

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: <u>PreSchoolInfo@Skokie69.net</u>, 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)
- D 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)



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

School District 69 Registration Form

			PLEA	SE PRINT USIN					
Student Last Name		First Name			Middle I	Name	Gender	Birth Cer	tificate No. Or Passport No.
Street Address			City			State	Zip Coo	le	Telephone Number
			- ,						()
Date Of Birth		Place of Birth							
									Who does the student
									live with?
Parent/Caregiver One Last Name	Parent/	Caregiver One First	Name	Date of Birtl	ר	Relationshi	p to Student		
									Both Parents in home
Parent/Caregiver One Business Phon	e	Name of Emp	oloyer						
									Single Parent Family
Parent/Caregiver One Cell Phone Nu	mber F	Parent/Caregiver Or	he E-Mail /	Address					Lives with an adult other than guardian
									other than guaraian
Parent/Caregiver Two Last Name	Parent/	Caregiver Two First	Name	Date of Birth	า	Relationshi	ip to Student		☐ Youth in care
Parent/Caregiver Two Business Phon	е	Name of Emp	oloyer	4					Parents have joint
									custody
Parent/Caregiver Two Cell Phone Nu	mber F	Parent/Caregiver Tw	vo E-Mail /	Address					
									_
If there are custody restrictions, pleas	e describe	e and present legal	document	s for the stude	nt's file.				
If student does not live with either par	ent, identi	ify with whom the st	udent lives	S:					1
What is your preferred mode of comm	unication	?							-
Email Phone Call Text Mes			tion						
List Members of Household	saye 🗆	Relationship			В	irth Date		lf	Student, Name of School
Emergency Information // inter-	th o x th	noronto/auli			Delect	nahin to Otical			outime Telephere Numb
Emergency Information (List names o	mer than	Í.			Relatio	onship to Studen	ι		aytime Telephone Number
			ency Only						
		Drop O	off & Pick l	Jp Only					
		□Both							
			ency Only						
		Drop O	off & Pick l	Jp Only					
		Both							

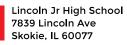
Edison Elementary School 8200 Gross Point Rd Morton Grove, IL 60053

Skokie, IL 60077



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

Date Family Moved to District 69:	Is Student a U.S Citizen?	If NO, provide date student f	iirst entered a US s	school:
	□Yes □No			
Doctor's Name		Hospital of Birth:	Doctor's Te	elephone Number
Dentist Name	I		Dentist f	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 educat If Yes, type of service(s):	ion or early intervention services or attended a d	levelopment screening? Yes No)	
Does student currently have an IEP? □Yes	□No Does student currently have a 5			
Please list medical problems or food restriction	ns, if any including life threatening food allergies	:		
	Previous Day Care / Presch	hool Experience		
0-3 Years Old	3 Years Old	4 Years Old	5 Ye	ears Old
Family Child Care	□ Family Child Care	□ Family Child Care	□ Family Child 0	Care
Center Based	Center Based	Center Based	Center Based	1
Preschool / Day Care	Preschool / Day Care	Preschool / Day Care	Preschool / D	ay Care
Facility Name:	Facility Name:	Facility Name:	Facility Name:	
□Full Day □Half Day	□Full Day □Half Day	□Full Day □Half Day	□Full Day □H	alf Day
# Days per week	# Days per week	# Days per week	# Days	s per week
	Previous school(s) student has attended: (S			
School and	District Name	City/State/Country		Grades Attended



Realison	Skokie – Morton Grove School Dis The state requires the district to collect a Home Language Survey for eve families speak a language other than English at home. It also helps to ide proficiency and may be eligible for English Learner services.	ry new student. This information is used to count the students whose
	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)
	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.	Ayon sa batas, kung "Oo" ang sagot sa parehong tanong, kailangan suriin ng paaralan ang kakayahan at kaalaman na mag- aaral sa wikang Ingles. Urdu ٩ <
	Assyrian جەدىلەكلە تىلەن ئەلەپ بەرىكىلىغى، بەرەلەكلە كىلەپ بەرىكە تىلەپ (مۇلىكى كەر ئەرىكە تەكلە ئەر بەر ئەرەكە تەكلە ئىلەپ تەر بەر ئەرىكە بەر بەر ئەر بەر ئەرىكە بەر بەر ئەر بەر ئەرىكە بەر بەر ئەر بەر ئەر بەر ئەر بەر بەر ئەر بەر بەر بەر بەر بەر بەر بەر ب	Arabic ٩. هل تُستخدم لغة أخرى غير اللغة الإنجليزية في منزلك؟ ١ ١ ٢ ١ ٢ ٢ <
	Parent/Guardian Signature	Date



