Palos School District 118
8800 W. 119th St. | Palos Park, IL 60464 | 708-448-4800 | www.palos118.org

IMPORTANT NOTICE OF HEALTH REQUIREMENTS FOR 6th Grade Students

ALL PHYSICAL EXAMS DUE JULY 1st

(No admittance on the first day of school without physical exam on file in health office)

The State of Illinois and Palos Consolidated School District 118 **require** that each student **provide proof** of having met the following health requirements for school:

1. **EVIDENCE OF A PHYSICAL EXAMINATION** by a State Licensed Health Care Provider (using the "Certificate of Child Health Examination" form) within one year of entering school.

2. **MEDICAL VERIFICATION OF COMPLETE IMMUNIZATION HISTORY,** which states month, day, year, and signature of the doctor or nurse for each immunization below.

a.	DTP/DTaP:	At least 4 doses (Note: Last dose MUST BE A BOOSTER ON OR AFTER THE 4th BIRTHDAY)
b.	Tdap:	1 dose required at age 11 years or older.
c.	POLIO:	At least 3 doses (Note: Last dose MUST BE A BOOSTER ON OR AFTER THE 4th BIRTHDAY)
d.	HEPATITIS B:	A series of three doses
e.	VARICELLA:	One dose on or after 12 months of age and the second dose no sooner than one month
f.	MEASLES:	The first dose after 12 months of age and the second dose no sooner than one month later (may have laboratory proof or verification of disease by Health Care Provider)
g.	MUMPS:	One dose on or after 12 months of age and the second dose no sooner than one month later (may have laboratory proof or verification of disease by Health Care Provider)
h.	RUBELLA:	One dose on or after 12 months of age the second dose no sooner than one month later (may have laboratory proof or verification of disease by Health Care Provider)
i.	MENINGGOCOCCAL:	One dose of meningococcal conjugate vaccine (MCV) at age 11 years or older.

3. **MEDICAL VERIFICATION OF DIABETES SCREENING IS REQUIRED.**
4. **APPROVAL OF PARTICIPATION IN PHYSICAL EDUCATION AND INTERSCHOLASTIC SPORTS** near the bottom of the page must be checked by the health care provider with modifications, if needed.
5. **HEALTH HISTORY** to be completed and signed by a parent/guardian and verified by the health care provider.

Please be sure that the physical form is completed entirely BEFORE you leave the doctor's office.

6. **COMPLETED DENTAL EXAMINATION** due by May 15th of the school year.
7. A yearly vision examination is recommended.

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						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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?	Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Child wakes during 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 ☐ 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**			
Bone/Joint problem/injury/scoliosis?	Yes No			**Signature**		**Date**	

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **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**

INSTRUCTIONS FOR COMPLETING

ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM

Who may use the *Certificate of Religious Exemption to Required Immunizations and/or Examinations Form:*

- Parents or legal guardians who are requesting a religious exemption to immunizations or examinations **must** use this form for students entering kindergarten, sixth, or ninth grades.
- A separate form must be used for **each child** with a religious exemption enrolled to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school.
- This form may not be used for exemptions from immunizations and/or examination for personal or philosophical reasons. Illinois law does not allow for such exemptions. (See excerpts below from Public Act 099-0249 enacted August 3, 2015 at page bottom.)

When use of this form becomes required: October 16, 2015

How to complete the *Certificate of Religious Exemption to Required Immunizations and/or Examinations Form*:

- Complete the Parent/Guardian sections, which include key information about the student and the school the student will be entering, and the immunizations or examinations for which religious exemption is being requested. Provide a statement of religious belief(s) **for each vaccination/examination requested**.
- The form must be signed by the child's parent or legal guardian **AND** the child's health care provider* responsible for performing the child's health examination.
- Submit the completed form to local school authority on or before October 15th of the school year, or by an earlier enrollment date established by a school district.

