Hillsboro PreK Screening & Enrollment Process

Coffeen Early Childhood Center • 200 School Street • Coffeen, IL 62017 • (217)532-7822 • prek.hillsboroschools.net

Thank you for your interest in Hillsboro PreK! Please read through the requirements for PreK Screening & Enrollment, and **fully complete and submit *all* required documents and forms** at least 2 days *before* your child's screening appointment.

Required NOW for Screening & Enrollment: *Items 1-3 Due at least 2 days before scheduled screening*

1. **Enrollment Packet** (may be completed & submitted online, or paper packet)
2. ASQ Cognition screening @ **www.asqonline.com/family/510c9a** (complete ONLINE)
3. ASQ Social Emotional Screening @ **https://www.asqonline.com/family/33794b** (complete ONLINE)
4. **Verification of Family Income** (please *EMAIL a* picture of **1** of the options below, *or* turn in a photocopy at screening)
    - Proof of public benefits: WIC, SNAP, TANF, SSI, CCAP, or Medical Card (in parent's name)
    - DCFS Authorization Form (if in foster care)
    - W2s (both parents if living in same house)
    - Tax Return (1st page of 1040...showing total gross income)
    - Pay stubs (2 most recent paystubs...from both parents if living in same house)

*(Proof of income is ***required*** by the Illinois Early Childhood Block Grant for enrollment in Preschool For All classrooms. Students with*out* income verification at screening will be placed on a waiting list & *not eligible for enrollment* until proof of income has been received.)

Due by August Registration *(but please bring to screening if you already have them!!)*

5. **Physical**
    - **"Health History"** section of physical must be completed & signed *by parent/guardian*
6. **Immunization Records**
7. **Lead Screening Results**
8. **Birth Certificate** *(from courthouse...NOT hospital footprints) or* **DCFS Authorization Form**

Screening Day Information:

- Screening will be held in person at COFFEEN SCHOOL.
- Please **bring the required & completed paperwork with you to screening** if not submitted online.
- Please arrive 5-10 minutes prior to your child's scheduled appointment time. Your appointment will last approximately 45 min to 1 hour. You will remain with your child throughout the entire screening process. They will be in a classroom with 2-3 other children to play and be observed.
- We ask that you not bring additional siblings/children to the screening please.

Return completed paperwork to:

Sarah VanMiddendorp; Coffeen Early Childhood Center; 200 School St.; Coffeen, IL 62017
Email: svanmiddendorp@hillsboroschools.net
Phone: 217-532-7822

Sincerely,

Sarah VanMiddendorp

Sarah VanMiddendorp
PreK Coordinator & Instructional Leader

Marci Gutierrez, Early Childhood Director
mgutierrez@hillsboroschools.net

Sarah VanMiddendorp, Instructional Leader
svanmiddendorp@hillsboroschools.net

Hillsboro PreK HCUSD#3 PreK Student Enrollment Form

Coffeen Early Childhood Center • 200 School St. • Coffeen, IL 62017 • (217)532-7822 • prek.hillsboroschools.net

The information you provide on this form is strictly ***confidential***. It is important for placement & enrollment decisions.

Child's FULL Name:_____ Preferred Name: _____ **Birthdate:** _____
First Middle Last *(to be called at school)*

Child's Address: _____ ☐Male ☐Female
Street PO Box # City Zip Code

Mother/Guardian 1 Email address (required)**:** _____

Father/Guardian 2 Email address (required): _____

Has this child ever attended another school? ☐Yes ☐No ***If yes*, where:** _____

Does this child have an Individualized Education Plan (IEP–Special Education Services)? ☐Yes ☐No

Mother's Name: _____**Age:** _____ **Highest Grade/Degree Completed or GED:** ____

Address if different than child:_____ Age when *1st* Child was born: _____

Mother Employment Status: ☐ Employed ☐Unemployed ☐ Stay-at-Home Parent ☐In School ☐On Disability

Employer: _____ Occupation: _____

Home Phone _____Cell Phone: _____Work Phone: _____

Father's name: _____**Age:** _____ **Highest Grade/Degree Completed or GED:** ____

Address if different than child:_____ Age when *1st* Child was born: _____

Father Employment Status: ☐ Employed ☐Unemployed ☐ Stay-at-Home Parent ☐In School ☐On Disability

Employer:_____ Occupation:_____

Home Phone _____Cell Phone: _____Work Phone: _____

Either Parent Active Duty Military? ☐ Yes ☐No

Child's Race: ☐American Indian ☐Asian ☐Black ☐Hispanic ☐White ☐ Multi-Racial ☐Other:_____

