CCSD 62 Early Learning Center
SPARK Early Learning Center

Preschool
2023-2024

Child's Name: _____

Please check time and days you want your child to attend.

Preschool

_____9:15-11:45 M-W-F $148.00/mo
_____ 9:15-11:45 T-R $107.00/mo
_____ 9:15-11:45 5 days $254.00/mo

Preschool Plus / Lunch Bunch	3 Days	5 Days	
_____9:15-1:00 M-W-F $222.00/mo			
_____ 9:15-1:00 T-Th $160.00/mo			_____ Mon
_____ 9:15-1:00 5 days $382.00/mo			_____ Tues
_____ 9:15-3:45 (Partial Day)	$382.00/mo	$661.00/mo	_____ Wed
_____ 7:00-6:00 (Full Day)	$583.00/mo	$1007.00/mo	_____ Thurs
_____ 7:00-3:45 or 9:15-6:00	$512.00/mo.	$867.00/mo	_____ Fri

Registration Fee is $50.00 per family. THE REGISTRATION FEE IS NON-REFUNDABLE and must accompany this registration. Make checks payable to District 62. PLEASE NOTE: THERE IS NO CREDIT FOR NON-ATTENDANCE, LATE ARRIVALS, OR EARLY PICK-UP. THERE IS NO BUS SERVICE PROVIDED FOR ANY SPARK PROGRAM. For families with more than one child actively participating in a SPARK Program, a 10% discount will be given.

*Any registration form printed from the website must be hand delivered to the ELC office. Registration is subject to availability and residency requirements. Proof of birth and residency required.

AUTHORIZATION FOR PICK-UP

1.Name: _____ 2.Name:_____

Relationship to Child _____ Relationship to Child _____

Phone number: _____ Phone number: _____

3.Name: _____ 4.Name: _____

Relationship to Child _____ Relationship to Child _____

Phone number: _____ Phone number: _____

The above people are authorized to pick up my child.

X_____ _____
Signature of Parent/Guardian Date

Des Plaines Community Consolidated School District 62
Student Registration Form 2023/2024 - Please Print

STUDENT INFORMATION

Last Name:_____ First Name:_____ Sex:_____

School: Grade: Birthdate:

Last Name:_____ First Name:_____ Sex:_____

School: Grade: Birthdate:

Last Name:_____ First Name:_____ Sex:_____

School: Grade: Birthdate:

PARENT/GUARDIAN LIVING WITH STUDENT

Name:_____

Circle person student lives with: Both Parents Mother Father Mother/Stepfather Father/Stepmother Other

Address:_____ Apartment # _____

City:_____ State:_____ Zip Code:_____ Primary Phone:_____

MOTHER INFORMATION

Last Name:_____

First Name:_____

Relationship to Student:_____

Home Phone:_____

Cell Phone:_____

Text messaging: Yes_____No_____
(standard text messaging rates may apply)

E-Mail Address:_____

Employer

Employer Name:_____

Work Phone:

FATHER INFORMATION

Last Name:_____

First Name:_____

Relationship to Student:_____

Home Phone:_____

Cell Phone:_____

Text messaging: Yes_____No_____
(standard text messaging rates may apply)

E-Mail Address:_____

Employer

Employer Name:_____

Work Phone:

STUDENT MEDICAL INFORMATION

Family Physician Name:_____

Physician Phone:_____

In case of emergency, I give the school authorities permission to call the local doctor named above, or any available doctor if the above is unavailable. I also give such doctor permission to take the necessary emergency measures.

Comments:

Medical Comments:

Emergency Contacts *(Other than parents or guardians)*

The following to be contacted only if parents cannot be reached, unless otherwise instructed by the parents

Name:_____

Relationship to Student:_____

Home Phone:_____

Cell Phone:_____

Work Phone:

Name:_____

Relationship to Student:_____

Home Phone:_____

Cell Phone:_____

Work Phone:

The above information is correct or I have made the changes that are necessary.