Religious Exemption from Immunizations and/or Examination Form Process:

- The local school authority is responsible for determining whether the information supplied on the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form constitutes a valid religious objection.
- The local school authority shall inform the parent or legal guardian, at the time that the exemption is presented, of exclusion procedures, should there be an outbreak of one or more diseases from which the student is not protected, in accordance with the Illinois Department of Public Health (IDPH) rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
- Exempting a child from health, dental, or eye examination does not exempt the child from participation in the program of physical education training provided in Section 27-5 through 27-7 of the Illinois School Code [105 ILCS 5/27-5 through 105 ILCS 5/27-7]. A separate request for exemption from physical education, if desired, would need to be presented.

Excerpt from Public Act 099-0249 enacted August 3, 2015:

Children of parents or legal guardians who object to health, dental, or eye examinations or any part thereof, or to immunizations or to vision and hearing screening tests on religious grounds shall not be required to undergo the examinations or immunizations if the parents or legal guardians present to the appropriate local school authority a signed Certificate of Religious Exemption detailing the grounds for objection and the specific immunizations and/or examinations to which they object. The grounds for objection must set forth the specific religious belief(s) that conflict with the examination, immunization, or other medical intervention. The certificate will be signed by the parent or legal guardian to confirm their awareness of the school's exclusion policies in the case of a vaccine preventable disease outbreak or exposure. The certificate must also be signed by the child's health care provider responsible for performing the child's examination for entry into kindergarten, sixth or ninth grade. This signature affirms that the provider educated the parent or legal guardian about the benefits of immunization and the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.

The religious objection provided need not be directed by the tenets of an established religious organization. However, general philosophical or moral reluctance to allow physical examinations, eye examinations, immunizations, vision and hearing screening or dental examinations will not provide a sufficient basis for an exception to statutory requirements. The local school authority is responsible for determining if the content of the Certificate of Religious Exemption constitutes a valid religious objection.

The local school authority shall inform the parent or legal guardian of exclusion procedures in accordance with IDPH's rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690) at the time the objection is presented.

ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM

PARENT OR LEGAL GUARDIAN - COMPLETE THIS SECTION

Note: *This form is required for all students entering kindergarten, sixth or ninth grades when parent(s) or legal guardian(s) is requesting a religious exemption on or after October 16, 2015. This form also must be submitted to request religious exemption for any student enrolling to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school on or after October 16, 2015.*

This form may NOT be used for personal or philosophical reasons. Illinois law does not allow for such exemptions.

Student Name:(last, first, middle) _____ **Parent/Guardian Name**: _____	**Student Date of Birth**: Month Day Year _____ **Gender**: ☐M ☐F	**School Name:** _____ **City:** _____	**Grade:** _____
Address: _____ _____	**Telephone Number(s)**: _____ _____	**Exemption requested for** (mark all that apply): ☐ **Hepatitis B** ☐ **DTaP** ☐ **Polio** ☐ **Hib** ☐ **Pneumococcal** ☐ **MMR** ☐ **Varicella** ☐ **Td/Tdap** ☐ **Meningococcal** ☐ **Health Exam** ☐ **Eye Exam** ☐ **Dental Exam** ☐ **Vision/Hearing Tests** ☐ **Other (indicate below)** _____	

To receive an exemption to vaccination/examination, a parent or legal guardian must provide a statement detailing the religious beliefs that prevent the child from receiving each required school vaccinations/examination being requested.
In the space provided below, state each vaccination or examination exemption requested and state the religious grounds for each request. If additional space is needed, attach additional page(s).

_____

_____

_____

_____

_____

_____

_____

_____

Religious Exemption Notice:
No student is required to have an immunization/examination that is contrary to the religious beliefs of his/her parent or legal guardian. However, not following vaccination recommendations may endanger the health or life of the unvaccinated student, others with whom they come in contact, and individuals in the community. In a disease outbreak, or after exposure to any of the diseases for which immunization is required, schools may exclude children who are not vaccinated in order to protect all students.
I have read the Religious Exemption Notice (above) and have provided requested information for each vaccination/examination being requested for religious exemption.

