SKOKIE - MORTON GROVE SCHOOL DISTRICT 69

5050 MADISON STREET • SKOKIE, IL 60077 • (847)-675-7666 • FAX (847) 675 -7675 • WWW.SD69.ORG

Welcome to District 69! Below is a checklist of items that are required by the District to complete the registration process.

If at any point you have any questions or need any assistance in completing the process, please contact your school's office:

- Pre-K: PreSchoolInfo@Skokie69.net, 847-675-7666
- Madison (K-2): MadisonInfo@Skokie69.net, 847-675-3048
- Edison (3-5): EdisonInfo@Skokie69.net, 847-966-6210
- Lincoln (6-8): LincolnInfo@Skokie69.net, 847-676-3545

Checklist of Forms for New District 69 Students (Kindergarten – 8th Grade)

- ☐ School District 69 Registration Form
- ☐ Skokie – Morton Grove School District 69 Home Language Survey
- ☐ Verification of Residency Form(s)
- ☐ Data Collection Form (ISBE)
- ☐ Physical, Dental, and Eye Exam Form
- ☐ Student COVID-19 Self-Certification and Verification Form
- ☐ Report Card Translation Waiver (optional)

Please prepare these personal documents that are needed to complete the registration process:

- ☐ Birth Certificate
- ☐ Residency Documents (please refer to the verification of residency form included in this packet for more information)
- ☐ Immunization and Health Records (forms are included in the packet)

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School District 69 Registration Form

PLEASE PRINT USING BLACK INK

Student Last Name	First Name	Middle Name	Gender	Birth Certificate No. Or Passport No.

Street Address	City	State	Zip Code	Telephone Number ( )

Date Of Birth	Place of Birth

Parent/Caregiver One Last Name	Parent/Caregiver One First Name	Date of Birth	Relationship to Student

Parent/Caregiver One Business Phone	Name of Employer

Parent/Caregiver One Cell Phone Number	Parent/Caregiver One E-Mail Address

Parent/Caregiver Two Last Name	Parent/Caregiver Two First Name	Date of Birth	Relationship to Student

Parent/Caregiver Two Business Phone	Name of Employer

Parent/Caregiver Two Cell Phone Number	Parent/Caregiver Two E-Mail Address

If there are custody restrictions, please describe and present legal documents for the student's file.

If student does not live with either parent, identify with whom the student lives:

What is your preferred mode of communication?

☐Email ☐Phone Call ☐Text Message ☐ Mobile App Notification

Who does the student live with?

☐Both Parents in home

☐Single Parent Family

☐Lives with an adult other than guardian

☐Youth in care

☐Parents have joint custody

List Members of Household	Relationship	Birth Date	If Student, Name of School

Emergency Information (List names other than parents/guardians)		Relationship to Student	Daytime Telephone Number
	☐Emergency Only ☐Drop Off & Pick Up Only ☐Both	dad	
	☐Emergency Only ☐Drop Off & Pick Up Only ☐Both		

Updated 12/21

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Date Family Moved to District 69:	Is Student a U.S Citizen? ☐Yes ☐No	If NO, provide date student first entered a US school:

Doctor's Name	Hospital of Birth:	Doctor's Telephone Number

Dentist Name	Dentist Phone Number

Has the student ever received any transitional language service? ☐Yes ☐No

☐ESL (English as a Second Language) ☐Bilingual Education ☐Currently in a program at this time ☐Released from program

Has student ever received any special education or early intervention services or attended a development screening? ☐Yes ☐No
If Yes, type of service(s):

Does student currently have an IEP? ☐Yes ☐No Does student currently have a 504? ☐Yes ☐No

Please list medical problems or food restrictions, if any including life threatening food allergies:

Previous Day Care / Preschool Experience

0-3 Years Old	3 Years Old	4 Years Old	5 Years Old
☐Family Child Care	☐Family Child Care	☐Family Child Care	☐Family Child Care
☐Center Based	☐Center Based	☐Center Based	☐Center Based
☐Preschool / Day Care	☐Preschool / Day Care	☐Preschool / Day Care	☐Preschool / Day Care
Facility Name:	Facility Name:	Facility Name:	Facility Name:
☐Full Day ☐Half Day	☐Full Day ☐Half Day	☐Full Day ☐Half Day	☐Full Day ☐Half Day
# Days per week	# Days per week	# Days per week	# Days per week

Previous school(s) student has attended: (START WITH KINDERGARTEN)

School and District Name	City/State/Country	Grades Attended

Skokie – Morton Grove School District 69 Home Language Survey

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 to identify the students who need to be assessed for English language proficiency and may be eligible for English Learner services.

Student Name: _____

English

1. Is a language other than English spoken in your home?

☐ No ☐ Yes_____(language)

2. Does the student speak a language other than English?

☐ No ☐ Yes_____(language)

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

Tagalog

1. May iba pa bang lengguwahe bukod sa Ingles na ginagamit sa iyong tahanan?

☐ Hindi ☐ Oo_____(Lengguwahe)

2. May ginagamit ba na ibang lengguwahe ang mag- aaral bukod sa Ingles?

☐ Hindi ☐ Oo (Lengguwahe)

Ayon sa batas, kung "Oo" ang sagot sa parehong tanong, kailangan suriin ng paaralan ang kakayahan at kaalaman na mag- aaral sa wikang Ingles.

Spanish/Español

1. ¿Se habla algún otro idioma que no sea Inglés en su hogar?

☐ No ☐ Sí_____ (Idioma)

2. ¿Habla el estudiante algún otro idioma que no sea Inglés?

☐ No ☐ Sí_____ (Idioma)

Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la habilidad de su niño en Inglés.

Urdu

1. کیا آپ کے گھر میں انگریزی کے علاوہ کوئی دوسری زبان بولی جاتی ہے؟

☐ نہیں ☐ ہاں _____ (زبان)

2. کیا طالب علم انگریزی کے علاوہ کوئی دوسری زبان بول سکتا ہے ؟

☐ نہیں ☐ ہاں _____ (زبان)

اگر کسی بھی سوال کا جواب ہاں میں ہے تو ، قانون کے تحت اسکول سے آپ کے بچے کی انگریزی زبان کی مہارت کا اندازہ لگانا پڑتا ہے۔

Assyrian

ܐ. ܡܬܝܠܦܝܢ ܠܟܘܢ ܡܠܬܐ ܕܠܐ ܡܬܝܠܦܝܢ ܒܗ ܒܒܝܬܟܘܢ ܐܢܘܢ؟

☐ ܐܝܢ ☐ ܠܐ ------- (ܠܫܢܐ)

ܒ. ܐܝܟ ܡܠܦܐ ܡܬܠܠ ܠܫܢܐ ܡܬܝܠܦܝܢ ܒܗ ܒܒܝܬܟܘܢ ؟

☐ ܐܝܢ ☐ ܠܐ ------- (ܠܫܢܐ)

ܐܢܘܢ ܕܡܫܬܡܫܝܢ ܒܗ ܒܒܝܬܟܘܢ ܐܝܟ ܡܠܦܐ ܠܫܢܐ ܕܠܐ ܡܬܝܠܦܝܢ ܒܗ ܒܒܝܬܟܘܢ ܠܡܕܥܢܐ ܕܐܝܟ ܡܠܦܐ (ܠܫܢܐ) ܕܛܠܝܐ ܡܬܝܠܦܝܢ ܒܗ ܒܒܝܬܟܘܢ.

Arabic

1. هل تُستخدم لغة أخرى غير اللغة الإنجليزية في منزلك؟

☐ لا ☐ نعم _____ (اللغة)

2. هل يتحدث الطالب لغة أخرى غير اللغة الإنجليزية؟

☐ لا ☐ نعم _____ (اللغة)

إذا كانت الإجابة على أي من السؤالين نعم ، فإن القانون يتطلب من المدرسة تقييم إتقان طفلك للغة الإنجليزية.