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

In case of emergency (other than yourself), contact:

Name:_____ Home phone ( )_____
Work phone ( ) _____

Physician's Name:_____ Phone ( )_____

1.Emergency Treatment and Transportation Permission: In case of accident or injury, I hereby give my permission for emergency treatment and transportation.
X_____

2. Is your child on daily medication?_____If yes, state name of medication and reason for taking it._____
_____

3. Does your child have any allergies?_____If yes, please list them: _____
_____

4. Important Information: Please list any information that we should be aware of concerning your family situation that might affect your child. _____

5. Photos: Pictures may be taken at programs and may be used for bulletin boards, scrapbooks or publicity. If you do not wish to grant photo permission, please state "No" otherwise we will assume permission is given. _____

6. Walking Field Trips: Walking trips around the school grounds or around the block may be taken on occasion.
I hereby give permission for my child to take walking trips.
Signature:_____

7. Tuition: Tuition is paid in advance. **DELINQUENT PAYMENT IS CAUSE FOR DISMISSAL**. There is **NO CREDIT** given for non-attendance (including sickness & vacations), late arrivals or early pick-ups. A two-week advance notice must be given for withdrawal from the program or any change of hours request.

8. **Late Fee: If you pick up your child after 6:00 P.M., you will be assessed $5.00 for every 10 minutes or any part of 10 minutes. This late fee will be assessed to your account and will appear on your billing statement. Habitual late pick-up will necessitate dismissal from the program.**

9. I have read this application and understand I am responsible for the fees related to the sessions I have checked off on the front of this application. If fees are not paid in a timely manner and become delinquent, my child will be dropped from the program. _____(Please initial)

10. The SPARK program is a service offered to CCSD 62 residents only.

11. If there are concerns with your child's current functioning (e.g. academic, behavioral, developmental) we reserve The right to request an evaluation.

12. Payment status needs to be current to register for the following school year. All documents required for your child's enrollment must be submitted within 30 days to ensure your child's placement. _____(please initial)

_____
Signature of Parent/Guardian Date

For Office Use Only

Date Rec'd:_____ Amt. Rec'd: _____ Cash: _____Check #: _____ Approved: _____

Snack Form_____ Lunch Form_____

Community Consolidated School District 62
SPARK Program
824-1065

Early Childhood Programs Questionnaire

School Data:

Child's Name: _____ Date of Birth: _____ Sex: _____

If your child is attending kindergarten, please indicate his/her home school: _____

In order to be sensitive to the cultural diversity of families, are there any cultural or religious preferences of which we should be aware?

What language is spoken in the home?

Will you need a translator when interacting with teachers? _____yes _____no

Does your child have any siblings? Please list names and ages:

Social Experiences:

1. What are your child's strengths? _____
2. What are your child's weaknesses?_____
3. Has your child attended any other nursery center or daycare center?
   If so, which one?_____ For how long? _____
4. Would you say your child is a leader or a follower? _____
5. What activities does your child enjoy outdoors? _____
6. What activities does your child enjoy indoors?_____
7. Does your child enjoy books?
8. Do you read to your child? _____ How often? _____
9. Is your child able to remember songs or rhymes?_____
10. Has your child had experiences with paints and crayons? _____Scissors? _____
11. Does your child select the clothing he/she wears? _____Dress themselves?
12. Please check the items your child can do:
    button _____ ties shoes _____ snap _____ zip _____ ace shoes _____ fasten _____
13. Does your child look forward to holidays? _____Favorite?
14. What holidays do you celebrate in your home? _____

Development:

1. Does your child have any health problems the center should be aware of? _____
   If so, what?
2. Does your child have any limitations in the following areas? Please describe.

   _____ Hearing impaired _____
   _____ Physically impaired _____
   _____ Learning disabled _____
   _____ Speech and/or language impaired _____
   _____ Visually impaired _____
   _____ Behaviorally challenged _____

3. Is your child or a sibling receiving or has received any special education intervention? If yes, please describe.
   _____
4. Does your child have any food allergies? _____ If so, what?
   How severe?_____ Do we need a plan? _____
5. Is your child able to print his/her name?
6. Is your child aware of dangers such as fire, electricity, traffic, and strangers?
   _____
7. Is your child able to be in a new or strange situation without an undue show of fear?
   _____
8. What kind of problems do you have most often with your child?
   _____
9. In what area(s) does your child need the most guidance?
   _____
10. What discipline techniques work best with your child?
11. Can your child take care of his/her own toilet needs?
12. Does your child wet the bed: _____ _____

    Never Occasionally Only rarely

13. Is your child prone to separation anxiety? _____Has your child had a problem with this in the past? _____
14. Does your child have any fears?_____
15. What best describes your child? _____

School Adjustment:

1. What do you expect your child to acquire through the SPARK Program?
   _____
2. What else would you like your child's SPARK teacher to know about your child?
3. When is the best time to meet with you? _____

Additional comments:

Remember:

You are your child's first and most important teacher. Because of this, the SPARK staff welcome and value your input concerning your child.

