Submit Enrollment Interest Form

Enrollment interest forms must be submitted by March 8th, 2018 online, by mail or fax, or in person. We encourage parents to use the online portal.

Registration Form

Parents will be notified of lottery results; families who would like to accept the offered must submit the student registration form no later than May 10th, 2018.

Upon receipt of the registration form, parents will be provided with the following enrollment packet:

Enrollment Documents and Form Requirements:

- CPS Elementary School Registration Checklist
- Authorization for Transfer and Release of Cumulative Records
- Home Language Survey
- Race and Ethnicity Survey
- Transportation Survey
- Emergency Contact Information and Permission for Emergency Care
- 2016-2017 Minimum Health Requirements for Chicago Public Schools
- CPS Student Medical Information
- Proof of Age must be 5 years old by Sept. 1st, 2018 to enter Kindergarten or 6 by 09/10/18 for First Grade
- Proof of Residence must live within Chicago city limits
- State of IL Certificate of Child Health Examination
- Proof of School Dental Examination Form
- Eye Examination Report
- Meal Application [to be finalized upon vendor selection]

Application Form for the 2018-2019 Academic Year

Deadline: March 8th, 2018 at 5:00 PM

| STUDENT INFORMAT | ION | | | | | | | | |
|--|--|-----------------------------|--|------------------------------|--|--|--|--|--|
| Student name: | | | | | | | | | |
| Date of Birth: | | | Gen | der: | | | | | |
| Current school (if applic | able): | | | | | | | | |
| Grade the student is in | TODAY: | | Grade the student will be i | n NEXT YEAR: | | | | | |
| | | | | | | | | | |
| CONTACT AND PARE | NT/GUARDIAN INFORMA | TION | | | | | | | |
| Student address | | | | | | | | | |
| | Street address | | City | State/Zip | | | | | |
| Parent/Guardian (1) | | | | | | | | | |
| | Name | Phone | Email | Relationship | | | | | |
| Parent/Guardian (2): | | | | | | | | | |
| | Name | Phone | Email | Relationship | | | | | |
| How did you hear abo | ut us? | | | | | | | | |
| □ Direct mailing | □ Internet search | □ Park District ever | nt 🛛 Newspaper | □ Recruiter | | | | | |
| □ Other parent | □ At community event | □ Church | □ Advertisement | □ Facebook | | | | | |
| □ Other: | | | | | | | | | |
| | | | | _ | | | | | |
| SIBLING INFORMATIO | N | | | | | | | | |
| Does the student have a also applying Chicago (| a brother or sister who is Classical? | □ No □ Yes | If yes, what is the siblings name: | | | | | | |
| Note: You must complete a separate application for each student. | | | | | | | | | |
| Apply online: | Send | by mail: | Send by fax: | | | | | | |
| www.chiclassical.org | [Sch | ool address] | Fax number | | | | | | |
| Submitting this application is | not a guarantee of admission. Cl | nicago Classical Academy is | a tuition-free, open-enrollment public | charter school. All students | | | | | |

residing in the municipal boundaries of the City of Chicago are encouraged to apply. If you are applying for Kindergarten, your child must be 5 years old by September 1, 2018. There are no exceptions. Students are accepted regardless of background, academic record, or special education eligibility. If we receive more applications than there are seats available, Chicago Classical Academy will hold a random lottery as required by law. Your application must be received by March 8th, 2018 in order to be included in the lottery. The lottery will be held on April 4th. Applications received after the lottery deadline will be added at the end of the waitlist in the order they are received. Lottery results will be mailed and emailed by April 11th, 2018.

Signature of Parent or Guardian

Date

CHICAGO CLASSICAL ACADEMY

Registration Form for the 2018-2019 Academic Year

Please return to [address] or submit registration form online no later than May 10th, 2018. If we do not hear back from you by then, your child's seat may be offered to someone else.

Dear Prospective Family

We are excited to inform you that your child has been offered a seat at Chicago Classical Academy for the 2018-2019 academic year. To complete the application process, you MUST submit this registration form.

| STUDENT INFORMATI | ON | | | | |
|-------------------------------------|--------------|------------------|-------|--------------|--|
| Student name: | | | | | |
| Date of Birth: | | | | Gender: | |
| Current school (if applic | able): | | | | |
| Grade (2018-19 school | year): | | | | |
| | | | | | |
| CONTACT AND PARE | NT/GUARDIA | AN INFORMATION | | | |
| Student address | | | | | |
| | Street addre | ess | City | State/Zip | |
| Parent/Guardian Information (1): | | | | | |
| | Name | Phone | Email | Relationship | |
| Parent/Guardian Information (2): | | | | | |
| | Name | Phone | Email | Relationship | |
| <u> </u> | | 0 11 11 | | | |
| Submit online: | | Send by mail: | | by fax: | |
| www.chiclassical.org | | [School address] | Fax n | umber | |