***** If the answer is "yes" to questions 1 and/or 2, the law requires the school to assess your child's English language proficiency *****

_____

Parent/Guardian Name

_____ _____

Parent/Guardian Signature Date

Updated 12/21

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Verification of Residency

You must provide documentation showing you ***live at*** the address included in your registration. Please bring the following documents to register your child at District 69. You must provide at least **one document from Category 1** and **two documents from Category 2**. To guard your security, please block out account and social security numbers on the documents before you present them.

All documents must be current (within the last 30 days) and show your name and address. Check the boxes for the documentation you are providing and include the documentation with this completed form. To guard your security, please block out account and social security numbers on the documents before you present them.

Category 1 – provide at least one (1)	Category 2 – provide at least two (2)	
☐ Property tax bill–(most recent for current year) ☐ Signed lease ☐ Mortgage document or payment ☐ Military housing letter ☐ Section 8 letter ☐ Other*: _____	☐ Gas bill ☐ Electric bill ☐ Water/sewer bill ☐ Phone bill (not mobile phone) ☐ Cable bill ☐ Vehicle registration ☐ Bank statement	☐ Public aid card ☐ Credit card statement ☐ Paycheck stub ☐ City sticker receipt ☐ Other*: _____

Living with another person or family (Homeowner)

- If you are living in a home that is owned by another person or family member you must complete **Affidavit A and B.**

Living with another person or family (Renter)

- If you are living in a home that is rented by another person or family member you must complete **Affidavit A, B and C.**

Please contact the District's McKinney-Vento Liaison at (847) 675-7666 if you:

- Do not have a permanent residence;
- Are living in a shelter, hotel, campground, train/bus station, or other similar situation; or
- Are sharing housing with others due to loss of housing, economic hardship, or similar reason

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Affidavit of Residence - No Evidence (Document A)

(District Resident)

I, _____ hereby state that I live at _____
(resident) (Street Address)

In the Village of _____, Illinois.

_____ and _____ have lived with me since _____
(parent/caregiver name) (child name)

For the following reasons (state any and all reasons):

_____

_____

_____

Number of rooms in residence:_____ Number of bedrooms:_____

Total number of adults living in residence:_____ Children:_____

	Yes	No
The student and parent/legal guardian eat meals regularly at the residence listed above.		
The student and parent/legal guardian sleep regularly at the residence listed above.		
The student and parent/legal guardian spend weekends regularly at the residence listed above.		
The student and parent/legal guardian spend summers regularly at the residence listed above.		

_____ I hereby swear that the information given is true and correct. I affirm that this residency arrangement is due
(initial) to unique family or personal reasons and not to qualify the child as a student eligible to attend Skokie School District 69. I understand that I may be subject to criminal prosecution for perjury and I may be liable for annual tuition charges in the amount of $15,474.00 if I have given false information.

_____
Name of Resident

_____
Signature of Resident

_____
Date

Subscribed and sworn on before me on this _____ day of _____, 20_____.

_____
Notary Public

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Affidavit of Residence - No Evidence (Document B)
(Parent/Guardian Living with District Resident)

I, _____ hereby state that I live at _____
(resident) (street address)

In the Village of _____, Illinois.

My former address is _____, _____, _____.
(street address) (city) (state)

I have lived with _____ since_____
(district resident)

For the following reasons (state any and all reasons):

_____

_____

_____

	Yes	No
The student and parent/legal guardian eat meals regularly at the residence listed above.		
The student and parent/legal guardian sleep regularly at the residence listed above.		
The student and parent/legal guardian spend weekends regularly at the residence listed above.		
The student and parent/legal guardian spend summers regularly at the residence listed above.		

_____ I hereby swear that the information given is true and correct. I affirm that this residency arrangement is due
(initial) to unique family or personal reasons and not to qualify the child as a student eligible to attend Skokie School District 69. I understand that I may be subject to criminal prosecution for perjury and I may be liable for annual tuition charges in the amount of $15,474.00 if I have given false information.

