization/Previous School: _____

Address: _____
(Street) **(City)** **(State)** **(Zip)**

Phone ( ) _____ **E-Mail Address:** _____

I hereby authorize that the following information will be released/exchanged *(please check all that apply):*

____ **All Permanent Records** (including, but not limited to: basic identifying information; birth certificate or other proof of student's identity; official academic transcript; attendance records; health records; and, where applicable, scores received on all state assessments administered in grades 9-12, including designation of student's achievement of the State Seal of Biliteracy or State Commendation Toward Biliteracy)

____ **All Temporary Records** (including, but not limited to: scores on state assessments administered in grades K-8; discipline records; health-related information; accident reports; family background information; psychological evaluation reports; aptitude and achievement test results; report cards; honors and awards; progress monitoring information; IDEA/special education records; and Section 504 records)

____ **Other** *(please specify)*: _____

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 et seq.), and the *Illinois Mental Health and Developmental Disability Confidentiality Act (740 ILCS 110/1 et seq.) and are to be made for the purpose of:**

____ **Educational evaluation and/or planning**

____ **Other** *(please specify)*: _____

** Prior to the release of protected health information, health care providers may require the parent/guardian to execute an additional authorization form to comply with the Health Insurance Portability and Accountability Act (HIPAA).*

Please send records to the attention of:

____ **Dr. Christine Flores, Director of Special Education Services (cflores@lhs210.net)**

____ **Heather Richa, Registrar/Counseling Secretary (hricha@lhs210.net)**

I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I also understand that my refusal to consent to the exchange of records and communications could result in incomplete and/or inappropriate educational planning for the student. This consent expires one year from the date indicated below. I understand that I have the right to revoke this consent in writing at any time.

PARENT/GUARDIAN NAME *(printed)*: _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** ____/____ / ____

WITNESS SIGNATURE: _____ **DATE:** ____/____ / ____
(required for mental health/developmental disability records)

STUDENT SIGNATURE: _____ **DATE:** ____/____ / ____
(required for mental health/developmental disability records, if student is age 12 or older)

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School /Grade Level/ID#**
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: **To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

REQUIRED Vaccine / Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:**		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR** ****MUMPS MO DA YR** **HEPATITIS B MO DA YR** **VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

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

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

ALLERGIES (Food, drug, insect, other)	Yes No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**	
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No			Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			Surgery? (List all.) When? What for?	Yes No		
Diabetes?	Yes No			Serious injury or illness?	Yes No		
Head injury/Concussion/Passed out?	Yes No			TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No		
Heart problem/Shortness of breath?	Yes No			Tobacco use (type, frequency)?	Yes No		
Heart murmur/High blood pressure?	Yes No			Alcohol/Drug use?	Yes No		
Dizziness or chest pain with exercise?	Yes No			Family history of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes No			Information may be shared with appropriate personnel for health and educational purposes. **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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed ☐** **Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm_____**
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐**

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

Address **Phone**

State of Illinois
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 _____
(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

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

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

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

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

Address _____

_____

Phone _____

Consent of Parent or Guardian

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

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

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

Printed by Authority of the State of Illinois
6/09

IOCI1271-09