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

Verification of Residency

You must provide documentation showing you <u>live at</u> 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)	
D Property tax bill-(most recent for	□ Gas bill	\Box Public aid card
current year)	□ Electric bill	□ Credit card statement
□ Signed lease	□ Water/sewer bill	□ Paycheck stub
□ Mortgage document or payment	\Box Phone bill (not mobile phone)	□ City sticker receipt
□ Military housing letter	□ Cable bill	□ Other*:
\Box Section 8 letter	□ Vehicle registration	
□ Other*:	□ Bank statement	

Living with another person or family (Homeowner)

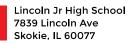
• If you are living in a home that is owned by another person or family member you must complete Affidavit A and B.

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





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

Affidavit of Residence - No Evidence (Document A)

(District Resident)

	hereby state that I live at	
(resident)	(Stre	et Address)
In the Village of	, Illinois.	
and _	have lived with me s (child name)	since
(parent/caregiver name)	(child name)	
For the following reasons (state any and a	ll reasons):	
Number of rooms in residence:		
Number of rooms in residence: Total number of adults living in resid	Number of bedrooms:	
Number of rooms in residence:	Number of bedrooms:	Yes No
Number of rooms in residence: Total number of adults living in resid	Number of bedrooms:	
Number of rooms in residence: Total number of adults living in residence The student and parent/legal guardian eat n	Number of bedrooms: dence: Children: meals regularly at the residence listed above.	Yes No
Number of rooms in residence: Total number of adults living in residence The student and parent/legal guardian eat no The student and parent/legal guardian so	Number of bedrooms: dence: Children: meals 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.

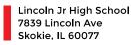
Name of Resident

Signature of Resident

Subscribed and sworn on before me on this day
of, 20
Notary Public

Date

Madison Elementary School 5100 Madison St Skokie, IL 60077





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

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		,				
(5	street address)	(city)	(state)			
I have lived with	sinc	e				
(distric	et resident)					
For the following reasons (state any a	nd 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.		

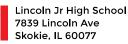
I hereby swear that the information given is true and correct. I affirm that this residency arrangement is due (initial) to unique family or personal reasons and not to qualify the child as a student eligible to attend Skokie School District 69. I understand that I may be subject to criminal prosecution 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

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

Signature of Resident

Date





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

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

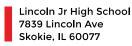
I,	, herby state that I live at	
(landlord)		(street address)
I am the landlord of the building located at		, in the Village of, IL.
	(street address)	
I verify that	and	
(parent/caregiver name)		(child name)
Have resided at(street address)	since(lease/arrangeme	
said lease/arrangement will expire on(anticipat	ted end date)	
Number of rooms in residence:	Number of bedrooms:	
Total number of adults living in residence:	Children:	
(1) I issued a new lease.	(2)	I have added this person to the lease.
I did not issue a new 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	Subscribed and sworn on before me on this day of, 20
Signature of Landlord	
	Notary Public
Phone Number	

Email Address

Date



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

Student's Name: ____

(pre-printed by school district)

SIS ID: (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.) <u>Choose only one</u>.

□ 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.)

<u>Note</u>: 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.