Chicago Classical Academy is a tuition-free, open-enrollment public charter school. All students residing in the city are encouraged to apply. Students are accepted regardless of background, academic record, or special education eligibility. If we receive more applications than there are seats available, Chicago Classical Academy will hold a random lottery as required by law. Your registration must be received by May 10th, 2018; if this form is not received by the deadline your child's seat may be offered to another family.

Signature of Parent or Guardian

Date

CPS Elementary School Registration Checklist

Research shows that healthy students have better attendance and perform better in school, academically. Children must have proof of required immunizations and health exams before October 15th, or they will face exclusion from school. Please remember that a healthy child is a healthy learner.

Kindergarten Enrollment Eligibility: All children residing in the City of Chicago, who are 5 years old on or before September 1 of the current school year, are eligible for enrollment into a CPS Kindergarten program.

The parent, legal guardian, or temporary custodian of any elementary age child enrolling in a Chicago public school is required to submit proof of age and required medical records to the school. Research shows that healthy students have better attendance and perform better in school, academically. Children must have proof of required immunizations and health exams before October 15th, or they will face exclusion from school. Please remember that a healthy child is a healthy learner.

Proof of age: Includes, but is not limited to, any ONE of the documents listed below:

- Child's birth certificate
- Child's baptismal record
- Passport
- Court documents
- Medical records

Proof of current address: Includes, but is not limited to, any TWO of the documents listed below:

- Current utility bill
- Illinois driver's license or State of Illinois identification card
- Deed
- Employee identification number
- MediPlan/Medicaid card
- Court documents
- Illinois Department of Public Aid card
- Stamped United States Post Office change of address form
- Illinois state aid check/social security check

Physical examination requirements: All students must have a physical examination within one year of:

- Entering schools in the State of Illinois for the first time, at any grade level
- Entering kindergarten or 1st grade, 6th grade, and 9th grade (ages 5, 10, 15 for ungraded programs)
- Entering preschool, up to age 6 (physical exam and lead screenings)

Immunization requirements:

- Diphtheria, Pertussis (Whooping Cough), Tetanus (DTP/Td)
- Inactivated Polio
- Measles
- Rubella
- Mumps
- Hepatitis B
- Varicella (Chicken Pox)
- Haemophillus Influenza, Type B (HIB)

Dental requirement: All students in Kindergarten, 2nd, and 6th grade must have a dental exam completed by a licensed dentist prior to: May 15th of the current school year

Vision requirement: All students entering Kindergarten and for all out-of-district transfer students must have a vision exam completed by an optometrist or physician who provides complete eye examinations no later than October 15 of the current school year.

Authorization for Transfer and Release of Cumulative Records

Parent/Guardian: Please complete this form and return to Chicago Classical Academy. We will submit this form to your child's current school in order to have the records transferred to Chicago Classical Academy.

The following student is being enrolled at Chicago Classical Academy Charter School for the 2018-19 school year. Please project them in IMPACT by June 1st, 2018. By law, we also need to obtain the of the student's cumulative records from the student's previous school.

STUDENT INFORMATION (to be filled out by parent/guardian)

| Name of student | |
|-------------------------------|--|
| CPS ID number (if applicable) | |
| Date of birth | |
| Previous school name | |
| Previous school address | |
| Previous school phone | |
| Previous school fax | |
| Parent/guardian name | |
| • | |
| Parent guardian signature | |

Please submit the following documents to Chicago Classical Academy: Birth certificate or other proof of age Proofs of address Medical forms All report cards and test scores All attendance and discipline reports If applicable, most recent IEP and most recent confidential report.

