SKOKIE - MORTON GROVE SCHOOL DISTRICT 69

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

New Student Enrollment Form 2021-22

PLEASE PRINT USING BLACK INK

Student Last Name	Student First Name	Student Middle Name	Sex (M/F)	Birth Certificate No. Or Passport No.

Street Address	City	State	Zip Code	Telephone Number ( )

Date Of Birth	Place of Birth

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

Parent One Cell Phone Number	Parent One E-Mail Address

Parent One Business Phone	Name of Employer

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

Parent Two Cell Phone Number	Parent Two E-Mail Address

Parent Two Business Phone	Name of Employer

In what language would you like the school district to communicate you? (i.e. Parent emails, newsletters, school updates, etc.)

☐English ☐Other Language Language: _____

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

☐Other: _____

_____

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		
	☐Emergency Only ☐Drop Off & Pick Up Only ☐Both		

Madison Elementary School
5100 Madison St
Skokie, IL 60077

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

Lincoln Jr High School
7839 Lincoln Ave
Skokie, IL 60077

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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:

Name of Non-Custodial Parent:	Address of Non-Custodial Parent:	Phone Number of Non-Custodial parent: Home / Cell ( )

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:

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:

Would you like information about Homeless resources or services? ☐Yes ☐No

If you have children under the age of 3, would you like to receive information about Early Childhood Opportunities? ☐Yes ☐No

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 student has attended. **START WITH KINDERGARTEN.**	**City/State/Country**	**Grades**

I certify that this information is true and correct. Upon verification by the school district, if this information relating to residency is found to be not true, I understand that the student will be removed from the district student roll and charged tuition for the period of non-resident enrollment. I agree that I will be responsible for tuition charged to the student as a result of non-resident enrollment.

Relationship to Student	Signature	Date

Side B

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STUDENT FEE SCHEDULE

The Board of Education has set the following school fees for the 2021-22 school year. Families do not need to pay school fees at the time of registration. Families may register students earlier and defer fee payment as long as all outstanding fees

	2021-22
Registration Fees	
Grades K-8	$90.00
Technology Fee	$65.00
Textbook Fee	$15.00
Field Trip Fee	$15.00
Recorders (Grade 3)	$4.00
Graduation (Grade 8)	$30.00
Student Device Fee	$0.00
After School Activites	
Annual Activity Fee	$52.00
Semester Activity Fee	$26.00
Quarterly Activity Fee	$13.00
Varsity/JV Sports	$90.00
6th Grade Sports	$50.00
Cross Country/Track & Field	$20.00
Transportation	
Bus Fees - Full	$180.00
Additional Child - Full	$90.00
Bus Fees - Waiver	$90.00
Additional Child - Waiver	$45.00
After-school Busing	$15.00

- **Refund of registration, book, and transportation fees for student withdrawals:**
  - **100% before 1st class day**
  - **50% before January 1st**
  - **No refund after January 1st**
- **Prorated registration, book, and transportation fees for new enrollees:**
  - **50% after January 1st**
- **Refund of activity/athletics fees:**
  - **100% before 1st practice or session**
  - **No refund after 1st practice or session**

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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 have ALL documents to complete your child's registration.

Homeowner

- ❑ Most recent mortgage statement or real estate tax bill
- ❑ Three (3) bills not dated older than 30 days (e.g., gas electric, phone, cable)

Renter

- ❑ Current signed lease
- ❑ Three (3) bills not dated older than 30 days (e.g., gas electric, phone, cable)

Living with Family (Homeowner)

- ❑ Most recent mortgage statement or real estate tax bill
- ❑ Three (3) bills not dated older than 30 days belonging to the District resident (e.g., gas electric, phone, cable)
- ❑ Three (3) bills in the parent's name not dated older than 30 days (e.g., phone, medical, credit card, bank statement)
- ❑ Affidavit Documents **A & B** (notarized and completed in their entirety by parent and District resident)

Living with Family (Renter)

- ❑ District resident's **current** lease
- ❑ Three (3) bills not dated older than 30 days belonging to the District resident (e.g., gas electric, phone, cable)
- ❑ Three (3) bills in the parent's name not dated older than 30 days (e.g., phone, medical, credit card, bank statement)
- ❑ Affidavit Documents **A, B, & C** (notarized and completed in their entirety by parent, District resident, and Landlord)

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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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.

Please answer the questions below and return this survey to your child's school.

Student's Name: _____

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

   Yes_____ What language? _____

   No_____

2. Does your child speak a language other than English?

   Yes_____ What language? _____

   No_____

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

I,_____ waive the right to receive my child's report card in their native language.

_____ _____

Parent/Legal Guardian Signature Date

Effective 1/2021

Illinois State Board of Education

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

DATA COLLECTION FORM

Student's Name: School:

INSTRUCTIONS: This form is to be completed by the parent or guardian 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 missing information by observer identification.

This race and ethnicity data will be used in the same manner as previously collected data, e.g., in reporting and analyzing test results by race and ethnicity. The information *will not* be used to check immigration status, and the confidentiality of the individual student information will be protected.

