

CCSD 62 Early Learning Center  
SPARK Early Childhood Programs

Preschool  
2026 - 2027

Child's Name: \_\_\_\_\_

Please check the 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-Th \$107.00/mo  
\_\_\_\_ 9:15-11:45 5 days \$254.00/mo

Preschool Plus / Preschool 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 (this includes emergency weather days.) 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. Registration for any SPARK program is subject to availability and residency requirements. Proof of birth and residency required.

AUTHORIZATION FOR PICK-UP

(Please Print)

1. Name: \_\_\_\_\_ 2. Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

3. Name: \_\_\_\_\_ 4. Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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 2026/2027 - 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: \_\_\_\_\_

**Comments:**

*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.*

**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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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: \_\_\_\_\_ Primary Phone: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of parent/guardian

**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: (please provide your doctor's allergy plan):

**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 of parent/guardian

**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 (including proof of residency and birth) must be submitted within 30 days of registration 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 \_\_\_\_\_ Credit \_\_\_\_\_

**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**

**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, (Ill. 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 \_\_\_\_\_

<b>OFFICE USE ONLY</b> Date _____ Date Student Transfer Out of District _____ Date of Student Graduation _____
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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, (Ill. 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 \_\_\_\_\_

<b>PARA USO DE LA OFICINA SOLAMENTE</b> Date _____ Date Student Transfer Out of District _____ Date of Student Graduation _____
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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:** \_\_\_\_\_

## Military-Connected Student

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**Student Name**

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**Birthdate**

The Military-Connected Student survey identifies a student, who at any time during the current enrollment, has at least one parent or legal guardian who is a member of the Army, Navy, Air Force, Marine Corps, or Coast Guard and is full-time duty in the active military service of the United States.

Such terms include full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law

- or by the secretary of the Military Department
- or is considered full time National Guard
- or other duty, other than inactive duty, performed by a member of the Army National Guard of the United States
- or the Air National Guard of the United States in the member's status as a member of the National Guard of a State or Territory, the Commonwealth of Puerto Rico
- Or the District of Columbia under section 316, 502, 503, 504, or 505 of title 32 for which the member is entitled to pay from the United States
- or for which the member has waived pay from the United States

**Military Family: Yes or No**

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**Parent/Guardian Signature**

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**Date**

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.

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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



# 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 \_\_\_\_\_ Please Circle: 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 \_\_\_\_\_

The state requires the district to collect a home language survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps identify the students who need to be assessed for English Language Proficiency. If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

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 język inny niż język angielski jest używany w domu? TAK NIE	Jaki?
Czy dziecko posługuje się językiem innym niż język angielski? TAK NIE	Jakim?
(Russian) Вы говорите у себя дома на ином языке, нежели на английском? Да Нет	На каком языке?
Ваш ребёнок говорит на ином языке, нежели на английском? Да Нет	На каком языке?
(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)



## 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	Work	
Street	City	Zip Code				

**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	<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 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:

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

<b>ALLERGIES</b> (Food, drug, insect, other)	Yes No	List:	<b>MEDICATION</b> (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	*If yes, refer to local health department.
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		
Dizziness or chest pain with exercise?	Yes No		Information may be shared with appropriate personnel for health and educational purposes		
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor <input type="checkbox"/> Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Parent/Guardian Signature		Date
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) BMD>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](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		<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