Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



To be completed by the parent (please print):

			1	
Student's Nan	ne: Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City	ZIP Code	Telephone:
Name of Scho	pol:		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Gua	ırdian:		Address (of parent/guard	lian):
To be comple	eted by dentist:			
Oral Health S	status (check all that app	oly)		
☐ Yes ☐ No	Dental Sealants Prese	ent		
□ Yes □ No	Caries Experience / R extracted as a result of caries	estoration History — s OR missing permanent 1 st	A filling (temporary/permanent) OR a molars.	tooth that is missing because it was
□ Yes □ No	walls of the lesion. These cri	teria apply to pit and fissure ooth was destroyed by carie	ture loss at the enamel surface. Brown cavitated lesions as well as those on es. Broken or chipped teeth, plus teeth	smooth tooth surfaces, if retained
□ Yes □ No	Soft Tissue Pathology	,		
□ Yes □ No	Malocclusion			
Treatment Ne	eds (check all that apply	y)		
☐ Urgent Tr	eatment — abscess, nerve e	xposure, advanced disease	state, signs or symptoms that include	pain, infection, or swelling
☐ Restorativ	∕e Care — amalgams, compo	osites, crowns, etc.		
☐ Preventive	e Care — sealants, fluoride tr	eatment, prophylaxis		
☐ Other — p	eriodontal, orthodontic			
Please not	te			
Signature of D	entist		Date	
1ddraee			T-1 5.	
TUUI 600	Street (Dity	Telephone _ 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

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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.

375 : 3 St.			(Last)			(First)	(Middle Initial)
Birth Date	mark (Line A	ear:		Gender	Grade		
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Parem or Guardian			· (Las			(First)	**** _ \
Phone						(PHSt)	
(Area Code)							
Address			,	····			
Carme	(Numb	er,		(Street)		(City)	(ZIP Code)
County				~- · · · · · · · · · · · · · · · · · · ·			
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Case History							
Date of exam							
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Medical history:	□ Nor	mal or	Positive	for		, with the second data to the se	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
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Other information			_			THE PARTY OF THE P	
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Uncorrected visual a Best corrected visual			<u> </u>				
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Best corrected visual	acuity	20/	20/	20/	20:		
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Best corrected visual Vas refraction perfo	acuity ormed wit	20/ 20/ th dilation	20/ 20/ 20/ 17	20/ 20/ /es I No Normal	20:	Not Able to Assess	Comments
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State of Illinois Eye Examination Report

Recommendations 1. Corrective lenses: Two 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 3. Recommend re-examination: \square 3 months \square 6 months \square 12 months U Other Print name___ License Number____ Optometrist or physician (such as an ophthalmologist) who provided the eye examination D MD DOD DO Consent of Parent or Guardian I agree to release the above information on my child or ward to appropriate school or health authorities. Address _____ (Parem or Guardian's Signature) Signature ____ Date ____

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

COMMUNITY UNIT SCHOOL DISTRICT 201 SCHOOL MEDICATION AUTHORIZATION FORM

STUDENT'S NAME:	BIRTH DATE:
ADDRESS:	TELEPHONE:
	GRADE:
I hereby grant permission for the above below for the above named child.	ove named school to issue the medication routine described
Parent/Guardian Signature	Date
TO BE COMPLETED BY THE PH	YSICIAN:
Name of Medication	
	Time
Date of Order	Discontinuation Date
Is this medication necessary in order (Diagnosis & intended effect)	
Side effects to be alerted to:	
	ol in 4 weeks 8 weeks
Doctor's Signature	Date
Emergency Number	
FURTHER INSTRUCTIONAL REA	AARKS

Administering Medicines to Students

Students should not take medication during school hours or during school-related activities unless it is necessary for a student's health and well-being. When a student's licensed health care provider and parent/guardian believe that it is necessary for the student to take medication during school hours or school-related activities, the parent/guardian must request that the school dispense the medication to the child and otherwise follow the District's procedures on dispensing medication.

No School District employee shall administer to any student, or supervise a student's self-administration of, any prescription or non-prescription medication until a complete and signed "School Medication Authorization Form" is submitted by the student's parent/guardian. No student shall possess or consume any prescription or non-prescription medication on school grounds or at a school-related function other than as provided for in this policy and its implementing procedures.

A student may possess an epinephrine auto-injector (EpiPen®) and/or medication prescribed for asthma for immediate use at the student's discretion, provided the student's parent/guardian has completed and signed a "School Medication Authorization Form." The School District shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector or the storage of any medication by school personnel. A student's parent/guardian must indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of a student's self-administration of an epinephrine auth-injector and/or medication, or the storage of any medication by school personnel.