Please submit to: Chicago Classical Academy [Address]

Please contact [Student Counselor] if you have any questions: [phone] [email]

| School: | Room: | School ID #: _ | Network: | |
|---|--|---|---|--|
| Student Name: | | Student IS | #: | |
| English 1. Is a language other than English No Yes 2. Does the student speak a langu No Yes If the answer to either question is y assess your child's English langua Spanish 1. ¿Se habla algún otro lenguaje or the student speak algún speak alg | n spoken in your home? (Languag age other than English? (Languag yes, the law requires the sch age proficiency. | Je) • The I questi • If two identif questi • Enter when Polish | MPACT REGISTRATION PRO (For Office use only) Non-English language identified of on is the Home Language. o different non-English languages ied, enter the language identified on 2 as the Home Language. r ENGLISH as a Home Language both questions are answered no | CESS on either are l in e ONLY o. |
| hogar? No Sí 2. ¿Habla el estudiante un lenguaj No Sí Si la respuesta a cualquiera de las preg que la escuela evalúe la fluidez de su n | (Lenguaje) guntas es "Sí", la ley requiere | Czyt uczeń mówi ir Nie Jeśli udzielili Państwo tw | Tak nnym językiem niż angielski? Tak rierdzącej odpowiedzi na którekolwieł ją, aby szkoła sprawdziła poziom zna ziecka. | |
| Chinese 1. 在家中是否說英語之外的- 「「否」」「是 2. 該學生是否會說英語之外的 「「否」」「是 | (語言))一種語言, | | ني لييت بلغة اخرى غير اللغة الإلجليز () نعم التلسيذ لغة اخرى غير قالغة الإتجليزية () نعم | |
| 如果你在兩個問題中之任一項的答響。要測試貴子女的英語通悉度。 | 案是"是",則法律規定校方 | انجليزية. | ة نعم علي أي من السوالين فإن اا ابنكم للكفاءة في استخدام اللغة الا | كانت الإجاب لرسنة تقييم |
| Bosnian/Croatian/Serbian 1. Da li se u kući govori na stra (različitom od engleskog)? []NE []DA 2. Da li učenik govori neki stra engleskog)? []NE []DA Ukoliko ste na bilo koje od ovih pitanj će biti zakonski dužna da procijeni niv kod vašeg djeteta | (jezik) mi jezik (različit od (jezik) ja odgovorili sa "Da", škola |) نیوں () بان اور زیان ہواتا ہے؟) نیوں () بان | اکیا گھر پر انگریزی کے علاوہ کوئ اور زی (زیان) اطاقہ عام گھر پر انگریزی کے علاوہ کوئ ا (زیان) (زیان) بھاتہاں ٹی چارتاری کارنا کھاتا کی ال کیا ہے ہے۔ | - |
| Signature of School Off | ficial Date | Signat | ure of Parent/Guardian | Date |
| language, identify the langua | age spoken by the parent ge cannot be determined ermined within two weeks | /guardian through ar I, enter "Other" as a after enrollment. | ave staff who speaks the party assistance available in the stemporary entry. If you enternisit the OLCE Forms page on the state of the | school. ed "Other," |