Are any other languages spoken in your home? ☐Yes ☐No If yes, which language? _____

Is your child's primary language English? ☐Yes ☐No If no, primary language _____

Child Lives With: ☐Both Parents ☐Father ☐Mother ☐Joint Custody ☐Foster Parents ☐Grandparents ☐ Other*

**LEGAL Guardian(s) if not parent:* _____

EMERGENCY CONTACT Information: In order to safeguard your child in case of early dismissal, illness, or accident: If you do not have a phone or cannot be reached, whom shall we contact and where shall we send your child? *(someone OTHER than the listed parents)* ***(REQUIRED)***

Relative/Friend #1: _____ Relationship: _____ Phone: _____

Relative/Friend #2: _____ Relationship: _____ Phone: _____

Child's Doctor: _____ Doctor's Phone:_____

Preferred Hospital: _____ Hospital's Phone: _____

Does your child have insurance? ☐Medical Card ☐Parent Work Insurance ☐ KidCare ☐No Insurance

HOUSEHOLD INFORMATION

Does child have siblings **NOT** living in your home? ☐No ☐Yes Names/Ages:_____

Please list the name, age and relationship to your child of ALL people living in the child's home:

Name (First, Last)	Age	Relationship	Name (First, Last)	Age	Relationship
1.			5.		
2.			6.		
3.			7.		
4.			8.		

ANNUAL family income. _____ /year **How many adults & children live on this income?** _____

DOCUMENTATION of income providing at screening *(only ONE of these required)*: ☐DCFS/Proof of Guardianship

☐W2 ☐Tax return ☐2 consecutive paychecks ☐TANF ☐SNAP ☐CCAP ☐WIC ☐SSI ☐Medical Card

**W2/tax/paystubs from both parents if living in same home* **Public benefit documentation must be in PARENT name*

Does the child's family receive support or services from any of the following agencies:

_____ EI/Early Intervention (Child & Family Connections)
_____ Hillsboro First Steps 0-3 Program: (PI/Prevention Initiative)
_____ Learning Express (ROE 0-3 program)
_____ Early HeadStart
_____ Salvation Army or Food Pantry Assistance
_____ Foster Care: ☐Curren ☐Past
_____ DCFS - Department of Child & Family Services
Indicate: ☐Open Case ☐Past/Closed
_____ "Intact" Family Services: ☐Current ☐Past

____ Medical Card
____ TANF (Temporary Assistance for Needy Families)
____ CCAP (Child Care Assistance Program)
____ SNAP (Supplemental Nutrition Assistance Program)
____ WIC (Women, Infants, & Children)
____ SSI (Social Security Insurance)
____ Hillsboro Health Therapy Services/Private Therapy
Indicate: ☐Speech ☐Occupational (OT) ☐Physical (PT)

Is your family currently experiencing any of the following:

____Crime Involvement/Prison/Probation
____Mental Health Issues
____Death of parent or sibling of the child
____Marital or Domestic Problems
____Unemployment

____Drug/Alcohol Use
____Serious Health Concerns of a parent or sibling
____Difficulty getting basic needs (food, housing, transportation, etc.)
____Permanent or long term separation from parent or sibling
____Homelessness *or* living with friend/relative to support basic needs

Explain if needed: _____

Has anyone in your family ever been enrolled in Speech or other Special Education Services? ☐Yes ☐No

If yes, who? ☐Sibling ☐Half-Sibling ☐Father ☐Mother **If Yes, which Services?** _____
(Ex. speech, physical/occupational, behavioral, social, math, reading, Title)

CHILD BIRTH & HEALTH HISTORY

Child's Birth Weight: _____ Was this child **premature?** ☐Yes ☐No If yes, born at what week? _____

Were there complications during birth? ☐Yes ☐No If yes, explain _____

Is it possible that this child was exposed to drugs or alcohol before birth? ☐Yes ☐No ☐Maybe

Did the child's mother smoke during pregnancy? ☐Yes ☐No ☐Maybe

Are you (mother) currently pregnant? ☐Yes ☐No ☐Maybe Due Date:_____

Has this child had a **hearing exam**? ☐Yes ☐No Where and results? _____

At what age did he/she **begin to walk?** (Give approximate age) _____

At what age did he/she **begin to speak**? (Give approximate age) First words _____ Sentences _____