_____
Name of Resident

_____
Signature of Resident

_____
Date

Subscribed and sworn on before me on this _____ day of _____, 20_____.

_____
Notary Public

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Affidavit of Residence - No Evidence (Document C)
(Landlord)

I, _____, herby state that I live at _____,
(landlord) (street address)

I am the landlord of the building located at _____, in the Village of _____, IL.
(street address)

I verify that _____ and _____
(parent/caregiver name) (child name)

Have resided at _____ since _____ and to the best of my knowledge,
(street address) (lease/arrangement start date)

said lease/arrangement will expire on _____.
(anticipated end date)

Number of rooms in residence:_____ Number of bedrooms:_____

Total number of adults living in residence:_____ Children:_____

(1) _____ I issued a new lease.

_____ I did not issue a new lease.

(2) _____ I have added this person to the lease.

_____ I have not added this person to the lease.

_____I hereby swear that the information given is true and correct. I affirm that this residency arrangement is due
(initial) to unique family or personal reasons and not to qualify the child as a student eligible to attend Skokie School District 69. I understand that I may be subject to criminal prosecution for perjury and I may be liable for annual tuition charges in the amount of $15,474.00 if I have given false information.

_____
Name of Landlord

_____
Signature of Landlord

_____
Phone Number

_____
Email Address

_____
Date

Subscribed and sworn on before me on this _____ day of _____, 20_____.

_____
Notary Public

Illinois State Board of Education

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

Student's Name: _____ **SIS ID:** _____

(pre-printed by school district) (pre-printed by school district)

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.

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.)

Note: Data collected on this form must be maintained by the school district for three years. However, when there is litigation, a claim, an audit, or another action involving this record, the original responses must be retained until the completion of the action.

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Dear Parent/Guardian of a New Student:

According to Illinois state law, all children must have a physical examination and an up-to-date immunization record upon entrance to school and at the beginning of 6th grade. Failure to comply with this state law is cause for the exclusion of your child from school on October 15, 2022.

The physical exam and immunization record must be completed on the State of Illinois Certificate of Child Health Examination form and signed by a physician, nurse practitioner, or physician assistant. Forms dated on or after August 29, 2021, will be accepted. A chart from the Illinois Department of Public Health listing in detail what immunizations your child needs for school entry is enclosed.

An eye exam is also required for any child enrolling in kindergarten or students that are new to Illinois schools. The eye exam must be turned into school no later than October 15, 2022. An Illinois Eye Exam Report has been included in this packet.

Additionally, a dental exam is required for all Kindergarten, 2nd grade and 6th-grade students. Examinations must be performed by a licensed dentist and they must sign the State of Illinois Proof of School Dental Examination Form. Forms are due by May 15, 2023, and dental examinations must have been completed within the 18 months prior to the May 15 deadline.

The necessary forms are enclosed with this letter. Please return them to your school office as soon as possible. If you have any questions about these forms, please contact your school nurse:

During the School Year

Madison School: Keyla Pagan at pagank@skokie69.net or 847-675-3048 ext. 1115
Edison School: Mary Pius at piusm@skokie69.net or 847-966-6210 ext. 1211
Lincoln School: Jenn Cherko at cherkoj@skokie69. net or 847-676-3545 ext. 1317

During the Summer

Madison School: madisoninfo@skokie69.net
Edison School: edisoninfo@skokie69.net
Lincoln School: lincolninfo@skokie69.net

Thank you,

Kristine Joaquin Schubert

Kristine Joaquin Schubert
Director of Special Services

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:** * indicates invalid dose		
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** **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 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
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name: Last First Middle			Birth Date: (Month/Day/Year)
Address: Street City			ZIP Code
Name of School: ZIP Code		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name First Name			
Student's Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown ☐ Other_____			

To be completed by dentist:

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment —** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____

☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Additional comments: _____

Signature of Dentist _____ License #:_____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