| Chicago Public Schools | | dent's initial enrollment in a Chicago Public School. of in the student's folder. | | | | |
|---|--|--|--|--|--|--|
| DE LANGUAGE | | School ID #: Network: | | | | |
| ONTHAN EDUCATION | Student Name: | Student IS #: | | | | |
| H O M E L | English 1. Is a language other than English spoken in your home? No Yes 2. Does the student speak a language other than English? No Yes If the answer to either question is yes, the law requires the school assess your child's English language proficiency. | The Non-English language identified on either question is the Home Language. If two different non-English languages are identified, enter the language identified in question 2 as the Home Language. Enter ENGLISH as a Home Language ONLY when | | | | |
| ANGUAGE | Romanian 1. În familia dvs. se vorbește și altă limbă decât engleza?? Nu Da (limba) 2. Studentul vorbește și altă limbă decât engleza? Nu Da (limba) | Yoruba 1. Njé e n so èdè miran yato si Èdè-Gèésì ninu idile yin bí? Bèékó Bèéni 2. Şe akékòó nàá n so èdè miran yato sí èdè-Gèésì bí? Bèékó Bèéni (Èdè) Ti débà so é dè bé lé bàch só hí | | | | |
| Ē | Dacă ați răspuns afirmativ la oricare dintre întrebări, prin lege, instituția de învățământ trebuie să evalueze cunoștințele de limbă engleză ale copilului dvs. | Tí ìdáhùn sí ibéèrè nàá bá jé Bèéni, òfin bèèrè pé kí ilé-èkó nàá şe ìgbéléwòn bí ọmọ rẹ şe gbó èdè Gèésì si. | | | | |
| S U | Assyrian منغدات به ناره منغا , masin . م نهان منع الشهري . مهان منع الشهري . | <u>Gujarati</u> 1. શું આપના ધરમાં અંગ્રેજી સિવાયની ભાષા અન્ય કોઈ ભાષા બોલવામાં | | | | |
| R V E | الته الله الله الله الله الله الله الله | □ના □ફા(ભાષા) 2. શું વિદ્યાર્થીઓ અંગ્રેજી સિવાયની કોઈ ભાષા બોલે છે? □ના □ફા(ભાષા) જો બનેમાંથી શેઈ એક મથનો જવાબ માણ કામાં કેશ તો કાશકો થાળા માને | | | | |
| Y HLS 1 of 2 Spanish | (حنف) حل ، جت) سنجه دفمانه دند بخ خامه محمد من فنمانه مناسی لخته نفانه دهنده المعفمه بمنابع دللنه (بالله من از المعنه) در المعنه از المعنه از المعنه از المعنه المعنه المعني المعني ا | | | | | |
| Polish Chinese Arabic Bosnian Croatian Serbian Urdu | Tagalog 1. May iba pa bang lengguwahe bukod sa Ingles na ginagamit sa iyong tahanan? Hindi Oo (Lengguwahe) 2. May ginagamit ba na ibang lengguwahe ang mag-aaral | Korean 1. 가정에서 사용하는 언어 중에서 영어를 제외한 다른 언어가 있습니까? ?아니오 ?예(언어) 2. 학생이 영어 이외의 다른 언어를 구사합니까? | | | | |
| HLS 2 of 2 Romanian Yoruba Assyrian Gujarati Tagalog Korean | bukod sa Ingles? Hindi Oo(Lengguwahe) Ayon sa batas, kung 'Oo' ang sagot sa parehong tanong, kailangan suriin ng paaralan ang kakayahan at kaalaman ng mag-aaral sa wikang Ingles. | ?아니오 ?예(언어) 상기의 질문 중 하나라도 "예"로 응답하신 경우에는, 관련 법에 따라 학교는 귀 자녀의 영어 구사 능력 개발을 지원해야 합니다. | | | | |
| Office of Language and Cultural | Signature of School Official Date Notes: If the parent/auardian does not speak English and the | Signature of Parent/Guardian Date | | | | |
| Education | language, identify the language spoken by the parent/g If exact name of the language cannot be determined, exact language must be determined within two weeks of | e school does not have staff who speaks the parent/guardian's guardian through any assistance available in the school. enter "Other" as a temporary entry. If you entered "Other," the after enrollment. n this HIS please visit the OLCE Forms page on the Knowledge | | | | |

Revised May 2016 • If the language spoken by the parent is not reflected in this HLS, please visit the OLCE Forms page on the Knowledge Center at <u>bit.ly/OLCEforms</u> and click on Home Language Survey in Additional Languages.



ENGLISH

Race and Ethnicity Survey

Student's Name: Gender: Birth Date: School Name: School ID:

INSTRUCTIONS: Please answer the questions below. <u>Both questions must be</u> <u>answered</u>. 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.) <u>Choose only one</u>.

□ 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.)

CHICAGO CLASSICAL ACADEMY

Transportation Survey

Parent/Guardian: Please complete this form and return to Chicago Classical Academy.

| PLE | ASE CHECK THE APPROPRIATE BOX (to be filled out by parent/guardian) |
|-----|--|
| | My child will walk to and from school |
| | My child will receive a ride to and from school |
| | My child will take the CTA to and from school |
| | I have a child with disabilities for whom transportation is provided pursuant to an Individualized Education Program (IEP) or Plan |
| | Carpool: our family is interested in carpool options, please share my information with other interested families |

Is there anything else regarding transportation that we should be aware of?

Emergency Contact Form and Permission for Emergency Care

| Student name: | |
|---|---------------|
| Date of Birth: | |
| | |
| CONTACT AND PARENT/GUARDIAN INFORMATION | |
| Parent/Guardian (1) | |
| Name: | Relationship: |
| Phone: | Email: |
| Parent/Guardian (2) | |
| Name: | Relationship: |
| Phone: | Email: |
| | |
| PICK-UP AUTHORIZATION (EMERGENCY ONLY) | |
| Emergency contact (1) | |
| Name: | Relationship: |
| Phone: | Email: |
| Emergency contact (2) | |
| Name: | Relationship: |
| Phone: | Email: |
| Medical provider | |
| Physician's name | Phone number |
| Dentist's name | Phone number |

I hereby consent to have Chicago Classical Academy Charter School (CCA) provide on-site first aid for minor, non-life threatening instances. In addition, for situations requiring medical intervention, I consent to CCA requesting emergency personnel to transport my child to the nearest emergency medical care facility. I understand that this will be provided at my own expense. I understand that this authorization may include providing medical care without first obtaining my consent.



