Park Forest –Chicago Heights School District 163
2015-2016 School Year

ANY STUDENT TRANSFERRING IN FROM AN ILLINOIS PUBLIC SCHOOL MUST HAVE THE "ILLINOIS STATE TRANSFER FORM" FROM THE PREVIOUS SCHOOL.

ALL NEW STUDENTS ENTERING THE DISTRICT WILL NEED TO PROVIDE THE FOLLOWING:

- Official Birth Certificate
- Proof of Physical with Immunizations
- Three Proofs of Residency (see list below)

ALL RETURNING KINDERGARTEN AND 6TH GRADE STUDENTS WILL NEED TO PROVIDE THE FOLLOWING:

- Proof of Physical with Immunizations
- Three Proofs of Residency (see list below)

PROOFS OF RESIDENCY Three (3) documents must be provided (see list below)

_____ Current Lease
_____ Mortgage Statement
_____ Tax Assessment or Tax Bill
_____ Current Utility Bill – 30 Days (Gas, Water, Electric)
_____ Homeowners Insurance/Auto Insurance
_____ Renters Insurance Policy
_____ Village or County Occupancy Permit
_____ SSN Documentation/Disability
_____ Medicaid Medical Card/906 Form
_____ Department of Children and Family Services Voucher
_____ Current Payroll Stub/Unemployment Statement – 30 Days
_____ State of Illinois Vehicle Registration

REGISTRATION FEES: CREDIT CARDS, DEBIT CARDS, CASH, AND MONEY ORDERS
(CHECKS WILL NOT BE ACCEPTED)

______ $50.00 Registration Fee
______ $20.00 Activity Fee
______ $10.00 Field Trip Fee
______ $10.00 Discount (if registered before August 1st)

Park Forest-Chicago Heights School District 163
242 S. Orchard Drive
Park Forest, IL 60466

NEW STUDENT DATA FORM

***Please Print All Information**

Grade Level________

____
Date

____
Pin # (office use only)

Student's Legal Name: ____________________ ____________________ ____________________
Last **First** **Middle**

Date of Birth: ________________ Gender (*circle one*): Male Female

Birth City: ________________ Birth State:____________ Birth Country:________________

Ethnicity (*Check one*):
☐ No, Not Hispanic/Latino ☐ Yes, Hispanic/Latino

Race: Circle One or More (If Multi-Racial, Circle All That Apply):
American Indian or Alaska Native Asian Black or African American White
Native Hawaiian or Other Pacific Islander

Home Language if other than English:____

List all School District 163 students who reside in this home. Please include the student's grade.

____________________ ____________________ ____________________

____________________ ____________________ ____________________

□ **Primary/1st Parent/Legal Guardian (*circle one*):** Mr. Mrs. Ms. Dr. Rev.

This is the student's (*circle one*): Father Mother Stepfather Stepmother Grandparent Legal Guardian
*Foster Parent (2nd parent =DCFS)

Name: ____________________ ____________________ ____________________
Last **First** **Middle**

Address: ____

City: ____________________ State: ____________ Zip Code: ____________

Home/Primary Phone (_____) ________________

Work Phone (_____) ____________Ext.________ Cell/Pager (_____) ________________

Preferred e-mail address ________________________________

*If 2nd Parent=DCFS Caseworker, Home phone # should be FAX number

□ **Secondary/2nd Parent/Legal Guardian (*circle one*):** Mr. Mrs. Ms. Dr. Rev.

This is the student's (*circle one*): Father Mother Stepfather Stepmother Grandparent Legal Guardian Foster Parent DCFS

Name: ______________________ ______________________ __________
Last First Middle

Address: ____

City: ______________________ State: __________ Zip Code: __________

Home/Primary Phone (_____) ______________

Work Phone (_____) __________Ext.______ Cell/Pager (_____) __________

Preferred e-mail address ______________________________

Student Currently Lives with (check one):

☐ **Parents (Both)** ☐ **Single Parent Home** ☐ **Guardian** ☐ **Foster Parent(s)** ☐ **Step Parent & Parent**

Does the Student have a Parent/Guardian currently serving in the Armed forces? (Circle one) Yes No

Is the Parent/Guardian currently deployed to Active Duty or is the Parent/Guardian expected to deploy during the school year? (Circle one) Yes No

Is the Child a Foster Child/Ward of the Court? (Circle one) Yes No

Emergency Release and Contact Phone Numbers

In the event of illness, when I cannot be reached, I give the school permission to call the emergency contact persons below.