Nothing in this policy shall prohibit any school employee from providing emergency assistance to students, including administering medication.

Procedures for dispensing medication:

- 1. All <u>prescription medications</u> brought to the school must be in a container labeled by the pharmacy or the physician. This will include the name of the student, the name of the physician, the name of the medication, the dosage, and time to be given.
- Medication brought to the school in a container labeled by the pharmacy or the physician
 may be administered by the school personnel, under the supervision of the school nurse
 unless otherwise directed.
- 3. Over the counter medications including Tylenol, cough medications, aspirin, etc. may be given at school with a completed "School Medication Authorization Form." Over the counter medication must be delivered to school in a new, unopened original container, except certain self-carry medications, and clearly labeled with the student's name.
- 4. All medications must be delivered to the school office/nurse.
- 5. The "School Medication Authorization Form" must be renewed each year. An individual form must be completed for each medication.
- 6. The School District retains the discretion to reject requests for administration of medication.
- 7. Parents are always allowed to dispense necessary medications to their child during school hours.



State of Illinois Certificate of Child Health Examination

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

Student's	Name									Birt	h Date			Sex	Rac	e/Ethn	icity		Scho	ol/Gra	de Leve	I/ID#
Last		····	First				М	iddle		Mon	th/Day/	Year										
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Student's Name Last		First		Middle .	rth Date Sex School					Grade Level/ ID #			
HEALTH HISTORY	Ţ	O BE CO	MPLET	ED AND SIGNED BY PARENT		FIED BY	HEAI	LTH CA	RE PR	OVIDER			
ALLERGIES (Food, àrug					MEDICATION (List all	Marking and Salar and Tall	DVS TO RIMANUA	Programme and the second secon					
Diagnosis of asthma? Child wakes during the	night	Yes Yes	No No		Loss of function of one organs? (eye/car/kidney			Yes	No				
Birth defects?		Yes	No		Hospitalizations?	···········		Yes	No .				
Developmental delay?		Yes	No		When? What for?								
Blood disorders? Hemo Sickle Cell, Other? Exp		Yes	No		Surgery? (List all.) When? What for?			Yes	No				
Diabetes?		Yes	No		Serious injury or illness			Yes	Na				
Head injury/Concussion			No		TB skin test positive (pa)?	Yes*		If yes, refer to local health department.			
Seizures? What are the	_	Yes	No		TB disease (past or pres	·····		Yes*	No	ucparunent.			
Heart problem/Shortnes			No		Tobacco use (type, frequency)? Yes No								
Heart murmur/High blo	······	e? Yes	No		Alcohol/Drug use?		······	Yes Yes	No No				
Dizziness or chest pain exercise? Eye/Vision problems?	se? before age 50? (Cause?)									••••			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)													
Ear/Hearing problems? Yes No Information may be shared with appropriate personnel for health and educational purposes. Rome/Joint problem/injury/scollogie? Was No Parent/Guardian													
Bone/foint problem/mjury/scollosis? Yes No Signature Date													
PHYSICAL EXAM	INATIO	N REQU	IREM	ENTS Entire section bel	ow to be completed by	MD/DO	D/AP	N/PA					
HEAD CIRCUMFEREN	CE			HEIGHT	WEIGHT		I	BMI		B/P			
DIABETES SCREENI Ethnic Minority Yes□	ING (NOT I	REQUIRED gns of Ins	FOR DAY ulin Re	CARE) BMI>85% age/sex sistance (hypertension, dyslipidemi	Yes□ No□ And any a, polycystic ovarian syndron	y two of ti	ne foll	owing: icans) Y	Famil s□ N	v History Vas 🗔 No 🗀			
	ONAIRR	E Required	for chile	iren age 6 months through 6 years en Blood Test Indicated? Yes I	rolled in licensed or public sci	hooi operat		care, pre	school.	nursery school and/or kindergarten.			
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 T Test performed T													
Skin Test: Date Read / / Result: Positive Negative mm Blood Test: Date Reported / / Result: Positive Negative Value													
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Mouth/Dental			··· ·· ·· ··		Spinal Exam				·····				
Cardiovascular/HTN					Nutritional status			······································					
Respiratory				☐ Diagnosis of Asthma	Mental Health								
Currently Prescrib □ Quick-rel □ Controller	ief medic	ation (e.g.S	Short Ac	ting Beta Antagonist)	Other		••••						
NEEDS/MODIFICATI	ONS requ	ired in the sa	chool set	ing	DIETARY Needs/Res	trictions							
SPECIAL INSTRUCT	IONS/DE	VICES e	o safery	glasses, glass eye, chest protector for	arrhahmia nagamakar nyag	thatia dania			61				
						mene devic	c, dent	ai bridge,	laise te	eth, athletic support/cup			
MENTAL HEALTH/O	THER	Is there any	thing els	se the school should know about this	student?								
				or school health personnel, check tit to child's health condition (e.g., seiz		er 🔲 Cou d, peanut al			incipal Problem	. díabetes, heart problem)"			
Yes□ No□ If yes, i					.,	, ,	67 - 1		0:4111	, and soon, now r propositif;			
On the basis of the examinat	ion on this	ює. day, Гаррго	ve this cl	nild's participation in	(If No or)	Modified,pl	ease at	tach exp	anation.)			
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Print Name		·	-	(MD.DO. APN, PA) Si	sature					Date			
ddress Phone													