If you are not presently

insured, please contact the Illinois Dept. of

1-800-543-6153 or

Human Services (IDHS) at

https://abe.illinois.gov/

2016-2017 Minimum Health

Requirements for Chicago Public Schools

Medical Home"Evidence shows that healthy students have better attendance patterns and perform better
academically". The following health requirements apply to all children enrolled in a Chicago
Public School. Children must provide proof of required immunizations and health exams
before October 15, 2016, or they will face exclusion from school.

EXAMINATION REQUIREMENTS

Physical Examination requirements due upon enrollment, or by 10/15/16

- Physical Examination must be completed within one year prior to entry to:
- Preschool and kindergarten (physical exam and lead screening through age 6)
- 6th grade and 9th grade (ages 5, 11, 15 for un-graded programs)
- Any student entering CPS for the first time

Vision Examination requirements due upon enrollment, no later than 10/15/16

- Entering the State of Illinois for the first time at any grade level.
- Entering kindergarten

Dental Examination requirements due <u>5/15/17</u> for kindergarten, 2nd and 6th grade.

IMMUNIZATION REQUIREMENTS

Diphtheria, Pertussis (Whooping Cough), Tetanus (DTaP & dap)

- Four (4) or more doses. The first 3 doses with intervals of 4 weeks apart. The interval between the 3rd and 4th dose is at least 6 months.
- The last dose qualifying as a booster and received on or after the 4th birthday
- One (1) dose of the Tdap vaccine for 6th to 12th grades.

Polio

- Three (3) or more doses of a polio vaccine with intervals of 4 weeks apart.
- The last dose qualifying as a booster and received on or after the 4th birthday

Measles, Mumps, and Rubella

- One (1) dose required for preschool, & a second dose required for all students kindergarten to 12th grade.
- 1st dose received at 12 months or later
- 2nd dose must be administered at least four weeks (28 days) after 1st dose

Hepatitis B

- Three (3) doses required for all students.
- 1st dose at birth.
- 2nd dose received no less than 28 days or 4 weeks after 1st dose.
- 3rd dose received no less than 2 months after the 2nd dose and 4 months after the 1st dose.

Varicella (Chicken Pox)

- Two (2) doses of varicella are required for kindergarten, 1st, 2nd, 6th, 7th, 8th, 9th, 10th and 11th, grades. The first dose on or after the first birthday and the second dose no less than four weeks (28 days) after the first dose.
- One (1) dose required on or after the first birthday for Prek, 3rd, 4th, 5th, & 12th grades.

Haemophilus Influenzae, Type B (HIB)

- Three (3) doses required for primary series.
- If none received before age 15 months, only one (1) dose required from age 15 months to 59 months of age. Not required age 5 years or older.

Pneumococcal Disease_(PCV)

- Four (4) doses required for primary series.
- If none received before age 24 months, only one (1) dose required from age 24 to 59 months of age. Not required age 5 years or older.

Meningitis (MCV4)

- One (1) dose of the meningitis vaccine for 6th and 7th grade
- Two (2) doses of the meningitis vaccine for 12th grade.

A medical home will allow your child and family to access better healthcare. The medical home is where you can access affordable, quality, culturally sensitive, competent and coordinated healthcare.

Most people who are found eligible for Medicaid must choose a Primary Care Provider (Medical Home). The Illinois Client Enrollment Broker will help you understand your healthcare choices, so that you can choose the best plan for you. <u>http://illinoisceb.com/</u>

If you are seeking a provider, you may call 311 or go to: <u>www.cityofchicago.org</u> and type in "Find a Community Health Center" in the Search box

For more information regarding health requirements contact your School Nurse.



Reviewed by: _____ Follow up: _____ Documents received: _____

Student Medical Information 2016/2017 School Year

INFORMATION MUST BE UPDATED AND SUBMITTED ANNUALLY AT THE BEGINNING OF THE SCHOOL YEAR

PLEASE PRINT ALL INFORMATION and RETURN FORM TO SCHOOL

SCHOOL NAME: _____

Student Name: _____ Date of Birth: _____ Grade: _____

Student ID: _____ Medicaid Number: _____

To ensure the safety of your child during the school day, extracurricular activities, on any field trip, and when being transported by CPS it is important that the school is aware of any health conditions that may impact your child. We are asking you to please complete this form. For confidentiality purposes, this information will only be shared with relevant CPS staff. Thank you for your cooperation in this important matter.