_____

Signature of parent or legal guardian (required) Date

HEALTH CARE PROVIDER* – COMPLETE THIS SECTION

Provision of information: I have provided the parent or legal guardian of the student named above, with information regarding ***1) the required examinations, 2) the benefits of immunization, and 3) the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.*** *I understand that my signature only reflects that this information was provided; I am not affirming the parent or legal guardian's religious beliefs regarding any examination, immunization or immunizing agent.*

_____
Signature of health care provider*

Date: _____
(Must be within 1 year prior to school entry)

Health Care Provider Name:

Address:

Telephone #: _____

*Health care provider responsible for performing child's health examination includes physicians licensed to practice medicine in all of its branches, advanced practice nurses, or physician assistants.

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City		ZIP Code
Name of School:	ZIP Code	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name		

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other _____

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ 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 **Urgent Treatment —** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date: _____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date: _____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date: _____

Additional comments: _____

Signature of Dentist _____ License #: _____ Date: _____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

State of Illinois
Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name: Last	First	Middle		Birth Date: (Month/Day/Year)
Address: Street	City			ZIP Code
Name of School:	ZIP Code		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name			
Student's Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown ☐ Other_____				

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid / All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid / All Kids.

☐ My child is enrolled Medicaid / All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid / All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Parent or Guardian Signature _____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

IOCI 0600-10 Printed by Authority of the State of Illinois

State of Illinois
Illinois Department of Public Health

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
Illinois Department of Public Health

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

License Number _____

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

IOCI 15-391

State of Illinois
Illinois Department of Public Health

Eye Examination Waiver Form

Please print:

Student Name _____ Birth Date _____
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name _____ Grade Level_____ Gender: ❑ Male ❑ Female

Address _____
(Number) (Street) (City) (ZIP Code)

Phone_____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

❑ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ ALL KIDS.

❑ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

❑ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations:

_____

_____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois

IOCI 13-378

Colleen Grant Schumann, RN
Supervisor
Palos Township

10802 S. Roberts Road
Palos Hills, Illinois 60465

Office (708) 598-4418
Fax (708) 598-4478
Health Service (708) 598-2441
Fax (708) 598-2717

Health Service

	HEALTH SERVICE HOURS	PHYSICIAN HOURS
MONDAY & FRIDAY	8:00 AM – 3:00 PM	9:00 AM – 3:00 PM
TUESDAY & THURSDAY	12:00 PM – 7:00 PM	2:00 PM – 7:00 PM
WEDNESDAY	2:00 PM – 6:30 PM	2:30 PM – 6:30 PM

Blood Pressure Monitoring: Let us help you keep track of your blood pressure. Come in anytime during Health service hours. **Free of charge.**

Physical Examinations: Our physicians will perform basic school, camp, or employment physicals. Call for an appointment. **Resident fee $25.**

Immunizations: Available from infancy through age 18 as recommended by the State of Illinois if not covered by private insurance. **Resident fee $10 administration per injection.**

Illness: Our physicians are available for MINOR illnesses only. Follow up must be provided by your own physician. Call for an appointment. **Resident fee $20.**

Strep Screens: If determined necessary by our physician. **Resident fee $25.**

Diabetes Monitoring: Fasting blood sugars are done Monday and Friday mornings from 8am to 9:30am without appointment. Do NOT eat or drink after midnight. **Resident fee $5.**

Cholesterol Screening: Gives total value only. Fasting is preferred. **Resident fee $15. Non-resident fee $20.**

Cholesterol Testing: For Total Cholesterol, High Density (HDL), Low Density (LDL), Ratios, Glucose & Triglyceride values. Do NOT eat or drink after midnight. **Resident fee $40. Non-resident fee $50.**

Hemoglobin A1C: For diabetics, reflects the average blood sugar level over the previous 2-3 months. No fasting is necessary. **Resident fee $15. Non-resident fee $20.**

TB Testing: Mantoux skin test. Must be able to return to the clinic in 48-72 hours for test to be read. Call for an appointment. **Resident fee $20.**

Foot Care: Nail cutting is available to Senior Citizens six days each month. **By Appointment ONLY. Free of charge.**

ALL FEES ARE CASH ONLY. No insurance is accepted or filed.
Our physicians cannot be your primary care provider.