Please mark all that apply to your child:

☐ Asthma ☐ Epilepsy (chronic seizures) ☐ Febrile Seizures (from high fever) ☐ Heart murmur/heart trouble ☐ ADHD/Hyperactivity ☐ Diabetes ☐ Wears Hearing Aides	☐ Underweight ☐ Overweight ☐ Frequent Headaches ☐ Nightmares ☐ Frequent stomach aches ☐ Frequent Diarrhea ☐ Has Cochlear Implant(s)	☐ Rashes ☐ Nose bleeds ☐ Frequent ear infections ☐ Frequent sore throats ☐ Frequent fevers ☐ Dental concerns/cavities ☐ Wears Glasses	☐ Autism: ☐ diagnosed ☐ suspected ☐ **Allergies:** (food/medicine/other) *List allergies, explain reaction, treatment, and & restrictions:*

Please list all medications being taken regularly:

1. Reason:
2. Reason:
3. Reason:

Will your child need **medication to be kept at or administered by the school**? ☐ Yes ☐ No

**(If yes, a "Medication Authorization Form" will need filled out and signed by your child's doctor & turned in prior to enrollment.)*

Has child had any serious illnesses, diseases, injuries or hospital stays ☐ Yes ☐ No If yes, explain: _____

_____

Does your child have a **diagnosed disability**? ☐ Yes ☐ No If yes, name of diagnosis & how it impacts your child: ___

_____

Do you have any **concerns about his/her speech?** ☐ Yes ☐ No Explain _____

Has anything happened in your child's life (or yours) that may influence their **social, emotional or physical development**?

_____

Do you feel your child **learns more slowly or is developing differently** than other children their age? ☐ Yes ☐ No

If Yes, please explain:_____

Is your child enrolled in **services at Hillsboro Health Therapy Services** or any other private therapy provider?

☐ Yes ☐ No ☐ On a waiting list to be evaluated ☐ Eligible, but on waiting list to begin services

If Yes, which services: ☐ Speech ☐ Occupational (OT) ☐ Physical (PT) ☐ Behavioral ☐ Other:_____

Briefly **describe your child and any concerns you might have** about or for them: _____

_____

Consent of Parent/Guardian: I agree to the release of health information on my child to appropriate school or health authorities and to Medicaid as needed for reimbursement.

Name of Person Completing Interview (**print**): _____Relationship to Child: _____

Signature of Person Completing Interview: _____ Date: _____

Hillsboro PreK Screening Interview

1. Does your child have **asthma?** ⬜Yes ⬜No
   If yes, will they need an inhaler *kept at schoo*l? ⬜Yes ⬜No
2. Do they have any other ongoing **medical conditions**?
   ⬜Yes ⬜No If yes, what?
3. Does your child have any **food allergies**? ⬜Yes ⬜No
   If yes, to what:

   What type of reaction do they have to this & how do you treat it when they do?:
4. Is your child **potty trained**?
   *(*Students do **NOT** have to be potty trained to be enrolled in our PreK)*
   ⬜ Yes, fully
   ⬜ Somewhat, but still working on it
   ⬜ No, not at all
5. Does your child have a regular **bedtime & bedtime routine**?
6. Do you have any concerns about your child's **nutrition**? (picky eater, picky about textures, fruits, vegetables, etc.?)
7. Are there any concerns with your child's **dental health** at this time? (cavities, pain, dental surgeries, etc.)
8. Do you **brush your child's teeth** 2x/day?
9. Does your child currently use a **pacifier or bottle**?
10. Is it a challenge to take your child out in **public places** like the grocery store or restaurant? If yes, please explain:
11. Is your child able to **use sentences** with several words to tell you about a story about something that happened when they weren't with you?
12. Are friends/family members able to easily understand your child's **speech**?
13. Has a doctor or any other provider ever recommended referring your child for speech therapy or any other developmental evaluations or support services? (If yes, explain)
14. Do you have any other **concerns about your child** or **their development** that you feel the school should be aware of? If so, what?

Goals:

What are the **social and/or educational goals** you have in mind for your child's time in Pre-K?

What goals do you have **for yourself as a parent or family** in which we could provide support? (ex. bedtime routines, potty training, behavior strategies, healthy meals, reading with your child, making time to "play" with your child, seeking employment, finding affordable housing/transportation, meeting basic needs, etc.)