Please check below if applicable:

- Food Allergies: (Type)
- □ Other Allergies: (Type)
- □ Asthma
- \Box Diabetes: Type 1 \Box Type 2 \Box
- \Box Seizures
- \Box Other Medical Condition
- □ My child has <u>NO</u>allergies, medical conditions and/or does not take any medications during school hours
- □ My child has a primary healthcare provider (e.g., Doctor, Nurse Practitioner, Physician Assistant, etc.)

For the medical condition identified above which requires prescribed medication during school hours, please provide written verification from your healthcare provider with diagnosis, type of medication, dosage, and time to be given. An Emergency Action Plan (Allergy, Asthma, or Diabetes) can also be requested from your healthcare provider. Your child may qualify for a **504 Accommodation Plan** due to his/her condition. Please make sure you follow up with your school nurse and/or case manager once you have submitted this form.

| Parent Name: (Please Print): | Date: |
|------------------------------|--------|
| Parent Signature: | |
| Phone Number: | Email: |

Educate • Inspire • Transform



State of Illinois Certificate of Child Health Examination

| Student's Name | | | | | | | 1 | Birth Da | ate | | Sex | Race | /Ethnici | ity | Scho | ol /Gra | de Level | /ID# |
|--|---|--------|------------------|---------|----------|----------------|--------|-----------|----------|----------|---------|-------|-----------|-------------|---------|---------------------|--------------------|----------|
| Last | First Middle 1 | | | | | Month/Day/Year | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | |
| Address Street | | | City lotod by | | Cip Code | nnovid | | Parent/Gu | | 011.0101 | dasa ad | | one # Hoi | | ad If | annai | Wo | |
| medically contraind | | | | | | | | | | | | | | | | | | |
| examination explain | | | | | | | | | oy the | neurth | cure p | oviac | i i copo | noibit | 101 001 | npretin | 5 the h | cuitii |
| REQUIRED | | DOSE 1 | | | DOSE 2 | | | DOSE 3 | | | DOSE 4 | | | DOSE 5 | | | DOSE 6 | |
| Vaccine / Dose | MO | DA | YR | MO | DA | YR | MO | DA | YR | MO | DA | YR | MO | DA | YR | MO | DA | YR |
| DTP or DTaP | | | | | | | | | | | | | | | | | | |
| Tdap; Td or | □Tda | p□TdI | DT | □Tda | ap□Td | DT | □Tda | ap□Tdl | DT | □Td | ap□Td□ | DT | □Tda | ıp□Tdl | DT | □Tda | ıp□Tdl | DT |
| Pediatric DT (Check specific type) | | | | | | | | | | | | | | | | | | |
| | | V D | OPV | | PV 🗆 | OPV | | PV 🗆 | OPV | | PV □(| OPV | | PV 🗆 | OPV | | PV 🗆 | OPV |
| Polio (Check specific type) | | | | | | | | | | | | | | | | | | |
| Hib Haemophilus | | | | | | | | | | | | | | | | | | |
| influenza type b | | | | | | | | | | | | | | | | | | |
| Pneumococcal Conjugate | | | | | | | | | | | | | | | | | | |
| Hepatitis B | | | | | | | | | | | | | | | | | | |
| MMR Measles Mumps. Rubella | | | | | | | | | | Com | ments: | | | | | | | |
| Varicella (Chickenpox) | | | | | | | | | | | | | | | | | | |
| Meningococcal conjugate (MCV4) | | | | | | | | | | | | | | | | | | |
| RECOMMENDED, B | UT NOT | T REQU | JIRED | Vaccine | / Dose | | | | | | | | | | | | | |
| Hepatitis A | | | | | | | | | | | | | | | | | | |
| HPV | | | | | | | | | | | | | | | | | | |
| Influenza | | | | | | | | | | | | | | | | | | |
| Other: Specify | | | | | | | | | | | | | | | | | | |
| Immunization Administered/Dates | | | | | | | | | | | | | | | | | | |
| Health care provide | r (MD. | DO. A | PN. P | A. scho | ol heal | th prof | ession | al. heal | th offic | rial) ve | rifving | above | immur | nizatio | 1 histo | rv mus | t sign h | elow. |
| If adding dates to the | | | | | | | | | | | | | | | | - j - II u s | • • • - - • | |
| Signature | | | | | | | | Ti | tle | | | | | Da | te | | | |
| Signature | | | | | | | | Tit | | | | | | Da | | | | |
| 0 | DOOF | OF IM | MUNI | ту | | | | 11 | lie | | | | | Da | ic | | | |
| 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. | | | | | | | I. | | | | | | | | | | |
| 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 | Date of | | | | | | | | | | | | | | | | | |
| Disease | | · | | ature | | M? | ~* | | | | D | | | <u>itle</u> | A 44 1 | | .e. 1. 1. | a nord t |
| | 3. Laboratory Evidence of Immunity (check one) Immunity Immunity< | | | | | | | | | | | | | | | | | |
| *All mumps cases d | | | | | | | | | | | | | | | | | | |
| 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 | | | OMPLI | ETED | AND SIGNED BY PAREN | T/GUAI | | BY HEA | LTH CAR | E PRO | OVIDER | |
| ALLERGIES | | List: | | | | MI | EDICATION (Prescribed or | Yes Li | | | | |