In order to help the staff best meet the emotional needs of your child, keep them posted about any major events that may effect your child, i.e. the birth of a baby, change in marital status, the move to a new house, the death of a grandparent or pet, etc. Your confidentiality will be respected at all times.

Community Consolidated School District 62
VERIFICATION OF RESIDENCY AND ENROLLMENT

Child's Name: _____ Birthdate: ___/___/___

I, _____, live at _____
Name of Adult *Address*

which is located within the boundaries of Community Consolidated School District 62.

(Completing this form does not establish residency. The District may investigate residency status, including through a home visit and additional documentation, before allowing enrollment. Enrollment is not complete until residency is confirmed.)

Step 1: Residency Verification (Part A)

Do you: ❑ Own your own home ❑ Rent ❑ Other: _____

You must provide documentation showing you ***live at*** the address listed above. Please provide three (3) of the following documents. You should black out account and social security numbers on the documents. If you can not produce all three (3) documents, skip to Residency (Part B).

All documents must be current and show your name and address.

You must provide one (1) document from Category A **and** two (2) documents from Category B.

Category A – One (1) document

- ❑ Real estate tax bill
- ❑ Signed lease
- ❑ Mortgage document or payment book
- ❑ Residency attestation
- ❑ Military housing letter
- ❑ Section 8 letter
- ❑ Other*: _____

Category B – Two (2) documents

- ❑ Gas bill
- ❑ Electric bill
- ❑ Water/Sewer bill
- ❑ Phone bill (land line phone)
- ❑ Cable bill
- ❑ Vehicle registration
- ❑ Bank statement
- ❑ Other*: _____
- ❑ Public aid card
- ❑ Medicaid card
- ❑ Food stamp card
- ❑ Credit card statement
- ❑ Pay check stub
- ❑ City sticker receipt
- ❑ Driver's license/State ID

*Please contact the registration staff if you are having trouble collecting all three documents. **The district may require a home visit and/or additional documentation to verify residency.**

Skip Residency (Part B) if you have all three (3) documents.

Step 1: Residency Verification (Part B)

I am unable to provide three (3) of the above documents because: (check all that apply)

❑ Our family has not had a permanent residence since ___/___/___

Address of last permanent residence: _____

Last school attended: _____

❑ Living in a shelter ❑ Sharing housing with others due to loss of housing, economic hardship, or similar reason ❑ Living at a train or bus station, park or in a car ❑ Living in a hotel, motel, campground, or other similar situation ❑ Abandoned apartment/building ❑ Disaster victim ❑ Unaccompanied Youth ❑The child is temporarily housed, awaiting DCFS permanent foster care placement.

❑ Other _____

Your child may qualify for additional services - please ask the registration staff for more information or contact the District's McKinney-Vento Liaison at 847-824-1159.

Please indicate any social service agency you are currently working with:_____

Community Consolidated School District 62
VERIFICATION OF RESIDENCY AND ENROLLMENT

Child's Name: _____ Birthdate: ___/___/___

Step 2: Relationship to Student

You must provide a certified, original birth certificate. A copy will be made and the original returned to you. If the birth certificate is not available at the time of registration, other proof of the child's identity and date of birth is required along with a signed affidavit.

Check one below:

- ☐ I am the natural or adoptive parent listed on the birth certificate. Please provide custody agreement, if applicable.
- ☐ I was granted court-ordered guardianship (provide copy of court document).
- ☐ I receive public aid on behalf of the child (provide copy of documentation showing receipt of aid).
- ☐ I have assumed and exercise responsibility for the child and provide him/her with a fixed, nighttime abode.

Please check each of the following boxes to be true and accurate.