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

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

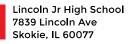
Madison School: madisoninfo@skokie69.net Edison School: edisoninfo@skokie69.net Lincoln School: lincolninfo@skokie69.net

Thank you,

Kristine Joaquin Schubert

Kristine Joaquin Schubert Director of Special Services

Madison Elementary School 5100 Madison St Skokie, IL 60077





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 Stre	eet City	Zip Code	Parent/Guardian			Telepho	one # Home		Wor	k
	5: To be completed by licated, a separate wi									
	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			IN	ino bit	
Tdap; Td or Pediatric DT (Check	□Tdap□Td□DT	□Tdap□Td□DT		□Td	ap□Td□	DT	□Tdap□Td□	DT	□Tdap□Td□	IDT
specific type)	□ IPV □ OPV	□ IPV □ OPV	□ IPV □ OPV		IPV □C)PV)PV		OPV
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										
	er (MD, DO, APN, PA above immunization					above	immunization	histo	ry must sign b	elow.
Signature			Title				Date	e		
Signature			Title				Dat	e		
ALTERNATIVE P	ROOF OF IMMUNI	ТҮ								
1. Clinical diagnosis copy of lab result. *MEASLES (Rubeola	(measles, mumps, h)) MO DA YR *	epatitis B) is allowed *MUMPS MO DA		-	an and su 40 DA				ation. Attacl	1
 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		ature	~* □\/	-	Dukalla	-	Title Wariaalla	A 441	ann cflat	
	ence of Immunity (ch diagnosed on or after.		1		Rubella	L	Varicella	Attach	n copy of lab re	sult.
	liagnosed on or after J	•	•	•						
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		Grade Level/ ID	
	OMPLETED	AND SIGNED BY PARENT/	•	BY HEA	LTH CAR	RE PRO	VIDER	
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.) Loss of function of one of pa	No ired	Yes	No		
Child wakes during night coughing?	Yes No		organs? (eye/ear/kidney/testi					
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/pr	-	Yes*	No	*If yes, refe department	er to local health
Seizures? What are they like?	Yes No		TB disease (past or present)?		Yes*	No	departmen	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency	()?	Yes	No		
Heart murmur/High blood pressure?	Yes No Yes No		Alcohol/Drug use? Family history of sudden dea	th	Yes Yes	No No		
Dizziness or chest pain with exercise?	res no		before age 50? (Cause?)	un	res	INO		
Eye/Vision problems? Glasses D Other concerns? (crossed eye, drooping lids,		Last exam by eye doctor	_ Dental □ Braces □	Bridge	□ Plate	Other		
Ear/Hearing problems?	Yes No		Information may be shared with a	ppropriate	personnel for	health a	nd educationa	l purposes.
Bone/Joint problem/injury/scoliosis?	Yes No	,	—Parent/Guardian Signature				Date	
PHYSICAL EXAMINATION REQ HEAD CIRCUMFERENCE if < 2-3 years of		NTS Entire section belo HEIGHT	w to be completed by MD WEIGHT BMI	/DO/AP	PN/PA bmi perc	CENTILI	E	B/P
DIABETES SCREENING (NOT REQUIRE Ethnic Minority Yes No Signs of								
LEAD RISK QUESTIONNAIRE: Required				olic schoo	l operated	day cai	re, preschoo	ol, nursery school
and/or kindergarten. (Blood test required Questionnaire Administered? Yes D N		Chicago or high risk zip code.) od Test Indicated? Yes N			T.	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	adults in high-	risk categories. See CDC guideline	es. <u>http://www.cdc.gov/tb/pu</u>	blications	/factsheets	s/testing	<u>g/TB_testin</u>	
No test needed Test performed		d Test: Date Read d Test: Date Reported	/ / Result: Positi / / Result: Positi		Negative □ Negative □		mm Value	
LAB TESTS (Recommended)	Date	Results		_	Ť	Date		Results
Hemoglobin or Hematocrit			Sickle Cell (when indic	ated)				
Urinalysis			Developmental Screening	0				
	nts/Follow-u	p/Needs		Normal	Commen	Comments/Follow-up/Ne		ds
Skin			Endocrine					
Ears		Screening Result:	Gastrointestinal					
Eyes		Screening Result:	Genito-Urinary		LMP		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 Controller medication (e.g. inhaled of	Acting Beta		Other					
	NEEDS/MODIFICATIONS required in the school setting DIETARY Needs/Restrictions							
SPECIAL INSTRUCTIONS/DEVICES	e.g. safety gl	asses, glass eye, chest protector for	arrhythmia, pacemaker, prosthetic	device, de	ntal bridge,	false tee	eth, athletic s	upport/cup
MENTAL HEALTH/OTHER Is then If you would like to discuss this student's health		the school should know about this school health personnel, check tit		Counsel	or 🗆 Pri	ncipal		
EMERGENCY ACTION needed while a Yes No I If yes, please describe.	at school due to	child's health condition (e.g., seize	ures, asthma, insect sting, food, pea	anut allergy	y, bleeding p	problem,	diabetes, he	art problem)?
On the basis of the examination on this day, I approximately PHYSICAL EDUCATION Yes			(If No or Modi SCHOLASTIC SPORTS	fied please Yes □	attach expla		fied 🗆	
Print Name			gnature			1.1.04		Date
Address			,		Phone		1	ruit