Services by appointment only unless noted.

Services are available to
Residents of Palos Township only unless otherwise stated .

Cook County DEPT of Public Health

Promoting health. Preventing disease. Protecting you.

www.cookcountypublichealth.org

Clinic Appointment Information

All Cook County Department of Public Health clinical services are conducted by appointment only. Eligibility requirements may apply and will be discussed when you call to make your appointment.

To make an appointment at one of our four clinics nearest your home, please call one of the following four numbers and an operator will assist you.

General Clinical Services

847-818-2860

TDD: 847-818-2023

708-786-4000

TDD: 708-786-4002

708-974-6160

TDD: 708-974-6043

708-232-4500

TDD: 708-232-4010

Tuberculosis (TB) Clinics

To make an appointment for at a CCDPH TB clinic or to report a case of Tuberculosis, call the number below. The operator will assist you in making an appointment at one of the four above-listed clinics.

708-836-8600

Additional Services

Breast & Cervical Cancer Screening

Medical/Immunization Records

Prenatal Program

Public Health Nursing

Tuberculosis

Vision and Hearing Screening

WORTH TOWNSHIP CLINIC . . . . . A PREVENTATIVE CLINIC

11601 SOUTH PULASKI ROAD • ALSIP, ILLINOIS 60803 • PHONE: 708-371-3393 FAX: 708-371-2542

SCHOOL, SPORT, and CAMP PHYSICALS *
IMMUNIZATIONS • FLU (When available)
FREE BLOOD PRESSURE CHECKS
PODIATRY SERVICES (preventative)*

*APPOINTMENTS REQUIRE FOR PHYSICALS

A parent must accompany all children under the age of 18. If coming in for an immunization, please bring a record of all previous immunizations or a letter from the school specifying what immunizations need to be given. We now offer services to non-residents of Worth Township at an increased cost. Proper Identification is a Driver's License and/or utility bill which must be provided at the time of visit.

CLINIC RATES • CASH or CHECK ONLY

	Resident	Non-Resident		Resident	Non-Resident
School / Sports Physicals	$25	$40	Children's Immunizations (each)	$10	$20
Work Physicals	$25	$40	TB Skin Test	$20	$20
Camp Physicals	$25	$40	Podiatry (Preventative)	$25	$40
Blood Pressure Check	FREE		Extra Forms	$5	$5

CLINIC HOURS

Monday, Tuesday, & Thursday: 9:00am - 3:30pm
Wednesday: 9:00am - 6:30pm
Friday- Closed*
*(Open Fridays in August for back to school rush: 9:00am-3:30pm)

Any patient with a medical condition or history such as, but not limited to: ASTHMA, SEIZURES, A.D.D., DIABETES, HEART CONDITIONS, OR FRACTURES must have written clearance from their doctor prior to examination at Worth Township Clinic.

The Township Clinic does not accept Public Aid, All Care, or any other type of insurance. Due to recent changes by the State of Illinois, Worth Township can only provide vaccines to children without insurance, anyone receiving MEDICAID (Title 19) or anyone who is a NATIVE AMERICAN or an ALASKAN NATIVE.

