



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:

- One proof of residency from Category A
- Two proofs of residency from Category B

IF YOU RENT OR LEASE:

- Current signed lease/rental agreement
- Two proofs of residency from Category B

IF YOU LIVE WITH ANOTHER FAMILY:

- 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) | _____ Driver's license |
| _____ Homeowner's/Renter's insurance statement | _____ Voter registration card |
| _____ Vehicle registration | _____ 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 | _____ Bank statement |
| _____ Insurance statement | _____ New Illinois driver's license receipt |
| _____ U.S. Postal Service change of address form | |

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

This form is valid for one year from the date of the parent/guardian signature.

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 () _____ **Email 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:** ___/___/___

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				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle		Month/Day/Year			
Address				Parent/Guardian		Telephone # Home	
Street	City	Zip Code					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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenzae 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:

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
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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
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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	Hospitalizations? When? What for?		Yes No
Birth defects?		Yes No	Surgery? (List all.) When? What for?		Yes No
Developmental delay?		Yes No	Serious injury or illness?		Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes No	TB skin test positive (past/present)?	Yes*	No
Diabetes?		Yes No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?		Yes No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?		Yes No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?		Yes No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?		Yes No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other	Information may be shared with appropriate personnel for health and educational purposes.	
Dizziness or chest pain with exercise?		Yes No	Parent/Guardian Signature	Date	
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____					
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?		Yes No			
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	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		<input type="checkbox"/> Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> 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 _____ (Month/Day/Year) Gender _____ Grade _____

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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____



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 _____

Signature _____

Date _____

<p>Consent of Parent or Guardian</p> <p>I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p>_____</p> <p style="text-align: center;">(Parent or Guardian's Signature)</p> <p>_____</p> <p style="text-align: center;">(Date)</p>
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(Source: Amended at 32 Ill. Reg. _____, effective _____)