LEMONT HIGH SCHOOL ENROLLMENT CHECKLIST
* TRANSFER STUDENTS *

Please contact School Registrar Colleen Amberg at (630) 243-3218 with questions concerning transfer student enrollment.
New student enrollment for transfer students is completed **by appointment only**.

DOCUMENTS TO UPLOAD INTO NEW STUDENT ONLINE ENROLLMENT MODULE

The documents below must be uploaded into the New Student Online Enrollment module. ***Please have these documents available (in either .pdf or .jpeg format) prior to beginning the module.*** *Biological, adoptive or foster parents may enroll a student. Guardians must have proper court authorization.*

REQUIRED FOR ENROLLMENT FOR ALL STUDENTS

_____ Parent/Guardian Photo ID *(driver's license or any photo ID is acceptable)*
_____ Student's Certified Original Birth Certificate or Passport *(passport only may be used for international students)*
_____ Required Proofs of Residency *(see below – one document for Category A and two documents for Category B must be provided)*
_____ Student's Most Recent Immunization Record *(from a student's physical or a medical provider's online portal)*

REQUIRED PROOF OF RESIDENCY FROM PARENT/GUARDIAN AND/OR HOMEOWNER

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

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

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

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

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

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

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

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

REQUIRED STUDENT INFORMATION

*Please bring this enrollment checklist and all required documents with you to your enrollment appointment. Students may not enroll until they have been withdrawn from their current school. Custody documentation is required when applicable.**

_____ Illinois Child Health Examination Form, completed by an Illinois physician *(w/ up-to-date immunization record)*
_____ State of Illinois Eye Examination Form, completed by an Illinois physician *(if transferring from out-of-state)*
_____ ISBE Student Transfer Form *(required if transferring from an Illinois public high school)*
_____ Discipline Records/"Good Standing" Letter *(required if transferring from out-of-state or a parochial school)*
_____ Withdrawal Form from Previous School, including Withdrawal Grades/Grades in Progress *(for in-year transfers)*
_____ Transcript *(required for upperclassmen and second-semester freshmen)*
_____ Authorization for Release/Exchange of Information Form
_____ Current/Future Schedule
_____ IEP/Special Education Records/Section 504 Plan *(if applicable)*
_____ Divorce/Custody/Guardianship Papers/906 Placement Form *(if applicable)* – ***NOTE:** If a non-custodial parent/guardian is enrolling the student, the Registrar may require that individual to complete the Non-Parent Custodial Form at the time of enrollment.

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

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

IMPORTANT: This authorization expires 30 days from: _____

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

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

School/Agency/Organization:_____

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

Records Administrator at School/Agency/Organization: _____

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

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

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

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

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

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

____ **Educational evaluation and/or planning**

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

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

Please send records to the attention of:

____ **Kelly Lucio, Director of Special Education Services (klucio@lhs210.net)**

_____ **Colleen Amberg, Registrar/Counseling Secretary (camberg@lhs210.net)**

_____ **Katie Dulle, School Nurse (kdulle@lhs210.net)**

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

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

PARENT/GUARDIAN NAME *(printed)*:_____

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

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

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

State of Illinois
Certificate of Child Health Examination

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

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

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

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

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

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

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

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

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

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

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

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

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

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

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

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

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

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

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

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

Address **Phone**

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

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

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

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

Was refraction performed with dilation? ❑ Yes ❑ No

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

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

Diagnosis

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

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

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

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

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

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

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

Address _____

_____

Phone _____

Consent of Parent or Guardian

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

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

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

Printed by Authority of the State of Illinois
6/09

IOCI1271-09