Revised March 2018

IMPORTANT INFORMATION REGARDING ATHLETIC PHYSICALS

If your child is interested in participating in any interscholastic athletics in at Palos South, he/she will need to have either an:

- ***IHSA/IESA Pre-participation Examination*** completed and dated within one year of participation in the sport

Or

- **The *State of Illinois Certificate of Child Health Examination*** (which is required for entrance into 6th grade) with the box pertaining to Interscholastic Sports checked by the physician

There are many, different athletic physical forms used by area physicians. The only one which will be accepted in School District 118, is the **IHSA/IESA Pre-Participation Examination** which can be downloaded from the District 118 or Palos South websites. Forms are also available in the main office at Palos South.

To ensure that a physical is valid for the entire sixth grade school year, schedule your child's appointment with the doctor after **May 20**.

Cross Country and Softball Teams hold try-outs the first week of school so make sure your child has this physical before the start of school if he/she is interested in these sports. Students will NOT be allowed to even try-out for a sport until the required physical is on file in the Health Office.

DISTRICT 118
ATHLETIC PERMISSION FORM

Agreement to participate in interscholastic sport(s), intramural athletics or sports clinics

Dear Parent or Guardian:

Your child has elected to tryout/participate in a Palos 118 Team, Intramural or Sports Clinic. Each student and his or her parent/guardian must read and sign this *Agreement to Participate* each year before being allowed to participate in interscholastic sport(s), intramural or clinic. The completed *Agreement* must be returned to the Coach prior to tryout or first day of participation.

If your child is participating in an interscholastic sport:
All physicals must be completed prior to the first scheduled try-out date in order for any student to participate. Public Act 096-0128 requires the use of the attached form and is available in the office at Palos South as well as the District 118 and Palos South websites. All completed forms remain on file with the school nurse. The Palos Township Health Service in Palos Hills charges a fee of $10.00 for a physical. All fees are cash only and no insurance will be accepted or filed. Their address is 10802 S. Roberts Road. Appointments are advised 708-598-2441. Parents may also use their personal physician. Please be advised that tryouts are closed to the public and all decisions by the coaching staff are final. Coaches of the athletic teams will issue a schedule of practices and games.

If you have any questions, please do not hesitate to call.

Sincerely,
Carolyn Schaver
Athletic Director
(708) 761-3973

STUDENT AGREEMENT TO PARTICIPATE
TO BE READ AND SIGNED BY THE STUDENT

1. I wish to participate in the interscholastic sport(s)/intramural/sport/clinic:
   _____
2. I agree to abide by all conduct rules and will behave in a sportsmanlike manner. I agree to follow the coaches' instructions, playing techniques, and training schedule as well as all safety rules.
3. I understand that Board policy 7:305, *Student Athlete Concussions and Head Injuries*, requires, among other things, that a student athlete who exhibits signs and symptoms, or behaviors consistent with a concussion or head injury must be removed from participation or competition at that time and that such student will not be allowed to return to play unless cleared to do so by a physician licensed to practice medicine in all its branches or a certified athletic trainer.
4. I am aware that with participation in sports comes the risk of injury, and I understand that the degree of danger and seriousness of risk vary significantly from one sport to another with contact sports carrying the highest risk. I am aware that participating in interscholastic sports involves travel with the team. I acknowledge and accept the risks inherent in the sport(s) or athletics in which I will be participating and in all travel involved. I agree to hold the district, its employees, agents, coaches, school board members, and volunteers harmless from any and all liability, actions, claims, or demands of any kind and nature whatsoever that may arise by or in connection with my participating in the school-sponsored interscholastic sport(s) or intramural athletics. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