_____ _____

Parent/Guardian Signature Date

_____ _____

Staff Initials Date

Hillsboro PreK Permissions

Coffeen Early Childhood Center • 200 School St. • Coffeen, IL 62017 • (217)532-7822 • prek.hillsboroschools.net

Screening and Testing

☐ Yes, my child may participate in the district-wide **screening** to identify possible developmental delays in cognition, speech/language, social-emotional, vision, or hearing. I also agree that their developmental progress in these areas can be monitored throughout the school year.

Field Trips

☐ **Yes**, my child **may attend field trips** during their enrollment in PreK. I understand that this may include riding a school bus, or walking to and from a local site to be visited. I also understand that I am giving permission for my child to attend field trips for the entire school year, and will not sign a consent each time a trip is taken.

☐ **No**, my child **may not** attend field trips. Please inform me of when trips are and I will keep them home from school on those days.

Lending Library

☐ **Yes,** my child may check out books, toys, or other age appropriate materials when available. I agree to return these items to the best of my ability.

☐ **No,** my child may not check out materials from the school lending library.

Internet Access

☐ **Yes**, I am aware that Hillsboro District #3 has internet access in the school buildings. I understand that it is available in my child's classroom as an educational tool, with the supervision of their teacher or assistant.

Photo and Video Usage

☐ **Yes**, I consent that photos and videos of my child taken at school or on field trips can appear in newspapers, school publications, or on the school website.

☐ **No**, photos or video of my child **cannot** be used outside of the classroom.

☐ Photos or video of my child **can** appear in newspapers, school publications, or on the school website **but ONLY WITHOUT THEIR NAME** connected to the photo or video.

"Parent Square" (School District Parent Communication App)

☐ **Yes**, my child's photo can be posted on the CLASSROOM **Parent Square** page *(visible only to parents/guardians of students in my child's class.)*

☐ **No**, my child's picture may NOT be used/posted on "Parent Square" for other classroom parents to see.

Health Information

☐ I agree to the release of health information on my child to appropriate school or health authorities and to Medicaid as needed for reimbursement.

I have read all of the information above, and indicated those I give consent for.

_____ _____ _____

Child's Name parent/guardian signature date

Hillsboro PreK Attendance & Participation

Coffeen Elementary School • 200 School Street • Coffeen, IL 62017 • (217)532-7822 • prek.hillsboroschools.net

ATTENDANCE

The Hillsboro PreK program stresses the importance of regular student **attendance**, as well as punctuality. When students are absent or late, they miss valuable opportunities for learning, and interrupt classroom routines for both themselves and others. By choosing to enroll your child in the Hillsboro PreK, *you are **agreeing to a partnership with us*** in your child's education and committing to having them **attend school daily** and ensuring that they **arrive to school on time**.

REPORTING ABSENCES

If your child will be absent for any reason, it is the school district policy that you **call the school to report their absence** (AM by 9:00 a.m. or PM by 12:00 p.m.) ***and*** **report the reason for the absence,** or your child will be counted as "unexcused." *(Please see our PreK Handbook for our policy on sickness.)*

PARENT PARTICIPATION & PARENT-TEACHER CONFERENCES

Another valued component of our pre-k program are the many opportunities for **parent participation**. We believe that parents are a child's first teacher, and that we are *partners with you* in their education. By enrolling your child in our free pre-k program, you are agreeing to partner with us in your child's education by participating in our **2 parent-teacher conferences** each school year, as well as some of the family engagement activities offered throughout the school year (parent workshops, family fun nights, Family Fun Fridays, field trips, volunteering, etc.).

Signing this partnership signifies your commitment to your child's **regular attendance**, **being on time**, **participation** in family engagement activities, and your awareness that we have a waiting list of children/families waiting for an unfilled spot in our program.

Signature of Parent/Guardian: _____ Date:_____

Student's Name (printed): _____ Teacher: _____

Marci Gutierrez, Principal
mgutierrez@hillsboroschools.net

Sarah VanMiddendorp, PreK Coordinator
svanmiddendorp@hillsboroschools.net

Hillsboro PreK Transportation

Child's Name: _____

**Class session & teacher preferences are* NOT *guaranteed.*

How do you plan for your child to get to school?

❑ **PT:** I plan to provide transportation

❑ **Bus:** My child will ride the bus

Teacher Preference* (optional) _____

Which Site & session do you *prefer**

❑ **Coffeen Early Childhood Center**

- ❑ AM Class (8:20am-10:50am)
- ❑ PM Class (11:50am-2:30pm)

❑ **HCCDC** (½ day PreK, with full-day childcare)
*must be enrolled & paying for full-day childcare @HCCDC
**No bussing to/from HCCDC; parent-transport only

AM CLASS (8:20-10:50 a.m.)