| (Food, drug, insect, other) Diagnosis of asthma? | No | | Yes | No | | | n on a regular basis.) | No red | Yes | No | | |
| Child wakes during ni | ght cough | ning? | Yes | No | | org | gans? (eye/ear/kidney/testic | | | | | |
| Birth defects? | | | Yes | No | | | ospitalizations? hen? What for? | | Yes | No | | |
| Developmental delay? | | | Yes | No | | | | | * 7 | | | |
| Blood disorders? Herr Sickle Cell, Other? E | | | Yes | No | | | rgery? (List all.) hen? What for? | | Yes | No | | |
| Diabetes? | 1 | | Yes | No | | Se | rious injury or illness? | | Yes | No | | |
| Head injury/Concussion | | l out? | Yes | No | | | 3 skin test positive (past/pre | sent)? | Yes* | No | *If yes, ref departmen | er to local health |
| Seizures? What are th | 5 | .1.0 | Yes | No | | | B disease (past or present)? | | Yes* | No | departmen | |
| Heart problem/Shortn Heart murmur/High b | | | Yes Yes | No No | | | bacco use (type, frequency) cohol/Drug use? |)? | Yes Yes | No No | | |
| Dizziness or chest pair | 1 | sure? | Yes | No | | | mily history of sudden deat | h | Yes | No | | |
| exercise? | | | 105 | 110 | | | fore age 50? (Cause?) | | | | | |
| Eye/Vision problems? Other concerns? (cros | | | | | Last exam by eye doctor | De | ental 🗆 Braces 🗆 H | Bridge | □ Plate | Other | _ | |
| Ear/Hearing problems | | ooping nus, | Yes | No | | | ormation may be shared with ap | propriate j | personnel for | health a | and education | al purposes. |
| Bone/Joint problem/in | njury/scol | iosis? | Yes | No | , | | rent/Guardian mature | | | | Date | |
| PHYSICAL EXAN | IINATI | ON REO | UIRE | MEN | NTS Entire section be | low to | be completed by MD/ | DO/AP | N/PA | | | |
| HEAD CIRCUMFEREN | | | | | HEIGHT | | WEIGHT | | BMI | | B | Р |
| DIABETES SCREEN Ethnic Minority Yes | | | | | BMI>85% age/sex stance (hypertension, dyslipide | | | | | | | |
| | | | | | lren age 6 months through 6 | | nrolled in licensed or publ | ic school | loperated | day ca | re, prescho | ol, nursery school |
| - | | - | | | Chicago or high risk zip cod | | DI J T4 D-4- | | г | 14 | | |
| Questionnaire Admin TB SKIN OR BLOO | | | | | od Test Indicated? Yes □ hildren in high-risk groups inclu | | Blood Test Date | o HIV inf | | esult | ditions freque | ent travel to or born |
| in high prevalence countri | ies or those | exposed to | adults in | high- | risk categories. See CDC guide | lines. h | ttp://www.cdc.gov/tb/pub | lications | /factsheets | /testin | g/TB_testir | |
| No test needed 🗆 | Test pe | erformed [| _] | | a Test: Date Read d Test: Date Reported | | / Result: Positiv / Result: Positiv | | legative □ legative □ | | mm_ Value | |
| LAB TESTS (Recomm | ended) |] | Date | 2100 | Results | , , | incourte i tostiliv | 1 | Ĭ | Date | , and | Results |
| Hemoglobin or Hema | atocrit | | | | | | Sickle Cell (when indicated) | | | | | |
| Urinalysis | | | | | | | Developmental Screening Tool | | | | | |
| SYSTEM REVIEW | Normal | Comme | nts/Foll | ow-u | p/Needs | | Ĩ | Normal | Commen | ts/Foll | low-up/Nee | eds |
| Skin | ļ | <u> </u> | | | | | Endocrine | | | | | |
| Ears | | | | | Screening Result: | | Gastrointestinal | | | | | |
| Eyes | | | | | Screening Result: | | Genito-Urinary | | | | LMP | |
| Nose | | ĺ | | | | | Neurological | | | | | |
| Throat | | | | | | | Musculoskeletal | | | | | |
| Mouth/Dental | | | | | | | Spinal Exam | | | | | |
| Cardiovascular/HTN | J | | | | | | Nutritional status | | | | | |
| Respiratory | | L | | | Diagnosis of Asthm | na | Mental Health | | | | | |
| Currently Prescribed Quick-relief me | dication (| e.g. Short | Acting | | | | Other | | | | | |
| Controller medication (e.g. inhaled corticosteroid) NEEDS/MODIFICATIONS required in the school setting DIETARY Needs/Restrictions | | | | | | | | | | | | |
| SPECIAL INSTRUC | CTIONS/ | DEVICES | e.g. sat | fety gla | asses, glass eye, chest protector | for arrhyt | hmia, pacemaker, prosthetic o | device, de | ntal bridge, | false te | eth, athletic s | support/cup |
| MENTAL HEALTH | | | | | the school should know about the school health personnel, check | | | Counsel | or 🗆 Pri | ncinal | | |
| EMERGENCY ACT | | eded while a | | | child's health condition (e.g., s | | | | | | , diabetes, he | art problem)? |
| On the basis of the exami PHYSICAL EDUCA | ination on t | | | | | DSCH | (If No or Modifi OLASTIC SPORTS | ied please Yes □ | attach expla | |) ified 🗖 | |
| | TION | | | IVI | | | | 1 63 🗖 | | IVIOU | | |
| Print Name | | | | | (MD,DO, APN, PA) | Signatur | e | | DI | |] | Date |
| Address | | | | | | | | | Phone | | | |