- ☐ The child is living with me because _____.
- ☐ I am at least 18 years of age.
- ☐ The child eats and sleeps at my residence on a regular basis.
- ☐ The child is not living with me for the sole purpose of having access to the educational programs of the school district.

Step 3: Affirmation and Warning (Must be completed in the presence of a District employee)

Please read the following statements and **initial each**:

_____ I affirm that the information presented in this verification form, in connection with any investigation of my residency or the 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 child for the purpose of enabling that child to attend any school in that district without the payment of nonresident tuition is a Class C misdemeanor.

_____ I understand that knowingly enrolling or attempting to enroll a child in the school of a school district on a tuition free basis when I know the child to be a nonresident of the school district, unless the nonresident child has a lawful right to attend, is a Class C misdemeanor and I will be liable for payment of tuition, fees, and all other applicable fines.

___/___/___	_____	_____
Date	*Adult (Signature)*	*Adult (Print Name)*

FOR OFFICE USE ONLY

___/___/___	_____	_____
Date	*Enrollment Personnel (Signature)*	*Enrollment Personnel (Print Name)*

☐ *Form Complete* ☐ *Form Incomplete*

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 62
DES PLAINES ILLINOIS

RE: PEST CONTROL PROCEDURES AT SCHOOL BUILDINGS

Dear Parent/Guardian:

In the Spring of 1999, the Illinois legislature passed SB0527 and SB0529, amendments to the Structural Pest Control Act and the Illinois Pesticide Act that affect how pests, mice, ants, etc., are controlled in the schools and on school property.

The legislation affects the schools in basically two ways:

1) All Illinois schools are required to adopt a pest control process called Integrated Pest Management or IPM.
2) Schools are required to notify staff, students and parents prior to certain types of pest control applications.

Integrated Pest Management emphasizes inspection and communication with the school administration. The focus of the program is to identify and eliminate conditions in the school which could cause pests to be a problem. Applications of pest control materials are made only when necessary to eliminate a pest problem. Regular spraying is not part of the program.

If it becomes necessary to use any pest control products other than traps or baits, notice will be posted two business days prior to the application. The only exception to the two-day notice would be if there is an immediate threat to health or property. Then notice will be posted as soon as practicable. If you would like to receive written notification prior to the application of any pest control materials subject to the notification requirements, please complete the form at the bottom of this letter and **return it to the principal of your school.**

The school district has contracted with Anderson Pest Control to provide IPM services inside school buildings. Anderson has had IPM programs in place, in schools they service since 1991. If you have any questions about the information and procedures from Anderson Pest Control, you may contact them at 847-537-8000.

The school district has contracted with TrueGreen/Chemlawn to provide IPM services on school property outside of the buildings. If you have any questions about the information and procedures from TrueGreen/Chemlawn, you may contact them at 847-520-4750.

I would like to be notified two days before the use of liquid or aerosol pest control materials at the schools. I understand that if there is an immediate threat to health or property that requires treatment before notification can be sent out, I will receive notification as soon as practicable.

Parent/Guardian Signature_____ Date_____

Student Name_____ Grade_____

Address_____ School_____

01/24/17

Illinois State Board of Education

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

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

Student Name:_____ **Grade:**_____

School:_____ **Student ID:**_____

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

Choose only one:

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

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

Part B. What is the student's race?

Choose one or more:

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

Parent Signature_____ Date _____

Observer Signature:_____ Date: _____

01/24/17

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 62
777 Algonquin Road
Des Plaines IL 60016
847-824-1136

CONFIDENTIAL HEALTH FORM

Health is an integral part of the child's ability to learn well. In order to help the student to benefit most from his/her experience, the school personnel need to be informed about your child's physical condition.

Child Name_____Grade_____

Does your child have a current IEP (special education)? Yes_____ No_____

Is your child presently under the care of a physician or medical specialist of any kind?
Yes_____ No_____

If the answer is yes, please state the condition for which the child is being observed or treated.

_____

Is your child presently taking any prescribed medication? Yes_____ No_____

If the answer is yes, name of medication _____

Does your child have any allergies? Yes_____ No_____

If the answer is yes, please list them _____

_____

Is your child under treatment for a hearing problem or have a known hearing loss?
Yes_____ No_____

Is your child presently wearing glasses or under treatment for a vision problem?
Yes_____ No_____

Is your child's activity here at school to be restricted or limited in any way?
Yes_____ No_____

If the answer is yes, please state specific limitations and the reason for these limitations.