State of Illinois Certificate of Child Health Examination

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

Student's Name			Nasay na ana an	/////////////////////////////////////				Birth D	ate		Sex	Race	/Ethnici	LŽ.	Sch	ool/Gra	de Lev	el/ID≓
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MMR Combined Measles Mumps, Rubella	· · · · · · · · · · · · · · · · · · ·																	
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Other/Specify Meningococcal. Hepatitis A, HPV.														Pakin annya		***************************************		STARLEGIZ UNDIGEN
Influenza Health care provider (M to the above immunization	D, DO, A history	APN, P section	A, scho A, scho put you	ol nealt i ır initial	n proi	essional.	health o sign her	fficial) e. ;	veriívir	g above	immun	ization	history i	nust s	ign beio	w. If a	dang d	Hes
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ALTERNATIVE PRO	OOF OF ceptable	IMN if veri	IUNIT ified by	V physich	an.	*(Ali	measies	ases dia	gnosed o	n or after J	uly 1. 2()02. must	be confir	nied by	laborator	y evidenc	×C.)	
*MEASLES (Rubeola) 1 2. History of varicella (ch Person signing below is verify	ickenpo	x) dise	ase is ac	S MO ceptabi is descri	e if ve	rified by	NCELL health o	are neg	mider (ari loorlo	a l + l + m -	n°s Sign ofession nd is acce	2 1	alth of	ficial. v as docu	pentation	of diseas	
Date of Disease			Signatur						Title	•			, , , , , , , , , , , , , , , , , , , ,		Date	are was used to \$4,000 ft	or misea:	The state of the s
3. Laboratory confirmati Lab Kesults	on (chec	k one)		isles late		Mumps	ŀ	ubelia	ì	Hepati	tis B	· V	iricelia					

Date							:							***************************************	i	•			:
Age/ Grade																			Code:
	R	<u>J.</u> .	1:	L	; P.	1,	R	Į.	R	L.	R	Ĺ.	I R	L.	l R	L.	R	<u> </u>	F = Fail
Vision				j I								:						:	U = Unabl R = Reierr
Hearing		į				:				:	 	- 					: :	<u> </u>	G/C = Glasses/Co

Date

DA YR

(Attach copy of lab result)

