



LAKE FOREST ACADEMY

SUMMER PROGRAM FORMS

PLEASE COMPLETE THESE FORMS AND MAIL THEM TO THE SUMMER SESSION OFFICE BEFORE JULY 1, 2020

These forms must be completed and received at Lake Forest Academy before July 1, 2020. These forms can also be found at <http://www.lfanet.org/esl>

- ☐ General Permission
- ☐ School Guardian in the United States
- ☐ Medical Emergency Authorization (MEA)
- ☐ Student Medical Insurance – complete only if the student has his/her own medical insurance
- ☐ Immunization Checklist
- ☐ Additional Health Information
- ☐ DHS, State of Illinois, Certificate of Child Health Examination, Final page
 - ☐ Page One: Immunizations
 - ☐ Page Two: Health history and **physical exam**

For questions, please contact:

Paul Dunlop, Dean of Summer Session

Email: pdunlop@lfanet.org

Phone: 1-847-615-3239

Fax: 1-847-615-4841

**PLEASE NOTE: STUDENTS MAY NOT ATTEND CLASSES
OR PARTICIPATE IN ACTIVITIES UNTIL COMPLETED FORMS
ARE RECORDED IN THE DEAN OF STUDENTS OFFICE.**

GENERAL PERMISSION FORM

Name of Student _____
FAMILY NAME GIVEN NAME PREFERRED NAME

I. Campus Store

All transactions in the Campus Store during the Summer Program are cash, or credit card.

II. Student Bank

Boarding students are also permitted to create a student bank account with the Business Office. Once the account has been created, students may withdraw up to \$150 per week. Students may take additional money with parents written permission (email)

Amount your child may withdraw per week (maximum \$150): \$_____ per week.

III. Leaving Campus (for boarding students only)

My child and I have discussed whether or not he/she may ride in a student-driven car.

He/she may _____ may not _____ (please check one) ride in a student-driven car.

(Please be aware that any changes to this permission must be sent in writing to the Dean of Students office and signed by the person who signed this form.)

IV. Information Services

I give Lake Forest Academy permission to include my child's name in press releases to the local newspapers.

_____ Yes _____ No

I give Lake Forest Academy permission to use my child's photograph in official school publications, including on the LFA website.

_____ Yes _____ No

Signature of Parent: _____ Date: _____

Signature of Student: _____ Date: _____

SCHOOL GUARDIAN IN THE UNITED STATES

International families must designate in writing an individual in the United States to act as a guardian ("School Guardian") for their child while the student is attending LFA. The school will regard such designated School Guardians to have the authorization to exercise parental authority over the student in the absence of the legal parent, unless the school is notified otherwise in writing. Such authority will include, but not be limited to, executing permission forms and approving a student's sign-out plans to leave campus. School Guardians will also receive copies of grades, bills, and other correspondence between the school and families.¹

All international families must designate a School Guardian for their child by identifying the following information, and both a Parent and the designated School Guardian should sign where indicated below.

Parent:

I, _____ [parent], parent of _____ [student],

hereby designate _____ [school guardian] to act as a School Guardian, as described above, for my child for the Summer Program.

The contact information for the School Guardian is:

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail: _____

Fax: _____

School Guardian:

I, _____ [school guardian], acknowledge and agree that I have been

designated to be the School Guardian, as described above, for _____ [student] for the Summer Program.

Signature of School Guardian: _____ Date: _____

Signature of Parent: _____ Date: _____

Signature of Student: _____ Date: _____

¹ Please note that whenever the term "guardian" is used in LFA documents or correspondence, including but not limited to the Student Handbook, that term includes designated School Guardians.

MEDICAL EMERGENCY AUTHORIZATION (MEA)

Student Information

Name of Student: _____ Cell Phone: _____
Date of Birth: _____ Social Security Number: _____
Allergies: _____
Chronic Medical Problems: _____
Current/Routine Medications: _____
Date of Last Diphtheria/Tetanus Immunization: _____

Parent Information

Father	Mother
Name _____	Name _____
Address _____	Address _____
Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____
Cell Phone _____	Cell Phone _____
Social Security # _____	Social Security # _____
Parent with Legal Custody: _____	

Emergency Contacts

Name _____	This person may authorize medical care <input type="checkbox"/> Yes <input type="checkbox"/> No
Home Phone _____	Relationship to the student _____
Work Phone _____	Cell Phone _____

Family Physician

Name _____ Phone _____

Medical Authorization

- During my child's attendance at Lake Forest Academy, I hereby give Lake Forest Academy permission and consent to make decisions to proceed with any emergency medical or surgical treatment required for my child's health and welfare.
- Any community hospital or emergency center utilized by my child during his/her attendance at Lake Forest Academy has my permission to release my child's medical record to Lake Forest Academy for continuity of care.
- We are attaching our insurance information which will be on record at LFA and Lake Forest Hospital. We agree to cover medical costs that are not met by our insurance carrier.
- Please check **one** (1) of the following:
_____ I hereby authorize the LFA Student Health Services personnel to administer to my son/daughter prescription medications as recommended by the Academy's licensed physician and non-prescription (over-the-counter) medications. I also allow the dorm staff to give my son/daughter over-the-counter medications (decongestants, analgesics, antihistamines, etc) as needed.
_____ I do **not** want the school nurse or faculty to administer non-emergency medications to my child. I will allow attending physicians to prescribe and administer medications as needed in emergency situations.
- Please note any medical conditions or allergies that may affect the dispensing of medication :

Signature of parent: _____ Date: _____

STUDENT MEDICAL INSURANCE

Medical insurance is included in the tuition for the Summer Program. However, Lake Forest Academy will give a \$270 refund to students who can prove that they have their own insurance coverage. This coverage must be with an insurance company with offices and a telephone contact in the United States. All other students will be enrolled automatically through LFA's recognized insurance company, United Healthcare Insurance Company.