_____

_____

If the answer is no, regarding restrictions or limitations, it is then assumed that your child can participate in the regular school program, which includes physical education classes, and outdoor activities on the school grounds.

PARENT/GUARDIAN SIGNATURE_____DATE_____

PLEASE NOTE: It is the parent or guardian responsibility to keep the school personnel informed regarding changes in the health status of their child.

01/24/17

Home Language Survey

(Requirement per Section 228.15 of Title 23 of Illinois Administrative Code: Identification of Eligible Students)

Today's Date _____ Home School _____ Grade _____

Office Use: District ID# _____ State ID# _____

Student's Name (last, first, middle)_____

Address _____

Telephone _____ Date of Birth _____ Male ____ Female ____

Student's Place of Birth (state, country) _____

Mother's Place of Birth _____ Father's Place of Birth _____

Mother's Native Language _____ Father's Native Language _____

Is a language other than English spoken in the home? YES NO	Which?
Does your child speak a language other than English? YES NO	Which?
(Spanish) *¿Se habla otro idioma en la casa que no sea el ingles? SI NO*	*¿Cual?*
¿Habla su niño otro idioma que no sea el ingles? SI NO	*¿Cual?*
(Polish) Czy jezyk inny niz jezyk angielski jest uzywany w domu? TAK NIE	Jaki?
Czy dziecko posluguje sie jezykiem innym niz jezyk angielski? TAK NIE	Jakim?
(Korean) 집에서 가족분들이 영어 말고 다른 언어를 사용합니까?	어떤 언어?
자녀분이 영어 말고 다른 언어를 사용할 수 있습니까?	어떤 언어?
(Urdu) 1. کیا آپ کے گھر میں انگریزی کے علاوہ کوئی دوسری زبان بولی جاتی ہے؟	ہاں _____ نہیں _____ کون سی زبان؟ _____
2. . کیا آپ کا بچہ انگریزی کے علاوہ کوئی دوسری زبان بولتا ہے؟	ہاں _____ نہیں _____ کون سی زبان؟ _____

The information above will be used to determine your child's eligibility to English as a Second Language Services.
The results will be communicated and you will have the option to accept or refuse services.

_____ _____ _____

Parent or Guardian Signature | Relationship to Student | Date

Office Use: Home Language _____
(Home Language to be written in by ELL teacher)

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 62
DES PLAINES ILLINOIS

STUDENT REQUEST FOR THE LOAN OF TEXTBOOKS

I hereby request the loan of secular textbooks in accordance with Section 18-17 of the School Code, (III. Rev. Stat. 1989, ch. 122, par. 18-17). I understand that this request will remain valid as long as my son/daughter, _____, is enrolled in Community Consolidated School District 62 that I may at any time withdraw this request.

_____ in Des Plaines/Illinois, Cook
Name of School City/State County

Parent/Guardian Signature_____

OFFICE USE ONLY
Date_____
Date Student Transfer Out of District_____
Date of Student Graduation_____

01/24/17

COMMUNITY CONSOLIDATED SCHOOL DISTRICT 62
DES PLAINES ILLINOIS

SOLICITUD PARA EL PRESTAMO DE LIBROS A LOS ESTUDIANTES

Por medio de la presente yo solicito el préstamo de libros escolares, en conformidad con la Sección 18-17 del Código Escolar, (III. Rev. Stat. 1989, ch. 122, par. 18-17). Yo entiendo que esta solicitud será válida mientras mi hijo/a,_____,este registrado en Community Consolidated School District 62 yo podré renunciar a esta solicitud a cualquier hora.

_____ en Des Plaines/Illinois, Cook
Nombre de Escuela ciudad/estado condado

Firma del Padre/Guardián_____

PARA USO DE LA OFICINA SOLAMENTE
Date_____
Date Student Transfer Out of District_____
Date of Student Graduation_____

01/24/17

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?	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.			
Bone/Joint problem/injury/scoliosis?	Yes	No	Parent/Guardian 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 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