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			ZIP Code
Name of School:	DI: ZIP Code		Grade Level:	Gender:
				🗆 Male 🛛 Female
Parent or Guard	ian: Last Name		First Name	
Student's Race/	•	_		
☐ White	Black/African Ameri	1		Asian
□ Native Americ □ Other		cific Islander □ Mult —	-racial	Unknown
To be completed	by dentist:			
Date of Most Rec	ent Examination: eaning Sealant		l services provided at this ent	examination date) tion of teeth due to caries
Oral Health State	us (check all that apply)			
☐Yes ☐No	Dental Sealants Present o	n Permanent Molars		
Yes No	Caries Experience / Resto extracted as a result of caries C			both that is missing because it was
☐Yes ☐No		a apply to pit and fissure cavi th was destroyed by caries. B	ated lesions as well as those	n to dark-brown coloration of the on smooth tooth surfaces. If retained eeth with temporary fillings, are
☐Yes ☐No	Urgent Treatment — absces swelling.	ss, nerve exposure, advanced	disease state, signs or symp	toms that include pain, infection, or
Treatment Needs completion date.	s (check all that apply). For	Head Start Agencies, pleas	also list appointment date	or date of most recent treatment
Restorative	e Care — amalgams, composites	s, crowns, etc. Ap	pointment Date:	
Preventive	Care — sealants, fluoride treatn	nent, prophylaxis Ap	pointment Date:	
Pediatric D	entist Referral Recommend	ed Tro	atment Completion Date:	
Additional com	nents:			
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



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)	(F	First)	(Middle Initial)
Birth Date		Gender	Grade	_	
	onth/Day/Year)				
Parent or Guardia	n				
		(Last)		(First)	
Phone					
(Area Code)					
Address				(2))	
A	(Number)	(Street)		(City)	(ZIP Code)
County					
		To Be Comp	oleted By Examinin	ig Doctor	
Case History Date of exam					
Ocular history:	Normal	or Positive for			
Medical history:	Normal	or Positive for			
Drug allergies:	L 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/

	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	y of the child	to complete the test	, not the inability of the do	ctor to provide the test.

Diagnosis

Normal	Myopia	Hyperopia	Astigmatism	Strabismus	Amblyopia
--------	--------	-----------	-------------	------------	-----------

State of Illinois Illinois Department of Public Health	State of Illinois Eye Examination Report
Recommendations	
 Corrective lenses: No Yes, glasses or contacts shout Constant wear Near visio May be removed for physical 	n 🗅 Far vision
 Preferential seating recommended: □ No □ Yes Comments 	
3. Recommend re-examination: □ 3 months □ 6 months □ 0 ther	□ 12 months
4	
5	
Print name Optometrist or physician (such as an ophthalmologist)	License Number
Address	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)
Phone	(Date)
Signature	Date

(Source: Amended at 32 III. Reg. _____, effective _____)



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.



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

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

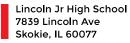
I will notify the school that my student will be absent pending further direction from the District if: (1) my student receives a diagnosis of COVID-19 or has a pending COVID-19 test (waiting for results); (2) my student is suspected of having COVID-19; (3) my student comes in close contact (definition 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 "<u>close contact</u>" 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





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