SD #125 – HEALTH REQUIREMENTS FOR ILLINOIS STUDENTS

School district 125 has instituted a FIRST DAY EXCLUSION POLICY requiring all students to be in compliance with the following:

1. a. Physical examination (required for ALL students entering Early Childhood, Pre-K, Kindergarten, 5th grade and students that are new to an Illinois school.) All physicals must be recorded on a State of Illinois form.

b. Lead assessment by physician (required for students age 6 years or younger.)

c. Health history (back of form), should be completed and signed by parent/guardian.

d. Diabetic risk assessment by physican.

2. Dental exam (required for students in K, 2nd and 6th grades.)

3. Eye examination (required for any student entering a State of Illinois school for the first time, K-8th grade.

4. Proof of required immunizations described below.

✓ **Diphtheria, Tetanus, Pertussis (DTP/DTaP)**
All students
- received three or more doses of DTP/DTaP at the recommended intervals with the last dose having been received on or after the fourth birthday.
- *6th, 7th & 8th grade students are required to provide documentation of having received one dose of Tdap.

Pre-Kindergarten
- received four doses of DTP/DTaP at the recommended intervals.

✓ **Polio (IPV/OPV)**
All students
- received four or more doses of any combination of IPV and OPV at the recommended intervals *or*
- received three or more doses of all-IPV or all-OPV at the recommended intervals.
- * last dose having been received on or after the fourth birthday.

Pre-Kindergarten
- received three doses of IPV at the recommended intervals.

✓ **Haemophilus influenzae type b (Hib)**
- received the series of Hib vaccine, if students are less than five years of age.

✓ **Hepatitis B (HB) for Pre K, 6th, 7th & 8th grade students**
- received three doses of Hepatitis B vaccine at the recommended intervals.

✓ **Varicella (Chicken Pox) for all students**
- received two doses of varicella vaccine on or after the first birthday.

✓ **Measles (Rubeola) for all students**
- received two doses of measles vaccine with the first dose on or after the first birthday.

✓ **German Measles (Rubella, 3 Day) for all students**
- received two doses of rubella vaccine on or after the first birthday.

✓ **Mumps for all students**
- received two doses of mumps vaccine on or after the first birthday.

✓ **Pneumococcal Conjugate (PCV)**
- received the series of PCV vaccine, if students are less than five years of age.

✓ **Meningococcal Conjugate (MCV4)**
- received one dose on or after 11 years of age

HEALTH CARE PROVIDERS

EYE

Meyer Eyecare
13114 S Western
Blue Island, IL
708-388-1228

Complete Vision Care
6209 W. 95th St
Oak Lawn, IL
708-423-2500

Eye Specialist
10436 S.W. Highway
Chicago Ridge,IL
708-423-4070

Mt. Greenwood Eyecare Ctr.
3135 W 111th St
Chicago, IL
773-233-4448

DENTAL

Dental Experts
12200 S Western
Blue Island, IL
708-385-3700

Drs. Zlotkowski & Papanicolas
3218 W 115th
Chicago, IL
773-233-6800

Alsip Dental Center
11808 S. Pulaski
Alsip, IL
708-489-6222

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.

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.

HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)	Sí / No	Anótelas todas:	MEDICINAS (Anote todas las recetadas o tomadas con regularidad)	Sí / No	
¿Tiene diagnóstico de asthma? ¿Despierta el niño tosiendo en la noche?	Sí No		¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí No	
¿Tiene defectos de nacimiento?	Sí No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	Sí No	
¿Tiene retrasos del desarrollo?	Sí No				
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	Sí No	
¿Tiene diabetes?	Sí No		¿Ha tenido heridas graves o enfermedades?	Sí No	
¿Tiene heridas en la cabeza/golpe/desmayo?	Sí No		¿Prueba positiva de TB (Pasado o Presente)?	Sí No	*Si contestó sí, refiera al departamento de salud local
¿Tiene convulsiones? Cómo se manifiestan?	Sí No		¿Enfermedad de TB (Pasado o Presente)?	Sí No	
¿Tiene problemas cardiacos/No respira bien?	Sí No		¿Usa tabaco (tipo, frecuencia)?	Sí No	
¿Tiene soplo en el corazón/presión arterial alta?	Sí No		¿Toma alcohol/drogas?	Sí No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	Sí No	
¿Problemas con los ojos/visión? ____ Lentes ☐ Lentes de Contacto ☐ Último examen ____ ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)			Dental ☐ Ganchos ☐ Puente ☐ Placas Otro		
¿Tiene problemas de los oídos/no oye bien?	Sí No		La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	Sí No		**Firma del Padre/Tutor**		**Fecha**

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:
☐ 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
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

IOC1271-09

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

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