Primary PICK-UP Before School

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

***Alternate* PICK-UP** (optional)

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Primary DROP-OFF After School:

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

***Alternate* DROP-OFF** (optional)

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

PM CLASS (11:50 a.m. - 2:30 p.m.)

Primary PICK-UP Before School

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

***Alternate* PICK-UP** (optional)

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Primary DROP-OFF After School:

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

***Alternate* DROP-OFF** (optional)

_____
Street Address Town

_____
Name of parent/caregiver at this location & Relationship to child

Hillsboro PreK

Friday Class Selection

Coffeen Early Childhood Center • 200 School St. • Coffeen, IL 62017 • (217)532-7822 • prek.hillsboroschools.net

*This box for Office-Use Only
☐ 4-day Program (Mon-Thurs)
☐ 5-day Program (Mon-Fri)

_____
Student Name (First & Last)

Hillsboro PreK offers classes Monday through Friday*, with bussing offered ***Monday through Thursday***.

***No bussing* is provided on Fridays**.

Families choosing to send their child to school on Fridays must provide their own transportation to and from school. PreK is only offered on Friday **MORNINGS** (but offered to both a.m. and p.m. students).

We understand that transportation may be a hardship for some families financially or due to childcare. Therefore, *enrolling for Friday Class is not required*. However, in order for us to plan, we do ask families to make a selection to enroll their child in a 4-day program (Monday -Thursday) or 5-day program (Monday - Friday). **Children signed up for Fridays will be expected to have regular attendance each week**.

*Children attending class on Fridays are likely to be in a classroom with different teachers & different classmates than they are with Monday - Thursday due to lower enrollment on Fridays & blending of classes.

Please indicate your selection below:

Students who do NOT have an IEP (Special Education Services)

_____ **YES,** my child will attend class on Friday Mornings, and we will provide transportation to and from school. **Drop-off at 8:15 a.m.; Pick-up at 10:50 a.m.**

_____ **NO,** my child will not be attending class on Fridays. *(Please indicate reason(s) below.)*

____ We are unable to provide transportation due to babysitting.

____ Providing transportation is a financial hardship for my family at this time.

____ I prefer that my child only attend school 4 days per week at this age.

Students with IEPs (Special Education Services) *(*Bussing IS provided on Fridays for students with full special education (IEP) services.*)

____ **YES**, my child has an IEP and WILL attend class on Fridays.

____ My child **will** ride the school bus on Fridays.

____ My child ***will NOT*** ride the bus on Fridays. We will provide our own transportation.

____ **NO**, my child has an IEP, but we are choosing NOT to have them attend on Fridays this year.

Parent Signature: _____ Date: _____

HILLSBORO COMMUNITY UNIT SCHOOL DISTRICT #3

McKinney-Vento Act

Student/Family Questionnaire

Your child may be eligible for additional services through the McKinney-Vento Assistance Act. Eligibility can be determined by completing this questionnaire.

1. Presently, are you and/or your family in any of the following situations? **CIRCLE YES OR NO**

YES / NO Living with relatives or others due to lack of housing (doubled-up)
YES / NO Staying in a shelter
YES / NO Temporarily living in a Motel/hotel due to loss of housing, economic hardship or similar reason
YES / NO Living in a car, park, campground, abandoned building or similar substandard housing
YES / NO Unknown nightly residence (non-permanent)



IF YOU ANSWERED NO TO ALL OF THE ABOVE, DO NOT COMPLETE THE REMAINDER OF THIS FORM

Fill in the names of the students that the above information pertains to:

Student First Name	Student Last Name	D.O.B.	Grade	School Name

I certify that according to information provided above, the student(s) listed meet the definition of "Homeless" as stated in the McKinney-Vento Homeless Assistance Act.

Print Parent/Guardian Name Signature Date

State of Illinois

Certificate of Child Health Examination

Student's Name (Last / First / Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address / City / ZIP Code	Parent/Guardian / Telephone (home/work)

HEALTH HISTORY: MUST 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		Hospitalization? 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 disorder? 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				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Additional Information:

Ear/Hearing problems? ☐ Yes ☐ No

Bone/Joint problem/injury/scoliosis? ☐ Yes ☐ No

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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

Signature _____ Title _____ Date _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

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

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

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

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