Updated 8/1/18 KK

Registration Health Requirements

All requirement exams and forms are due on or before the first day of school. If proper documentation is not turned in by October 15th of the current year, ***your child is subject to exclusion from school.***

Grade	New to District	New to Illinois	Returning Student
Pre-K	Physical exam, immunization records	Physical exam, immunization records	Immunization records
Kindergarten	New physical exam, immunization records including K shots, eye exam, dental exam,	New physical exam, immunization records including K shots, eye exam, dental exam,	New physical exam, immunization records including K shots, eye exam, dental exam,
1st Grade	Physical exam, Immunization records	Physical exam, immunization records, eye exam.	n/a
2nd Grade	Physical exam, immunization records, dental exam	Physical exam, immunization records, eye exam, dental exam	Dental exam
3rd Grade	Physical exam, immunization records	Physical exam, immunization records, eye exam	n/a
4th Grade	Physical exam, immunization records	Physical exam, immunization records, eye exam	n/a
5th Grade	Physical exam, immunization records	Physical exam, immunization records, eye exam	n/a
6th Grade	New physical exam, immunization records including 6th grade shots, dental exam.	New physical exam, immunization records including 6th grade shots, dental exam, eye exam.	New physical exam, immunization records including 6th grade shots, dental exam.

7th Grade	Physical exam, immunization records	Physical exam, immunization records including 6th grade shots, eye exam.	n/a
8th Grade	Physical exam, immunization records	Physical exam, immunization records including 6th grade shots, eye exam.	n/a

Physical Examination:

1. All students entering kindergarten or first grade for the first time (no previous Kindergarten attendance), 6th grade students, and any student who enters an Illinois school for the first time, must turn in a valid physical examination **prior to the first day of student attendance**. Students without a valid physical exam after October 15th of the current school year are subject to exclusion from classes (CCSD 181, 2016).(CCSD 181, 2016).

2. In order to be valid, the physical exam must include the following (77 Ill. Admin Code §§ 665, 2017):

   - Health examinations shall be reported on the forms that the Department of Public Health and the Illinois State Board of Education prescribe for statewide use. The required form is the Certificate of Child Health Examination provided by the Department.

   - State of Illinois Certificate of Child Health Examination can be accessed and printed from: http://www.dph.illinois.gov/sites/default/files/forms/certificate-ofchild-health-examination-03032017.pdf

   - For transfer students from out of the State or out of the country, or from a federal Head Start program, a health form that is comparable to the Illinois requirements may be accepted only at the time of first entry into an Illinois school. (A statement by a physician or other health care provider indicating only that an examination was conducted is not acceptable.)

   - Exam must be dated.

   - Date must be within 12 months prior to the student's start date in district.

   - Child's gender

- Child's date of birth
- An evaluation of child's height, weight, BMI & blood pressure,
- System exams of the child including: skin, eyes, ears, nose, throat, mouth/dental; cardiovascular, respiratory, gastrointestinal, genito-urinary, neurological, and musculoskeletal evaluations; spinal examination; evaluation of nutritional status; lead screening and other evaluations deemed necessary by the health care provider.
- Lead screening for children <6 years of age, or children >6 years of age considered high risk by physician.
- A diabetes screening shall be included as a required part of each health examination. Diabetes screening is the assessment of an asymptomatic individual for risk factors for the purpose of identifying whether the individual is likely to have diabetes.
- The medical history section of the form shall be completed and signed by the parent or legal guardian of the student.
- For transfer students using out of state forms, the medical history section must include the same fields as found on the Illinois State form and signed by parent, and physician
- Participation in PE section must be filled out. If child requires modifications, they must be detailed by the examiner.
- If the student is required to have a sports physical in the year that coincides with the child health examination requirement, the Certificate of Child Health Examination may be accepted as proof of examination for interscholastic sports if the statement regarding participation in interscholastic sports is completed by the health care provider.

Immunizations

All students in preschool, kindergarten, 6th grade and any student who is new to District 181 must submit proof of up-to-date, accurate and complete immunization records **immediately prior to 1st day of attendance** (77 Ill. Admin Code §§ 665, 2017)**.** Illinois students without immunization records after October 15th of the current school year are subject to exclusion from classes (CCSD 181, 2016).

