LIBERTYVILLE SCHOOL DISTRICT 70

Adler Park School • Butterfield School • Copeland Manor School
Rockland School • Highland Middle School

IMPORTANT HEALTH INFORMATION for Grades K – 6

The Illinois State School Code Health Law, Section 665, requires that a child have a complete "Certificate of Child Health Examination," including mandated immunizations, upon entrance into **kindergarten**, **sixth**, and ninth grades.

The physical examination can be administered within the 12 months previous to the child's entrance into school. The physical examination form **requires 3** signatures to be considered "in compliance".

1. Immunization section signed by health care provider
2. Health history signed by parent or legal guardian
3. Physical examination signed by MD, APN, or PA.

An eye examination is required for all children entering kindergarten, and all transfer students from out of state or country. A licensed physician who does eye examinations or a licensed optometrist must complete the exam. It can be completed within one year from the start of the school year.

A dental examination is required for children entering **kindergarten, second**, and **sixth** grade.

It is recommended that parents make arrangements with their physicians as soon as possible to ensure their child/children will have the required physical examination(s) and immunizations before registration in August. Failure to comply with the above statutory requirements will result in your child's exclusion from school.

IMPORTANT SPORTS PHYSICAL INFORMATION for Grades 6 – 8

A yearly Sports Physical is required if your child plans to participate in any interscholastic sports! **Sports physicals are good for only one year from the date given**.
(Per school code section 1.530 part b., athletic code 3.060.)

SPORTS: Basketball, Cheerleading, Cross Country, Soccer,
Poms, Track and Field, Volleyball, Wrestling

NO ONE IS ALLOWED TO TRY OUT WITHOUT A CURRENT PHYSICAL ON FILE IN THE NURSE'S OFFICE.

A PARENT MAY NOT SIGN A WAIVER RELEASING THE SCHOOL OF LIABILITY IN LIEU OF A PHYSICAL.

OVER →

NOTE FROM HEALTH SERVICE

The following are the immunization requirements for the State of Illinois:

POLIO - Children immunized according to an all IPV or all OPV schedule must show evidence of having received at least three (3) doses, with intervals of no less than four (4) weeks apart, and the last dose having been received on/after the fourth (4th) birthday. Children who received any combination of IPV and OPV must show evidence of having received at least four (4) doses, with intervals of no less than four (4) weeks apart, and the last dose having been given on/after the fourth (4th) birthday.

DTD/DtaP/Td - Four (4) or more doses, with the last dose administered on/after the fourth (4th) birthday, at intervals of no less than four (4) weeks apart, last dose at least six (6) months since previous dose. For children entering school other than Pre-Kindergarten, Kindergarten, and First (1st) grade, three (3) doses of DTP/DtaP/Td, with the last dose administered on/after the fourth (4th) birthday, at intervals of no less than four (4) weeks apart, last dose at least six (6) months since previous dose.

MEASLES - Two (2) doses, first (1st) administered on/after the first (1st) birthday, second (2nd) dose no less than four (4) weeks after first (1st) dose.

RUBELLA - Two (2) doses, administered on/after the first (1st) birthday.

MUMPS - Two (2) doses, administered on/after the first (1st) birthday.

HEPATITIS B - *Not required for Kindergarten through fourth (4th).* Three (3) doses, interval of at least four (4) weeks between first (1st) and second (2nd) dose, interval between the first (1st) and third (3rd) dose must be at least four (4) months.

Tdap - One (1) dose for all students entering sixth grade or one (1) dose for all students entering seventh through twelfth grades who have not already had one (1) dose.

VARICELLA - Two (2) doses (Chickenpox) Entering Kindergarten: administered on/after the first (1st) birthday.

The dates of all immunizations must be noted on the Certificate of Child Health Examination Form (include month, day and year).

Health Clinics are available as follows:

Lake County Health Department
2400 Belvidere Road Waukegan, IL
Call 847-360-6500

Health Reach Medical Clinic
109 N. Seymour Avenue Mundelein, IL
By appointment only 847-360-8800

Rosalind Franklin University Clinic- Thursdays/Free
3471 N. Green Bay Road North Chicago, IL
847-578-8500

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

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. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	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						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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 is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying 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** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																			**Code:** **P = Pass** **F = Fail** **U = Unable to test** **R = Referred** **G/C = Glasses/Contacts**
Age/ Grade																			
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																			
Hearing																			

Student's Name (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)			**MEDICATION** (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the 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 **HEIGHT** **WEIGHT** **BMI** **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 QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionairre Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

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. **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			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**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 Antagonist) ☐ 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** (for one year) **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name: Last First Middle		Birth Date: (Month/Day/Year) / /
Address: Street City ZIP Code		Telephone:
Name of School:	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian:	Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ 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 **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note ______________________________

Signature of Dentist ______________________ Date of Exam ______________

Address ______________________ Telephone ______________
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

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
6/09

IOCI1271-09