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). **(MUST COMPLETE)**

☐ **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. (MUST COMPLETE)

☐ **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 will 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 response must be retained until the completion of the action.

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PERMISSION FOR RELEASE OF INFORMATION

The undersigned authorizes

_____

Former School/Physician/Agency

_____

Address

To release all permanent and temporary records, including special education files of *

_____

Full name of Student

_____

Date of Birth

Please send records to:

☐ Madison School, 5100 Madison Street, Skokie, IL 60077
(847) 675-3048 (phone) (847) 675-1691 (fax)
madisoninfo@skokie69.net

☐ Edison School, 8200 Gross Point Road, Morton Grove, IL 60053
(847) 966-6210 (phone) (847) 966-6236 (fax)
edisoninfo@skokie69.net

☐ Lincoln Jr. High School, 7839 Lincoln Ave, Skokie, IL 60077
(847) 676-3545 (phone) (847) 676-3595 (fax)
lincolninfo@skokie69.net

_____ _____

Parent/Legal Guardian Signature Date

*A regulation of the Illinois State Board of Education provides parents with the opportunity to inspect, challenge and copy information contained in the pupil's records at the time they are transferred to another school.

OFFICE USE ONLY:

Records request sent on: _____

Reports received from: _____

Date received: _____

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Dear Parents/Guardians:

Our School District has the ability to enhance your child's education through the use of electronic networks, including the Internet. Our goal in providing this service is to promote educational excellence by facilitating resource sharing, innovation, and communication.

The District filters access to materials that may be defamatory, inaccurate, offensive, or otherwise inappropriate in the school setting. If a filter has been disabled or malfunctions it is impossible to control all material and a user may discover inappropriate material. Ultimately, parents/guardians are responsible for setting and conveying the standards that their child or ward should follow, and the School District respects each family's right to decide whether or not to authorize Internet access.

With this educational opportunity also comes responsibility. The use of inappropriate material or language, or violation of copyright laws, may result in the loss of the privilege to use this resource. Remember that you are legally responsible for your child's actions. If you agree to allow your child to have an Internet account, sign the Authorization form on the back and return it to your school office. Students in Grades 3-8 must also sign the form.
If you have any questions about Internet access, please feel free to contact me at millerc@skokie69.net.

Sincerely,

Chris Miller
Director of Technology

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Authorization for Electronic Network Access Form

Students must have a parent/guardian read and agree to the following before being granted unsupervised access:

All use of the Internet shall be consistent with the District's goal of promoting educational excellence by facilitating resource sharing, innovation, and communication. **The failure of any user to follow the terms of the *Acceptable Use of Electronic Networks* will result in the loss of privileges, disciplinary action, and/or appropriate legal action.** The signatures at the end of this document are legally binding and indicate the parties who signed have read the terms and conditions carefully and understand their significance.

I have read this *Authorization* form. I understand that access is designed for educational purposes and that the District has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the District to restrict access to all controversial and inappropriate materials. I will hold harmless the District, its employees, agents, or Board members, for any harm caused by materials or software obtained via the network. I accept full responsibility for supervision if and when my child's use is not in a school setting. I have discussed the *Acceptable Use of Electronic Networks* with my child. I hereby request that my child be allowed access to the District's electronic network, including the Internet.

_____

Parent/Guardian Name (*please print*)

_____ _____

Parent/Guardian Signature Date

GRADES 3-8 STUDENTS MUST ALSO SIGN

Students must also read and agree to the following before being granted unsupervised access:

I understand and will abide by the above *Authorization for Electronic Network Access*. I understand that the District and/or its agents may access and monitor my use of the Internet, including my email and downloaded material, without prior notice to me. I further understand that should I commit any violation, my access privileges may be revoked, and school disciplinary action and/or legal action may be taken. In consideration for using the District's electronic network connection and having access to public networks, I hereby release the School District and its Board members, employees, and agents from any claims and damages arising from my use of, or inability to use the District's electronic network, including the Internet.

_____

Student Name (*please print*)

_____ _____

Student Signature Date Date

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Use of Student Photo, Video, and Information

Student photos, videos, or work samples are used by District 69 in publications, on its website, for presentations, or with school social media. In addition, print/broadcast/online media and approved D69 partners may visit District schools to photograph or video students involved in activities. In both cases, first names of students may be used to identify their work.

No names will be posted with photographs, except in yearbooks and/or school/class composites, without parent/guardian notification.

By signing this form, I hereby give permission and consent for District 69 and its approved partners to use my child's photograph and projects as described above. This agreement will be valid for the duration of your child's enrollment in District 69 unless you revoke it by submitting a Do Not Use Student Photo or Information Form. Please contact your building principal to obtain this form.

Please note that it may not be possible for District 69 to identify all students in the background of photographs or videos so completion of this form may not prevent a student from appearing in a non-identifiable way.

_____

Student Name (*please print*)

_____

Parent/Guardian Name (*please print*)

_____ _____

Parent/Guardian Signature Date

Revised 2/2021

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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, 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 or students that are new to Illinois schools. 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, 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, 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 about these forms, please contact your school nurse:

<u>During the School Year</u>

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

<u>During the Summer</u>

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 _____ License Number _____

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

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

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