My child is to do the following in case of an emergency dismissal from school:

□ **1) Come home. My child has a key available and can come into the house until an adult arrives.**

□ **2) My child has permission to leave with the emergency contacts listed below:**

Emergency Contact #1______________________phone______________

Cell phone______________Relationship______________________

Emergency Contact #2______________________phone______________

Cell phone______________Relationship______________________

Emergency Contact #3______________________phone______________

Cell phone______________Relationship______________________

***If additional Emergency contacts are needed, please fill out the additional contact form.**

Parent Signature______________________________**Date**__________

PARK FOREST-CHICAGO HEIGHTS SCHOOL DISTRICT 163

STUDENT TRANSPORTATION FORM

2015-2016 SCHOOL YEAR

STUDENT'S NAME: ______________________________

STUDENT'S TEACHER: ______________________________

STUDENT'S ADDRESS: ______________________________

My Child: (please check one)

____ walks home alone (1st grade and up only)

____ walks home with sibling(s) Names: ______________________________

____ gets picked up by: ______________________________

____ is a bus rider **Bus #** __________

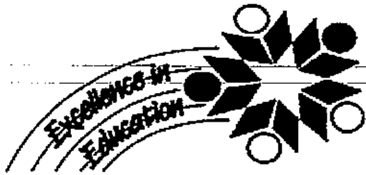
____ is a day care transportation student **Duration:** ____ **AM Only** ____ **PM Only** ____ **BOTH**

Day Care Provider: ______________________ **Phone:** ______________________

Contact Name: ______________________ **Mode of Pick up:** ____ **Bus** ____ **Van** ____ **Other** __________

You are giving the following individuals listed below permission to pick up your child: (Picture identification will be required)

Name of Individual	Relationship to Student
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________



Park Forest –Chicago Heights School District 163
242 S. Orchard Drive
Park Forest, IL 60466

NEW STUDENT HISTORICAL INFORMATION PROFILE

Student's Name: ______________________________Birthdate:__________Grade___________

Has your child ever been retained in a grade? Yes ______ No ______

Has your child ever been enrolled in an Early Childhood Program, other than regular preschool?
Yes _____ No _____

Was the first language your child learned English? Yes ______ No ______

Can your child speak a language other than English? Yes ______ No _____

If yes, what language? ____

List Previous school (s) your child has attended:

Kindergarten ________________________ Fourth ________________

First ________________________________ Fifth __________________

Second ______________________________ Sixth _________________

Third _______________________________

Has your child received any of the following special services? If so, in what grades?

Speech ____________________ Chapter 1 Reading ______________

Reading Recovery ___________ Chapter 1 Math ________________

Learning Disabilities _________ Other ________________________

Has your child ever received Physical or Occupational Therapy? Yes _____ No _____

What are your perceptions of your child's previous school experiences?

____
____
____
____

List any additional information that could help us to insure a successful year for your child.

____
____
____
____

Illinois State Board of Education

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

Note: The student's parents or guardians should respond to both questions (Part A and Part B). If the parents or guardians decline to respond to either question (Part A or Part B), school district staff are required to provide the missing information by observer identification.

Student's Name: ______________________ **SIS ID:**______________________

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, 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 the missing information by observer identification.

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.) **Choose only one.**

☐ **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.

☐ **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 must 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 responses must be retained until the completion of the action.

Park Forest – Chicago Heights School District 163
242 S. Orchard Drive
Park Forest, IL 60466

Home Language Survey

Student Name: ______________________________

School: __________________________

Grade: ________

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 that need to be assessed for English language proficiency.

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

   Yes ____

   If yes, what language? ______________________

   No _____

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

   Yes ____

   If 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.