State of Illinois
Illinois Department of Public Health

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

License Number _____

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

IOCI 15-391

SKOKIE - MORTON GROVE SCHOOL DISTRICT 69

5050 MADISON STREET • SKOKIE, IL 60077 • (847)-675-7666 • FAX (847) 675 -7675 • WWW.SD69.ORG

Student COVID-19 Self-Certification and Verification Form

***Must be Signed by Parent/Guardian prior to Student's First Day of School Attendance**

In response to the COVID-19 pandemic and in order to ensure a safe and healthy environment for our school community, Joint Guidance from the Illinois State Board of Education and the Illinois Department of Public Health requires that every student undergo a daily symptom screening prior to utilizing School District transportation or entering any School District building. Parents/Guardians will be conducting this daily symptom screening prior to their student departing for school and reporting consistent with the parameters outlined below. This form must be signed and returned to the School District prior to your child returning to District 69 buildings for In-Person Learning.

Name of Student: _____ **Date of Birth:** _____

School: _____ **Grade Level:** _____

Certification and Verification of Daily Symptom Screening

I verify that prior to utilizing District transportation and/or entering a District building, my student will receive a daily symptom screening at home by an adult caregiver to determine if my student is experiencing any of the following COVID-19 symptoms:

- Temperature of 100.4 (or greater) degrees Fahrenheit/38 degrees Celsius;
- Cough;
- Shortness of breath or difficulty breathing;
- Chills;
- Fatigue;
- Muscle and body aches;
- Headache;
- Sore throat;
- New loss of taste or smell;
- Congestion or runny nose;
- Nausea and/or vomiting;
- Diarrhea; or
- Any other COVID-19 symptoms identified by the CDC or IDPH.

By sending my student on District transportation and/or to school on any given day, I am certifying and verifying that my student has received a daily symptom screening and is not experiencing any COVID-19 symptoms.

If my student is experiencing any of the above symptoms at the time of the daily screening, I will notify the school in writing of my student's absence by sending an email to the appropriate email address or calling the Attendance line as listed below, and indicating which of the above symptoms that my student is experiencing.

Attendance lines:

- Madison Attendance Line: 224-470-6291
- Edison Attendance Line: 224-470-6292
- Lincoln Attendance Line: 224-470-6293

Email:

- Madison: MadisonInfo@Skokie69.net
- Edison: EdisonInfo@Skokie69.net
- Lincoln: LincolnInfo@Skokie69.net

If District staff contacts me to gather additional information related to the results of my student's daily screening, I will provide the necessary information as requested.

Certification and Verification of Other COVID-19 Related Exposures

I will notify the school that my student will be absent pending further direction from the District if: (1) my student receives a diagnosis of COVID-19 or has a pending COVID-19 test (waiting for results); (2) my student is suspected of having COVID-19; (3) my student comes in close contact (definition below) with an individual who tested positive for COVID-19 or is suspected of having COVID-19; or (4) my student traveled internationally. If the District staff contacts me to gather additional information related to the reason(s) for my student's absence, I will provide the necessary information as requested.

By sending my student on District transportation and/or to school on any given day, I am certifying and verifying that my student is not subject to an isolation or quarantine protocol related to COVID-19.

For COVID-19, the CDC defines a "close contact" as "any individual who was within 6 feet of an infected person for at least 15 minutes starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to positive specimen collection) until the time the patient is isolated."

_____ _____

Parent/Guardian Signature **Date**

SKOKIE - MORTON GROVE SCHOOL DISTRICT 69

5050 MADISON STREET • SKOKIE, IL 60077 • (847)-675-7666 • FAX (847) 675 -7675 • WWW.SD69.ORG

Report Card Translation Waiver

Please check one and return to the school office:

☐ I waive the right to receive a copy of my child's report card in our home language.
I will get my child's report card in English.

Child's name: _____

Parents' signature: _____

Date: _____

☐ I request a copy of my child's report card in our home language of _____.
If it is not possible to translate the report card into our home language, then I will contact my child's teacher to request a conference for an explanation on of the report card.

Child's name: _____

Parents' signature: _____

Date: _____

Updated 12/21