Lockport Elementary School District 91
808 Adams Street
Lockport, Illinois 60441

Dear Parent/Guardian,

Please use the following information to help complete your child's health record for the upcoming school year.

The following are Physical, Eye, & Dental Requirements:

- **Physical Examination** (within the last 12 months of the start of school) including all components of the physical and required immunizations. We ask that the Health Examination form be turned in prior to the start of school in order to avoid the school exclusion date of October 15, as described in the school code of Illinois. **All children entering kindergarten, sixth grade, and any children registering from an out-of-state school or entering an Illinois school for the first time must have have an Illinois physical completed.**
- **Eye Examination** - Eye examinations are required for all students in Kindergarten or entering an Illinois school for the first time. The exam must be completed within one year before the start of school. Completed forms must be to the school by October 15 of the current school year.
- **Dental Examination** – A dental examination is required for all children entering kindergarten, second grade, and sixth grade by May 15 of the current school year. Dental exams must be dated within 18 months of the May 15 deadline.
- Children in **Special Education Programs (Early childhood, Phonological / Speech) or in the Early Learner Program** need to register with their home school district. A physical and immunization record is required for all children in any school program, therefore a documented physical/immunization form must be given to the school your child attends as well as your home school.

The following are Immunization and other health requirements:

- **Entering Pre-School Age Program**
  - 1 dose of MMR
  - 4 doses of DTP/DTaP/Td
  - HIB vaccine (primary series or proof of 1 dose at 15 months or older)
  - Pneumococcal conjugate vaccine series
  - 1 dose of Varicella or documentation of varicella disease documented by physician
  - 3 OPV series or IPV series (Polio)
  - Hepatitis B series
- **Entering Kindergarten:**
  - 2 doses of MMR
  - 4 or more doses of DTP/DTaP
  - 4 OPV series or IPV series (Polio)
  - 2 doses of Varicella or documentation of varicella disease documented by physician
- **Entering 6th- 8th grade:**
  - 2 doses of MMR
  - 3 or more doses of Polio
  - 1 dose of the Meningococcal Conjugate Vaccine - **NEW**
  - 1 dose of Tdap vaccine regardless of the interval since the last DTap, DT, Td dose
  - 2 doses of Varicella or documentation of varicella disease documented by physician
  - 3 or more doses of DTP/DTaP
  - 3 doses of Hepatitis B
- **Lead Screening - Mandatory for all first time entrants to preschool, kindergarten, and first grade.** The physician should complete a Lead Risk Questionnaire and document all necessary information on the physical.

Please look over your student's Health Examination form to ensure the Health Care provider completed the following:

1. All shot dates are entered and the Doctor / PA / APN has signed and dated both the immunization section and the physical section.
2. Height, weight, BMI, blood pressure, diabetes screening, and review of body systems are filled out.
3. Checked yes or no for physical education and interscholastic sports (serves as a sports physical).
4. **Parent/Guardian must complete and then sign and date the Health History section located on the backside of the Health Examination form.**

As a reminder, parents should always keep a copy of the physical for their own records before sending the original to school. To assure physicals get to the office they should be hand delivered or mailed directly to the office. In addition, if during the school year, there are any changes (i.e medications, major illness, surgeries, or allergies) in your child's health status, please call or send a note to the nurse's office to update your child's health record.

Note: Immunizations and physicals are provided through Will County Health Department.
For more information please contact the school nurse.

Revised 03/10/2016

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments:

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.

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?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	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**

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING (410 ILCS 45/6.2)

Name _____ Today's Date _____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes No Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher?	Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area?	Yes No Don't Know

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A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _____ Test 2: Blood Lead Result_____mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_____ _____

Signature of Doctor/Nurse Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

Illinois Department of Public Health
Guidelines for Blood Lead Screening and Lead Risk Assessment

- **Blood lead screening** is defined as obtaining a blood lead test. **Lead risk assessment** is defined as evaluation of potential for exposures to lead based on questionnaire responses.

- **It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or potential exposure to lead has been identified, regardless of child's age.**

- Federal mandates and the Illinois Department of Healthcare and Family Services' (HFS) policy require that all children enrolled in HFS medical programs be considered at risk for lead poisoning and receive a screening blood lead test prior to age **12 months and 24 months.** Children older than the age of 24 months, up to 72 months of age, for whom no record of a previous screening blood lead test exists, also should receive a screening blood lead test. **All children enrolled in HFS medical programs are expected to receive a blood lead test regardless of where they live.** (Consult *Handbook for Providers of Healthy Kids Services,* Chapter HK-203.3.1, for more blood lead screening and reporting information.)

- Illinois has defined ZIP code areas at high risk and low risk for lead exposure based on housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.

Childhood Lead Risk Assessment Questionnaire

- Complete the Childhood Lead Risk Assessment Questionnaire during a health care visit at ages 12 months and 24 months.
  - If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.
  - If any response is "YES" or "DON'T KNOW," obtain a blood lead test.
- Consider evaluating children before 12 months of age, depending on the area.
- If the child is age 3 years to 6 years ***and***
  1) there are any "YES" or "DON"T KNOW" answers ***and***
  2) has had two successive blood lead test results that were each less than < 10 mcg/dL with one of these tests at age 2 years or older ***and***
  3) risks of exposure to lead have not changed, **further blood lead tests are not necessary.**
- If the child is 3 years to 6 years of age, ***and***
  1) all answers to the Childhood Lead Risk Assessment Questionnaire are "NO," ***and***
  2) risks of exposure to lead have not changed, a blood lead test is not necessary.
- If the child is 3 years to 6 years of age and risks of exposures to lead have increased, obtain a blood lead test.
- Continue to use the Childhood Lead Risk Assessment Questionnaire through age 6.

For children living in Chicago:

- A blood lead test for children age 3 and younger should be obtained at 6, 12, 18, 24 and 36 months **OR** at 9, 15, 24 and 36 months.
- Children 4 years through 6 years of age with prior blood lead levels of <10 mcg/dL should have an annual risk assessment. A blood lead test should be performed if risk increases or if the child exhibits persistent oral behaviors.

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (For Deaf, Hard of Hearing Use Only) 800-547-0466
Printed by Authority of the State of Illinois
P.O. #5511502 2M 10/10

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

IOCI 0600-10

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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 _____

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 _____ (Month/Day/Year) Gender _____ Grade _____

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 _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

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
Department of Public Health
Eye Examination Waiver Form

Please print:

Student Name _____ Birth Date _____
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name _____ Grade Level _____ Gender ❑ Male ❑ Female

Address _____
(Number) (Street) (City) (ZIP Code)

Phone _____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

❑ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ALL KIDS.

❑ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

❑ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations: _____

_____

Signature _____ Date _____

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

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6/09

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