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: |
| Parent or Guardia | n: | | 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.
- D Preventive Care sealants, fluoride treatment, prophylaxis
- □ **Other** periodontal, orthodontic

Please note

| Signature of Dentist | | Date of Exam | |
|----------------------|--|--------------|-----------|
| Address | | | Telephone |
| Street | City | ZIP Code | • |
| 217-7 | Illinois Department of 785-4899 • TTY (hearing impa | | |

State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than $October 15^{th}$ 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 child beginning school.

| Student Name: | / | First) | | | | | | Grade: | |
|---|--|-----------------------|----------------|-----------------|------------------------|---|-------------|------------------------|--|
| (Last) | · · · | First) | (Midd | dle Initial) | (MC | o.) (Day) (Yr | , | | |
| Parent or Guardian: | (Last) | | | (First) | | _ Phone: _ | (Area Code) | | |
| Address: | | | | | | | | | |
| (Number) | (| Street) | | (City) (Z | ip Code) | | | | |
| | | | To Be Comp | leted By Exam | ining Doctor | | | | |
| Case History | | | | | | Date of | Exam: | | |
| Ocular History: Medical History: Drug Allergies: Other Information: | Normal Normal NKDA | | Positive for: | | | | | | |
| Examination | | | | | | | | | |
| Refraction: | | | | Distance | | | Near | | |
| Unaided Visua Best Corrected Visua | al Acuity: | Right 20 / 20 / | 20 / 20 / | Left | Both 20 / 20 / | 20 / 20 / | Both | _ | |
| Was refraction perform | ied with cy | ciopiegic a | | Yes 🛛 No |) | | | | |
| External Exam (eye an Internal Exam (media, Neurological Integrity (Binocular Function (ste Accommodation and V Color Vision IOP (glaucoma) Oculomotor Assessme Other: | lens, fundu pupils) ereopsis) ergence nt | | Normal | Abnormal | Not Able to A | Assess | Con | nments | |
| Diagnosis | | | | | | | | | |
| □ Normal □ Myopia □ H | | | Hyperopia | 🗅 Asti | gmatism | Strabi | smus | Amblyopia | |
| Other: | | | | | | | | | |
| Recommendations | | | | | | | | | |
| 1. Corrective Lenses: | 🗅 No | 🛛 Yes, ç | lasses shou | Id be worn for: | | t Wear DN Removed for | | Far Vision ducation | |
| 2. Preferential seating | recommer | nded: 🛛 | No 🛛 Yes | Comments: _ | | | | | |
| Recommend re-exa | | | 3 months | G months | 12 month | ns 🛛 Othe | er | | |
| 5 | | | | | | | | | |
| Print Name:Optometrist or Physician Who Provides Eye Examinations Address: | | | | | I agree to rel to a | 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) | | | |
| Signature: | trist or Physic | ian Who Pro | vides Eye Exan | ninations | Phone: | | | | |