_____ _____
Student signature Date

PARENT PERMISSION TO HAVE THEIR CHILD PARTICIPATE IN INTERSCHOLASTIC SPORT(S), INTRAMURAL ATHLETICS OR SPORTS CLINIC

TO BE READ AND SIGNED BY THE PARENT/GUARDIAN

1. I am the parent/guardian of the above named student and give my permission for my child or ward to participate in cut sports, interscholastic sport(s), sports clinics or intramural athletics indicated. I have read the above *Agreement to Participate* and understand its terms.
2. I acknowledge having received the attached *Concussion Information Sheet*.
3. I understand that all sports can involve many risks of injury, and I understand that the degree of danger and seriousness of risk vary significantly from one sport to another with contact sports carrying the higher risk. I am aware that participating in sports involves travel with the team. In consideration of the school district permitting my child to participate, I agree to hold the district, its employees, agents, coaches, school board members and volunteers harmless from any and all liability, actions, claims or demands of any kind and nature whatsoever that may arise by or in connection with the participation of my child in the sport(s) or athletics. I assume all responsibility and certify that my child is in good physical health and is capable of participation in the above indicated sport or athletics.
5. **If participating in interscholastic sport(s)**, before your child will be allowed to participate, you must provide the school district with a certificate of physical (the pre-participation physical examination form serves this purpose); show proof of accident insurance coverage, and complete any forms required by Palos 118 and the Illinois High School Association (IHSA).

_____ _____

Parent/Guardian signature Date

Emergency Contact Information

Name: _____ Relationship to student: _____

Day phone number: _____ Evening phone number: _____

Cell phone number: _____ Other: _____

Attachments: Concussion Information Sheet
IHSA Pre-Participation Examination Form

THIS COMPLETED FORM SHOULD BE RETURNED TO THE COACH PRIOR TO PARTICIPATION.

Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name _____ School Year _____
Last First Middle

Address _____ City/State _____

Phone No. _____ Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____ Phone No. _____

Address _____ City/State _____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ **Signature of parent/guardian** _____ **Date** _____

Pre-participation Examination

PHYSICAL EXAMINATION FORM **Name** _____ (Last / First / Middle)

EXAMINATION			
Height	Weight	☐ Male ☐ Female	
BP / (/)	Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL		**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)			
Eyes/ears/nose/throat • Pupils equal • Hearing			
Lymph nodes			
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)			
Pulses • Simultaneous femoral and radial pulses			
Lungs			
Abdomen			
Genitourinary (males only)[b]			
Skin • HSV, lesions suggestive of MRSA, tinea corporis			
Neurologic [c]			
MUSCULOSKELETAL			
Neck			
Back			
Shoulder/arm			
Elbow/forearm			
Wrist/hand/fingers			
Hip/thigh			
Knee			
Leg/Ankle			
Foot/toes			
Functional • Duck-walk, single leg hop			

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes _____ No _____ Limited _____ Examination Date _____

Additional Comments:

Physician's Signature _____ Physician's Name _____

Physician's Assistant Signature* _____ PA's Name _____

Advanced Nurse Practitioner's Signature* _____ ANP's Name _____

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

• Headaches	• Amnesia
• "Pressure in head"	• "Don't feel right"
• Nausea or vomiting	• Fatigue or low energy
• Neck pain	• Sadness
• Balance problems or dizziness	• Nervousness or anxiety
• Blurred, double, or fuzzy vision	• Irritability
• Sensitivity to light or noise	• More emotional
• Feeling sluggish or slowed down	• Confusion
• Feeling foggy or groggy	• Concentration or memory problems (forgetting game plays)
• Drowsiness	
• Change in sleep patterns	• Repeating the same question/comment

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays incoordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can't recall events prior to hit
- Can't recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering

from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. IHSA policy requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with state law, all IHSA member schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

Adapted by the Illinois High School Association from the CDC and the 3rd International Conference on Concussion in Sport, Document created 7/1/2011.

** I acknowledge having read the above *Concussion Information Sheet.* I understand that Board policy 7:305, *Student Athlete Concussions and Head Injuries*, requires, among other things, that a student athlete who exhibits signs and symptoms, or behaviors consistent with a concussion or head injury must be removed from participation or competition at that time and that such student will not be allowed to return to play unless cleared to do so by a physician licensed to practice medicine in all its branches or a certified athletic trainer.

Parent Signature_____