				one somethic		Fech	a de Nacimiento	Sex ₀	Escue	12	 	Grado/Núm. de Ident.
Apellion	Non		1 10 / Y	AND DESCRIPTION OF	niciai	l DEC (EX	Mes / Dia / Año					
HISTORIAL MEDICO -			CIADO) Y FIL	MADO POR PAL	HANDARA SANTANIA NA PARANTANIA		energy of the second second	CONTRACTOR OF THE PARTY OF THE	en in the second	and the same of	UIDADO DE SALUD
ALERGIAS (Alimenios, drog	us, insectos, o	a.d.i					MEDICINAS (Anote toda	is las tecejadas	o tomadas	con regula	ndad.:	
¿Tiene diagnostico de asma ¿Despierta el niño tosiendo		he?	Si Si	No No			Tiene pérdida de Funcion organos? (Ojos/Oldos/Riñ			5	No	
¿Tiene defectos de nacimi			Si	Νo			¿Ha sido hospitalizado? ¿Cuando? ¿Por Qué?			Si	Мo	
Tiene retrasos del desarro			Si	No								
, Tiene problemas de la sar Globulos Falciformes (Sic	4.0		Si	No		- 1	¿Ha atendido cirugia? (an ¿Cuándo? - ¿Para Oué^	***		Si Si	Νo	
Tiene diabetes?			Si	No			¿Ha tendido heridas gravo	Мο				
Tiene heridas en la cabez	 		S:	No			¿Prueoa positiva de TB (f	JN0	*Si contesio si, refiera al departamento de salud			
¿Tiene convulsiones? ¿Con			Si	No		<u> </u>	¿Enfermedad de TB (Pasa		Si.	No.	ioca:	
Tiene probiemas cardiacos /)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Si Si	No.			¿Usa tabaco (tipo, Frecue	neia)".		Si	No	
¿Tiene sopio en corazón /			Si	No No		}	¿Toma alcohol / drogas?	A		IS:	No.	
¿Tiene mareos o dolor de ejercicios?	pecno ai n	acer	31	INO			¿Historial de familiares di antes de los 50 años ? (¿		enuna	Si	ÌVO	
¿Problemas con los Ojos? ¿Otras Preocupaciones? The					Ultimo Examen ad cuando lee)		Dental Gancho	s Pue	nte	Placa	s Otro	
¿Tiene problemas de oidos	Mo oye	bien?	Sí	No			La información en este foru salud y educación.	пијало ѕе ри	de compa	itir con e	el persor	iai apropiado para propositos de
¿Tiene problemas de los hueso escoliosico	os / articulac	iones / heridas	S)	No			Firma del Padre/Tut	or			ř e	echa
PHYSICAL EXAMIN HEAD CIRCUMFERENCE			EME	NTS	Entire section HEIGHT	below to	be completed by N WEIGHT	1D/DO/A	PN/PA		WWW.DALLERS	В/Р
DIABETES SCREENING Ethnic Minority Yes N				RE: E	MI>85% age/sex	Yes	No And any rw	o of the fo	liowing	Fami	iiy His	story Yes No
LEAD RISK QUESTION nand/or kindergarten.												i i
Ouestionnaire Administer	red? Yes.	No	Bio	od Test	Indicated? Yes	No .	Blood Test Date		(Blood	test ten	nuired i	if resides in Chicago.)
TB SKIN OR BLOOD TE in high prevalence countries or Skin Test: Date Rea Blood Test: Date Rea	those expos	mmended only led to adults in / /	n high-i R	risk cate _l t esult:	gories. See CDC gui Positive Ne	inding chil delines gative gative	No test needed	ue to HIV in Test pe			mdition	is. frequent fravel to or bon;
LAB TESTS (Recommended	POSICIONO SUNTO TOTAL	Date			Results	ACCUPATION OF THE PARTY OF				Date		Results
Hemoglobin or Hematocri						· · · · · · · · · · · · · · · · · · ·	 Sickle Cell (when inc	dicated)			***************************************) KOGUTES
Unnalysis							Developmental Scree	ning Too!	_		***************************************	
SYSTEM REVIEW	Norma!	Comments	Folio	w-up/N	eeds			Normal (ommer	ıts/Foli	ow-up	/Needs
Skin							Endocrine	[
Ears			~~~~				Gastrointestinal				·····	Į. I
Eyes					Amblyopia Yes.	No	Genito-Urinary				1	-M ^p
Nose							Neurological					
Throat							Musculoskeletal					
Mouth/Dental							Spinal Exam					ř
Cardiovascular/HTN							Nutritional status				· 	
Respiratory					Diagnosis of A	sthma	Mental Health					
Currently Prescribed Quick-relie Controller i	f medican	on (e.g. Sho					Other					T A STATE OF THE S
NEEDS/MODIFICATIO					2 4 4 1		DIETARY Needs/Re	strictions				**************************************
SPECIAL INSTRUCTION	NS/DEV	CES e.g. sa	fery gia	isses, gia	ss eye, chest protecto	or for arrhy	thmia, pacemaker, prostne	iic device, d	ental brid	ge, faise	ieeth. 2	ithletic support/cup
MENTAL HEALTH/OT If you would like to discuss the	HER is	there anythu health with sc	ig eise hool o	the school	ol should know abou health personnel, che	t this stude ck title:	n!? Nurse Teacher	Coun	seio: .	Princ	ipa!	
EMERGENCY ACTION Yes No If yes, pie	ease describ	÷.				.seizures.	astinma, insect sting, food,	peanut aller	y, bieedi	ing probi	en, dia	oetes, heart problem?"
On the basis of the examination PHYSICAL EDUCATIO				i s partic odifie c		INTER	(If No or Mo SCHOLASTIC SPOR	-		xpianati Yes		No Limited
Print Name					MD.DO. APN. PA1	Signatu	:F¢					Date
Address						1)	Phone					