Transfer students from out of state/out of the country have 30 days from date of enrollment to submit valid immunization records(77 Ill. Admin Code §§ 665, 2017).

All students must provide evidence of being protected for diseases and at intervals listed per Illinois State Board of Education's 2018-2019 immunization timetable to be considered in compliance with state law (ISBE, 2018).

Students who have a medical contraindication to receiving a vaccination, should submit a physician letter, dated before October 15th of the school year, or after October 15th of the school year, upon enrollment which states:
- Reason for medical contraindication
- Date of next scheduled dose (if applicable)
- Signed and dated by physician

While it is not recommended, it is possible for students to have vaccinations (not the physical exam) waived due to parental religious objection. In order for a student to qualify under "religious objection" the following need to be submitted and reviewed by the school nurse:

Illinois Certificate of Religious Exemption for each child completed. See: https://www.isbe.net/Documents/immun-exam-gdlns-religious-exempt.pdf

*Please note, if your child qualifies under "religious exemption" they will be placed on susceptible lists at their school and are subject to exclusion from classes in the event of a vaccine-preventable disease outbreak (CCSD 181, 2016).

Dental Examination

Dental Examinations are required for all children in kindergarten, second, and sixth grades. The completed Proof of School Dental Examination Form is due by May 15th of the current school year[1,3].

Dental examinations completed 18 months prior to the May 15th deadline are acceptable. The child's final report card will be withheld until a completed dental examination is submitted, or the parent presents proof that a dental examination will take place within 60 days after May 15th[1,3].

The Superintendent or designee shall ensure that parents/guardians are notified of the dental examination requirement at least 60 days before May 15th of each school year.

Eye Examinations

Eye Examinations are required for each child entering kindergarten or upon initial entry to an Illinois School. This requirement does not apply to students entering an early childhood program for the first time. The Eye Examination Report must be submitted by October 15th of the current school year. Eye examinations completed within 12 months prior to October 15th of the current school year are acceptable (77 Ill. Admin Code §§ 665, 2017).

Hearing and Vision Screening

Vision and hearing screenings are performed by trained and certified Vision & Hearing staff in accordance with the Illinois Child Vision and Hearing Test Act [410 ILCS 205]. Vision screening is performed annually on all children in special education, children new to the district, and teacher/parent referrals. Vision screening is also performed beginning at age 3 in all licensed daycare/preschool programs. Once a child begins school, vision screening is performed in grades K, 2 and 8. Children wearing glasses or contact lenses are included in the screening program, however the vision screening assessment is not administered. At the time of the screening, the examiner checks the frames for breaks, and the lenses for scratches.

Please remember vision screening is not a substitute for a complete eye and vision evaluation by an eye doctor. Your child is not required to undergo the vision screening if an optometrist or ophthalmologist has completed and signed a report indicating that an examination has been administered within the previous twelve months. Hearing screening is performed annually on preschool children 3 years of age or older, and for all school age children in grades kindergarten, first, second and third, in a special education program, and/or have been referred by a teacher or parent; or are transfer students (77 Ill. Admin Code §§ 665, 2017).

Please contact the school nurse if you have any questions or would like further information regarding vision/hearing screenings.

References:

Community Consolidated School District 181 (2016). *7:100: Health examinations, Immunizations, and exclusion of students.* District 181 Policy Manual [Policy Manual] Clarendon Hills, IL: Community Consolidated School District 181. Retrieved from http://www.boarddocs.com/il/hccsdil/Board.nsf/Public#

Community Consolidated School District 181 (2016). *7:280: Communicable and chronic infectious disease.* District 181 Policy Manual [Policy Manual] Clarendon Hills, IL: Community Consolidated School District 181. Retrieved from http://www.boarddocs.com/il/hccsdil/Board.nsf/Public#

Illinois Administrative Code. 77 Ill. Adm. Code §§ 665 (2017). *Child and student health examination and immunization code.* Retrieved from http://www.ilga.gov/commission/jcar/admincode/077/07700665sections.html

Illinois State Board of Education (2018). *Clarification of the immunization status of students' compliance with state law for 2018-2019 school year.* Retrieved from https://www.isbe.net/Documents/Clarification-immunization-requirements-school.pdf

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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	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.

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Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)	Yes No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**

Diagnosis of asthma? 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. 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
Illinois Department of Public Health

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
Illinois Department of Public Health

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

IOCI 15-391

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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