____ ___________
Parent/Guardian Signature Date

Park Forest – Chicago Heights School District 163
242 S. Orchard Drive
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PARENT/GUARDIAN - SCHOOL COMPACT

SCHOOL: ____________________ STUDENT: ________________________

School District 163 believes that all students can achieve, and that parent/guardian involvement helps to guarantee that success.

Our Title I grant requires that we have a Parent/Guardian-School Compact designed to outline activities which will help students succeed in school. We are asking all parents/guardians to help their child by verifying the following:

- ❖ I will review the school handbook.
- ❖ I will review the discipline policies with my child.
- ❖ I will establish a place in our house for my child to do homework.
- ❖ I will read notices sent home by the school.
- ❖ I will call the school to share my concerns.
- ❖ I will talk with my child, about school, several times a week.
- ❖ I will periodically review my child's homework.

THE SCHOOL WILL:

- Send home notices in a timely fashion
- Communicate concerns early
- Notify parents/guardians of student performance difficulties
- Review all homework
- Return student work in an appropriate time frame
- Review discipline policies at the beginning of the school year
- Establish and maintain a safe, secure learning environment
- Provide copies of all handbooks, rules and procedures
- Listen to your concerns and feedback

Signed:________________________________

Relationship:____________________________

Together we can help our students achieve more!

Park Forest – Chicago Heights School District 163
242 S. Orchard Drive
Park Forest, IL 60466

PARK FOREST – CHICAGO HEIGHTS SCHOOL DISTRICT 163

Safe Learning Environment

I understand that in order to maintain a safe learning environment for all children, the School District has installed audio/visual recording devices on school buses and in the common areas of the schools, that my child is subject to recording by these devices, and that these devices may be used by the District without the consent of me or my child. I understand that these recordings are not student directory information.

Use of Photo/Digital Image

I understand that the District has no control over a third parties' (for example, the parent of another student or a news-media outlet) use or publication of photos, images, or videos it has taken of my child while s/he is participating in school or in school-sponsored activities, organizations, or athletics.

I understand that many opportunities exist at school and school related activities for my child to be photographed and/or video recorded. I understand that Park Forest – Chicago Heights School District 163 has the right to create these recordings of my child without the consent of me or my child.

I understand that the District uses photographs of students participating in school, school-sponsored activities, organization and athletics in its publications. I hereby give consent to the District to make use of and publish photographs and images of my child and to identify my child in District publications and materials including, but not limited to: newspapers, yearbooks, social media, and on District web pages. I understand that by giving my consent, the District may use images/photographs of my child without my prior approval of the particular image/photograph. I further understand that no compensation will be provided on the basis of the District's use of images/photographs of my child. I waive any rights that I or my child may have to the images/photographs of my child. I understand that I may revoke this consent at any time by *notifying* the building principal in writing; however, my child will still be subject to recording at school and school related activities, in school buses and in school common areas for security and safety purposes as specified above under Safe Learning Environment. This consent is valid for the 2015-2016 school year.

☐ **I DO give consent to the District to make use of and publish photographs and images of my child.**

☐ **I DO NOT give consent to the District to make use of and publish photographs and images of my child.**

☐ **I DO NOT give consent to the District to make use of and publish photographs of my child with EXCEPTION of the school yearbook.**

__________________________ __________________________
Child's Name (Print) Attendance Building

____
Parent/Guardian Name (Print

__________________________ __________________
Parent/Guardian Signature Date

Park Forest – Chicago Heights School District 163
242 S. Orchard Drive
Park Forest, IL 60466

PARENTAL CONSENT FORM

Authorization for Electronic Network Access Form

Use of Internet

I understand and will abide by Park Forest – Chicago Heights School District 163's 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 e-mail 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 appropriate 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 Internet.

*** Students are required to have a parent/guardian read and agree to the following:**

I have read Park Forest – Chicago Heights School District 163's Authorization for Electronic Network Access. 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 have discussed the terms of this Authorization with my child.

I hereby request that my child be allowed access to the District's Electronic Networks. I am aware that any unauthorized or misuse of the electronic network, or school technology, may result in loss of privileges, disciplinary action, possible referral for legal action, possible suspension, and/or expulsion. I will notify the school principal in writing, should I decide to revoke this decision.

