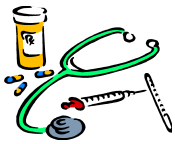
## Important Health Information For Grades Pre-K to 8



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 **pre-k**, **kindergarten and sixth grades.**

The physical examination can be administered within the 12 months previous to the child's entrance into school. The physical examination form is two-sided (both sides must be completed) and 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.

Immunization requirements for students entering Grade K-8 are listed on the following page.
Immunization requirements for Pre-K (Early Childhood) students are also listed separately on the following page.

## 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 for sports without a <u>current</u> physical on file in the nurse's office.
- A parent may not sign a waiver releasing the school from liability in lieu of a physical.

# Following are the immunization requirements for the State of Illinois

## Immunization Information for Students Entering Kindergarten - 8th Grade for the 19-20 school year

- **POLIO** - *Kindergarte*n: Four (4) or more doses of the same type of Polio vaccine with the last dose being the booster and received on or after the 4th birthday. *Other grades*: Three or more doses with the last dose qualifying as a booster and received on or after the 4th birthday. If the series is given in any combination of polio types, 4 or more doses are required with the last being a booster on or after the 4th birthday. Minimal interval between doses is 4 weeks (28 days).
- **DTD/DtaP/Td** - *Kindergarten*: Four (4) or more doses with the last qualifying as a booster and received on or after the 4th birthday. Other grades: Three (3) or more with the last dose qualifying as a booster given on or after the 4th birthday. Minimal interval between doses is 4 weeks (28 days).
- **MEASLES/MUMPS/ RUBELLA** - 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.
- **HEPATITIS B** - *Not required for Kindergarten through fifth (5h).* For students entering 6th grade: Three (3) doses, interval of at least four (4) weeks (28 days) between first (1st) and second (2nd) dose, interval between the second and third shot (56 days), first (1st) and third (3rd) dose must be four (4) months (112 days).
- **Tdap** - One (1) dose for all students entering 6th thru 12th grade.
- **MENINGOCOCCAL** - First dose administered on or after 11th birthday.
- **VARICELLA** - *Kindergarten & 1st Grade*: Two (2) doses administered on/after the first (1st) birthday. *Grade 5:* One dose received on or after 1st birthday. *All other Grades:* Two doses. The first dose must have been received on or after 1st birthday. The 2nd dose no less than 4 weeks (28 days) from 1st dose.

## Immunization requirements for Early Childhood (Pre-K)

- **NEW: PNEUMOCOCCAL CONJUGATE VACCINE** (PCV13)- Four (4) doses- The first 3 doses 2 months apart, 4th dose at age 1 to 1 ½ years old.
- **POLIO** - Three (3) or more doses, at intervals of no less than four (4) weeks apart.
- **DTD/DtaP/Td** - Three (3) or more doses, at intervals of no less than four (4) weeks apart, last dose at least six (6) months since previous dose.
- **MEASLES/MUMPS/RUBELLA** - One (1) dose, administered on/after the first (1st) birthday.
- **HEPATITIS B** - Three (3) doses. Interval between dose 1 and 2 has to be at least four 4 weeks (28 days). Last dose to be administered on or after 6 months of age (168 days)
- **Hib** - Follow the appropriate schedule. Children twenty-four (24) to fifth-nine (59) months of age who have not received a primary series according to the Hib schedule, must show proof of receiving one (1) dose at fifteen (15) months of age or older.
- **VARICELLA** - (Chicken Pox) One (1) dose, 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:

Erie Health Center
2323 Grand Avenue
Waukegan, IL
847-666-3494

Lake County Health Department
2400 Belvidere Road
Waukegan, IL
Appointments 847-377-8400

Healthy Families Clinic
3471 N Green Bay Rd
North Chicago, IL
Thursday 4pm-7pm no appointment needed
(847) 578-3000

# 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:** | | |
| **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?<br>Child wakes during night coughing? | Yes No<br>Yes No | | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes No | | |
| Birth defects? | Yes No | | | Hospitalizations?<br>When? What for? | Yes No | | |
| Developmental delay? | Yes No | | | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes No | | | Surgery? (List all.)<br>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 _____<br>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.<br>**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** **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:<br>☐ Quick-relief medication (e.g. Short Acting Beta Agonist)<br>☐ 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

**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 _____ 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
6/09

IOCI1271-09