

SKOKIE - MORTON GROVE SCHOOL DISTRICT 69

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

Dear Incoming Sixth Grade Parents:

According to Illinois state law, all children must have a physical examination and an up to date immunization record upon entrance to sixth grade. Failure to comply with this state law is cause for the exclusion of your child from school on October 15, 2021.

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 30, 2020, 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.

Additionally, a dental exam is required for all sixth-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, 2022, and dental examinations must have been completed within the 18 months prior to the May 15 deadline.

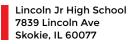
The necessary forms are enclosed with this letter. Please return them to your school office as soon as possible. If you have any questions, contact the Lincoln Nurse, Jenn Cherko at cherkoj@skokie69.net or 847-676-3545 ext. 1317. During the summer you may contact the school at lincolninfo@skokie69.net.

Thank you,

Kristine Joaquin Schulert

Kristine Joaquin Schubert Director of Special Services

Edison Elementary School 8200 Gross Point Rd Morton Grove, IL 60053





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

Dear Incoming Kindergarten Parents:

According to Illinois state law, all children must have a physical examination and an up to date immunization record upon entrance to kindergarten. Failure to comply with this state law is cause for the exclusion of your child from school on October 15, 2021.

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 30, 2020 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. The eye exam must be turned into school no later than October 15, 2021. An Illinois Eye Exam Report has been included in this packet.

Additionally, a dental exam is required for all kindergarten 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, 2022, and dental examinations must have been completed within the 18 months prior to the May 15 deadline.

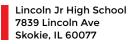
The necessary forms are enclosed with this letter. Please return them to your school office as soon as possible. If you have any questions, please contact Keyla Pagan, Madison Nurse at 847-675-3048 ext. 1115. During the summer you may contact the school at madisoninfo@skokie69.net.

Thank you,

Kristine Joaquin Schubert

Kristine Joaquin Schubert Director of Special Services

Edison Elementary School 8200 Gross Point Rd Morton Grove, IL 60053





State of Illinois Certificate of Child Health Examination

Student's Name			Birth Date		Sex	Race	/Ethnicity	Scho	ol /Grade Level/	ID#
Last	First	Middle	Month/Day/Year							
Address Str	eet City	Zip Code	Parent/Guardian			Telepho	one # Home		Wor	k
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> 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										
	ning the medical reas	on for the contraind DOSE 2	ication. DOSE 3	1	DOSE 4		DOSE 5		DOSE 6	
REQUIRED Vaccine / Dose	MO DA YR	MO DA YR	MO DA YR	мо		YR		YR	MO DA	YR
DTP or DTaP	MO DA IR	MO DA IR			DI				into bit	IR
Tdap; Td or Pediatric DT (Check	□Tdap□Td□DT	□Tdap□Td□DT		□Td	ap□Td□	DT	□Tdap□Td□	DT	□Tdap□Td□	lDT
specific type)	□ IPV □ OPV	□ IPV □ OPV	□ IPV □ OPV		□ IPV □ OPV		□ IPV □ OPV)PV
Polio (Check specific type)										
Hib Haemophilus influenza type b										
Pneumococcal Conjugate										
Hepatitis B										
MMR Measles Mumps. Rubella				Com	ments:					
Varicella (Chickenpox)										
Meningococcal conjugate (MCV4)										
RECOMMENDED, B	UT 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				Dat	e		
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) Immunity Immunity<										
**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	
	OMPLETED	AND SIGNED BY PARENT/	•	BY HEA	LTH CAR	RE PRO	OVIDER		
ALLERGIES Yes List:			MEDICATION (Prescribed or	Yes Li	ist:	_ 10			
(Food, drug, insect, other) No Diagnosis of asthma?	Yes No	I		taken on a regular basis.) No Loss of function of one of paired			Yes No		
Child wakes during night coughing?	Yes No			organs? (eye/ear/kidney/testicle)					
Birth defects?	Yes No		Hospitalizations? When? What for?						
Developmental delay?	Yes No								
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Surgery? (List all.) When? What for?					
Diabetes?	Yes No		Serious injury or illness?						
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/pr	Yes*	No	*If yes, refer to local health department.			
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes*	No	departmen	ι.		
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency	Yes Yes	No No				
Heart murmur/High blood pressure?	Yes No Yes No		Alcohol/Drug use? Family history of sudden dea	-					
Dizziness or chest pain with exercise?	res no		before age 50? (Cause?)	Yes	No				
		Last exam by eye doctor	_ Dental □ Braces □	Bridge	□ Plate	Other			
Ear/Hearing problems?									
Bone/Joint problem/injury/scoliosis?	Yes No	,	—Parent/Guardian Signature						
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA HEAD CIRCUMFERENCE if < 2-3 years old									
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes No And any two of the following: Family History Yes No E 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				olic schoo	l operated	day cai	re, preschoo	ol, nursery school	
and/or kindergarten. (Blood test required Questionnaire Administered? Yes □ N		Chicago or high risk zip code.) od Test Indicated? Yes N			Ŀ	Result			
TB SKIN OR BLOOD TEST Recommen				to HIV inf			litions, frequ	ent travel to or born	
in high prevalence countries or those exposed to No test needed Test performed	adults in high-			blications		s/testing	g/TB_testin		
10 test needed 🗆 1 est periormed		d Test: Date Reported	/ / Result: Positi		legative ∟		mm Value		
LAB TESTS (Recommended)	Date Results					Date		Results	
Hemoglobin or Hematocrit			``	Sickle Cell (when indicated)					
Urinalysis			Developmental Screening	0	l Comments/Follow-up/Needs				
	nts/Follow-u	p/Needs		Normal	Commen	ts/Foll	ow-up/Nee	eds	
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)									
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:									
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 I 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 I INTERSCHOLASTIC SPORTS Yes No Modified I									
Print Name (MD,DO, APN, PA) Signature Date Date									
	Address Phone						suit		

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	City ZIP Code					
Name of School:		ZIP Code	Grade Level:	Gender:				
				🗆 Male 🛛 Female				
Parent or Guard	ian: Last Name		First Name					
Student's Race/	•	_						
☐ White	□ Black/African American □ Hispanic/Latino □ Asian							
□ Native Americ □ 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 State	us (check all that apply)							
☐Yes ☐No								
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	es 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	e Care — amalgams, composites	s, crowns, etc. Ap	pointment Date:					
Preventive Care — sealants, fluoride treatment, prophylaxis			Appointment Date:					
Pediatric De	entist Referral Recommend	ed Tro	atment Completion Date:					
Additional comments:								
Signature of De	ntist	Licer	se #:	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