________________________ ________________________ ____________
Student/User Name (please print) **Student Signature** **Date**

________________________ ________________________ ____________
Parent/Guardian Name (please print) **Parent/Guardian Signature** **Date**

Children Names:

________________________ ________________________

________________________ ________________________

________________________ ________________________

Park Forest – Chicago Heights School District 163
242 S. Orchard Drive
Park Forest, IL 60466

STUDENT HEALTH INFORMATION FORM

Student Name ________________________ School ____________________ Grade __________

The following information is necessary to ensure that your child receives proper medical care in the event of an emergency or health-related issue

1) Does your child have any medical conditions that we should know about?
____

2) What prescription medicine does your child take on a daily basis? Is this at home or at school?
____

3) What over-the-counter medicine does your child take regularly? How often?
____

4) Does your child have any food allergies? If so, what are the reactions and treatments?
____

5) Is your child allergic to bees or any other items? If so, what are the reactions and treatments?
____

Health History	Circle One		Comments
Diagnosis of Asthma?	Yes	No	
Wheeze/Cough during or after play?	Yes	No	
Birth Defects?	Yes	No	
Developmental Delays?	Yes	No	
Blood Disorders? Hemophilia? Sickle Cell? Other? Explain	Yes	No	
Diabetes?	Yes	No	
Head Injury/Concussion/Passes out?	Yes	No	
Seizures? What are they like?	Yes	No	
Heart Problem/Shortness of breath?	Yes	No	
Heart Murmur/High Blood Pressure?	Yes	No	
Dizziness or Chest Pain with exercise?	Yes	No	
Bone/Joint problems/Injury?	Yes	No	
Scoliosis?	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List All) When? What for?	Yes	No	
Ear/Hearing problems?	Yes	No	
Eye/Vision Problems? Glasses or Contacts? Last Exam?	Yes	No	
Other concerns?	Yes	No	

Physician's Name ____

Physician's Address ____

Physician's Phone ____

In case of accident or serious illness, I request that school personnel contact me. If I cannot be reached, I hereby authorize school personnel to call the paramedics to treat and transport my child to a medical facility at my expense.

I authorize the release of medical information including dental, vision, physicals and/or immunization records.

Parent/Guardian Signature ________________________________ ***Date*** ____________

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

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

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 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 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. 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 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 ☐ Limited ☐

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

Address Phone

(Complete Both Sides)

PARK FOREST-CHICAGO HEIGHTS SCHOOL DISTRICT 163
Health Services Department

IMMUNIZATION CLINIC - FREE TO COOK COUNTY RESIDENTS:

Cook County Department of Public Health
16501 S. Kedzie Ave
Markham, IL 60426

An appointment is necessary.
A parent must accompany children under 18 and bring their immunization records. Call ***(708) 232-4500*** for information.

OTHER PLACES WHERE IMMUNIZATIONS CAN BE RECEIVED AT A MINIMAL FEE:

Park Forest Health Dept.
400 Forest Blvd.
Park Forest, IL 60466

Call **(708) 748-1118** for an appointment and to find out cost for physicals.

Hazel Crest Community Health Center-Aunt Martha's
17850 S. Kedzie Suite 1150
Hazel Crest, IL 60429

Call **(708) 335-5200** for an appointment.

Chicago Heights Community Health Center- Aunt Martha's
1536 Vincennes Rd.
Chicago Heights, IL 60411

Foster children or children in state custody must have DCFS written consent. Call **(708) 756-1135** for an appointment.

Family Health Society
152 W. Lincoln Hwy.
Chicago Heights, IL 60411

Call **(708) 754-9687** for an appointment. Cost is based on a sliding scale.

For dental services, call **1-888-286-2447**.

BRING A COPY OF YOUR CHILD'S IMMUNIZATION RECORD AND SCHOOL REQUIREMENT LETTER WITH YOU TO ANY CLINIC YOU ATTEND

IMPORTANT HEALTH SERVICES INFORMATION REGARDING MEDICATION

The policy of School District 163's "Self-Administration of Medication Under Supervision" policy requires written orders from the doctor and written permission from the parent in order for a student to take prescription or non-prescription medication at school. The form that needs to be completed can be obtained from the Health Assistant at your child's school.