Please note: payment for medical bills and other charges not covered through the insurance policy are the responsibility of the student, not the responsibility of Lake Forest Academy. LFA assumes no burden of medical expenses.

1. If your child does not have insurance, an insurance policy will be purchased for him or her automatically.

OR

2. If your child has medical insurance, and the insurance company has offices in the United States, please complete the following to apply for a \$260 tuition refund. Please attach a **photocopy of both the front and back of your child's insurance card.**

[] Please do not enroll _____ in an insurance plan.
Student Name

In making this selection, I accept full responsibility for all medical costs incurred by my child. My current, active plan is with:

Insurance Company Name

Policy Number & Phone Number

Insurance Company Address

City, State & Zip Code

I understand that medical insurance for the student identified above is a condition of admission to the Lake Forest Academy Summer Program, and that LFA assumes no burden of any medical expenses.

Signature of Parent/Guardian

Date

DHS FORM AND IMMUNIZATION CHECKLIST

All students must complete the DHS (State of Illinois, Department of Human Services, and Certificate of Child Health Examination) form.

Front side of DHS form:

- I ____ Complete personal information on the top two lines
- II ____ Immunizations (**ALL** shots from the day you were born until today)
1. ____ **TDAP** (Diphtheria, Pertussis, Tetanus) (**TD does NOT meet the requirement!**)
ALL shots from birth must be on your record (**3** or **4** dates required)
Last date must be within 10 years of today
 2. ____ **Oral Polio**
3 dates required
 3. ____ **Hepatitis B**
3 dates required
 4. ____ **Varicella or Chicken Pox**
2 dates required (or the date of disease at the bottom of the form)
 5. ____ **MMR** (Measles, Mumps, Rubella)
2 dates required
- III ____ Signature and date by the doctor

Back side of DHS form:

- I ____ Health History completed by the parent
- II ____ Physical Examination
- **Signed and dated** by your doctor **before** you come to Lake Forest Academy
1. ____ **Diabetes** screening question
 2. ____ **TB Test**
 - *If this test is positive, a chest X-ray is required*

Please note:

1. The DHS form must be filled **completely** before your child arrives at LFA.
2. All dates of all immunizations are required.
3. Bring an additional photocopy of the DHS form with you when you arrive at LFA.
4. Do **not** bring medications from your country. All medications you use at LFA must come from the school nurse. If you take medications daily, you must report this to the school nurse.

ADDITIONAL HEALTH INFORMATION

Please have your physician review and complete this as part of your child's examination.

Students sometimes complain about chronic conditions of which we have no medical record (some examples include migraines, asthma, depression, excessive menstrual cramps, diabetes, an orthopedic condition, Crohn's disease, ADD, etc.). Please use the space below to indicate any medical treatments which are being administered to this student and any prescription drugs which will be taken during the school year.

Name of Student _____

Name of Physician _____

Signature of Physician _____ Date _____



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

Please Print

Student's Name				Birth Date		Sex	School	Grade Level /ID#					
Last		First		Middle		Month/Day/ Year							
Address		Street		City		ZIP code		Parent/ Guardian Telephone # Home Work					
IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for <u>every</u> dose administered. The day and month is required if you cannot determine if the vaccine was given <u>after</u> the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.													
VACCINE/DOSE		1		2		3		4		5		6	
		MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
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)											Comments		
Varicella (Chickenpox)													
Combined Measles, Mumps and Rubella (MMR)													
Measles (Rubeola)													
Rubella (3-day measles)													
Mumps													
Pneumococcal (not required for school entry)		<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23	
Check specific type (PCV7, PPV23)													
Other (Specify hepatitis A, meningococcal, etc.)													

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

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)											
*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature											
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.											
Date of Disease		Signature		Title		Date					
3. Laboratory confirmation (check one)		<input type="checkbox"/> Measles		<input type="checkbox"/> Mumps		<input type="checkbox"/> Rubella		<input type="checkbox"/> Hepatitis B		<input type="checkbox"/> 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														Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
Age/Grade															
	R	L	R	L	R	L	R	L	R	L	R	L	R		L
Vision															
Hearing															

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

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

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)									
PHYSICAL EXAMINATION REQUIREMENTS			HEIGHT		WEIGHT		BMI		B/P
DIABETES SCREENING BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>									
LEAD RISK QUESTIONNAIRE * Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (Blood test required in Chicago and other high risk zip codes.)									
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read ____ / ____ / ____ Result _____ mm									
LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES			Date		Results		Date		Results
Hemoglobin * or Hematocrit *					Sickle Cell * (as indicated)				
Urinalysis					Other				
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs				Normal	Comments/Follow-up/Needs		
Skin						Endocrine			
Ears						Gastrointestinal			
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____ Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/>				Genito-Urinary		LMP	
Nose						Neurological			
Throat						Musculoskeletal			
Mouth/Dental						Spinal examination			
Cardiovascular/HTN						Nutritional status			
Respiratory						Mental Health			
NEEDS/MODIFICATIONS required in the school setting						DIETARY Needs/Restrictions			
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup									
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal									
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.									
On the basis of the examination on this day, I approve this child's participation in (If No or Modified, please attach explanation.) PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>									
Physician/Advanced Practice Nurse/Physician Assistant performing examination									
Print Name			Signature				Date		
Address					Phone				

(Complete both sides)