All medications are kept locked in the health office in each school. If your child uses an inhaler and you wish him/her to carry it on his/her person, this needs to be a part of the doctor's written order. We will accept the prescription label as a doctor's order for asthma medication only. If your child has asthma, diabetes or seizures, please obtain a care plan from your physician.

Medications are to be brought to and from school by an adult. MEDICATION WILL NOT BE SENT HOME WITH STUDENTS.

CAN USE MEDICAL CARD AT:

Dental:

Gordon Dental
2555 W. Lincoln Highway Ste. 111
Olympia Fields
708-679-0668

Chicago Heights Community
Health Center-Aunt Martha's
1536 Vincennes
Chicago Heights
708-756-1135

Access-Agarwal Dental Clinic
1415 Emerald Avenue
Chicago Heights
708-756-7384-services special needs children

Hazel Crest Com.Ctr-Aunt Martha's
17850 S. Kedzie, Suite 1150
Hazel Crest
708-335-5200

Dr. Bellur Chandrashekar
17577 S. Kedzie, Suite 106
Hazel Crest
708-335-3366

Vision:

Dr. Greenspan
366 Dixie Highway
Chicago Heights
708-754-0080

Dr. Roby
15437 Broadway
Harvey
708-331-4441

Dr. Nesta
4131 Sauk Trail
Richton Park
708-481-2000

Physicians:

Dr. K. Murthy
2555 Lincoln Highway
Olympia Fields
708-747-5615

Dr. Jordan
165 W. 10th Street
Chicago Heights
708-754-3507
708-754-6153 fax

Cottage Grove Clinic
1645 Cottage Grove
Ford Heights
708-753-5800

Medicaid HMO:

Contact Harmony Health Plan
1-800-608-8158 for a list of doctors

SAMPLE FORMAT: Format may be modified and/or copied to meet specific School-Based Child Nutrition Programs record keeping needs. Do not return to Illinois State Board of Education.

School-Based Child Nutrition Programs
PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION

CHILD'S NAME	AGE	DATE

Dear Parent/Guardian:

This school participates in a federally-funded School-Based Child Nutrition Program and must serve meals and/or milk meeting program requirements. Reasonable food accommodations must be made when the accommodation being requested is due to a disability and supported by a physician's statement. Reasonable food accommodations may be made for children without disabilities who may still have special dietary needs; a medical statement may be required. If you are requesting a meal accommodation or substitution, please ask your physician to complete and sign this form. If you have any questions, please contact me at

______________________________.
School Phone Number

Sincerely,

____
Food Service Director/Contact

____
School Name

____
Address (Street)

____
Address (City, State, Zip Code)

PHYSICIAN STATEMENT

1. Does child have a disability according to 7 CFR Part 15b that requires food accommodation? *(Does he/she have a "physical or mental impairment which substantially limits one or more major life activities"?)*

   ☐ No **If no, go to item 2 below.**

   ☐ Yes **If yes, provide the following information and complete items 3, 4, and 5 below.**

   a. What is the disability? ______________________________

   b. What major life activity is affected? ______________________________

   c. How does the disability restrict the diet? ______________________________

2. Child has no disability but requires a special diet. Identify medical problem which restricts the child's diet and complete items 3, 4, and 5 below.

3. List food/type of food to be omitted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.

4. List food/type of food to be substituted. For the safety of the child, please be as specific as possible. A menu may also be developed and attached.

5. ______________________________ ______________________________
   Date *Signature of Physician*

FOR SCHOOL USE ONLY:

☐ Form received on ______________________________.

☐ Form complete and accommodations will begin on ______________________________.

☐ Form complete, but accommodation will not be made. ☐ Child does not have a disability ☐ Request not reasonable

☐ Form incomplete. Parent contacted on ______________________________.

______________________________ ______________________________
Date Signature of Food Service Director/Contact

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 ______________________________

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)

Address ______________________________

____

Phone ______________________________

Signature ______________________________ Date ______________

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

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

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 ______________________ (Street, City, ZIP Code) Telephone ______________

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
Department of Public Health

DENTAL EXAMINATION WAIVER FORM

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):	

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).

☐ My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature ______________________________ Date ____________________