FORRESTVILLE VALLEY SCHOOL DISTRICT #221

SUPERINTENDENT
Mrs. Sheri Smith

March 1, 2017

Dear Parents or Guardians;

The **Illinois School Code** requires students to meet various requirements at certain grade levels. Please use this letter as a guide to the requirements your child needs to fulfill for school enrollment in the fall.

Preschool: Completed Illinois Physical Exam form (when first entering preschool), including physician verification of having received all required immunizations including: varicella and pneumococcal vaccines.

Kindergarten: Completed Illinois Physical Exam form including physician verification of having received all required immunizations including two doses of varicella vaccine. A completed professional eye examination and completed dental form.

2nd grade: Completed dental form.

6th grade: Completed Illinois Physical Exam form including physician verification of having received all required immunizations including: a Td booster, Meningitis vaccine, and 2 doses of varicella vaccinations. A completed dental form.

9th grade: Completed Illinois Physical Exam form including physician verification of having received all required immunizations including: a Td booster (if not received in 6th grade) and two doses of Meningitis vaccine (unless 1st dose was administered after 16yrs of age then only 1 is required).

Students first entering a school in Illinois from out of state are required to complete: a physical exam, professional eye examination and dental exam, all documented on Illinois forms.

Completed Dental forms are to be on file by May 15th. Students must have been seen by a dentist in the previous 18months of the deadline to complete the requirement.

If you object to this process for health reasons, a physician's statement is needed stating the required immunizations are detrimental to the health of the child. Objections to vaccinations due to religious beliefs must be submitted in writing stating supporting biblical scripture with references and parent signatures. Also, an Illinois Certificate of Religious Exemption must be completed and signed by parents and a MD, DO, APN or PA. The district is required to comply with state requirements when enrolling students into school. If the requirements stated above are incomplete as of October 15th, students will be dismissed from school until they can be completed.

If you have any questions, please leave me a message with a building secretary and I will return your call.

Sincerely,

Jennifer Nelson RN

Jennifer Nelson RN

P.O. Box 665 ◆ Forreston, IL 61030 ◆ PH (815) 938-2036 ◆ FAX (815) 938-9028

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

License Number _____

Address _____
_____

Phone _____

Signature _____

Date _____

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)

(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 _____ 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

Printed by Authority of the State of Illinois

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		Hospitalizations? When? What for?	Yes No			
Birth defects?	Yes No		Surgery? (List all.) When? What for?	Yes No			
Developmental delay?	Yes No		Serious injury or illness?	Yes No			
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.		
Diabetes?	Yes No		TB disease (past or present)?	Yes* No			
Head injury/Concussion/Passed out?	Yes No		Tobacco use (type, frequency)?	Yes No			
Seizures? What are they like?	Yes No		Alcohol/Drug use?	Yes No			
Heart problem/Shortness of breath?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No			
Heart murmur/High blood pressure?	Yes No						
Dizziness or chest pain with exercise?	Yes No						

Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Dental ☐ Braces ☐ Bridge ☐ Plate Other

Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes.
Bone/Joint problem/injury/scoliosis?	Yes No		**Parent/Guardian Signature** **Date**

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**

REQUEST FOR ADMINISTRATION OF MEDICINE

We recognize that there are children who are able to attend school because of the effective use of medication in the treatment of disabilities or illnesses. We firmly believe that medication should be administered at home and strongly discourage medications at school. Please check with your physician to see if there is any way to avoid your child taking medication at school. If there are no alternatives and it is absolutely necessary, a pupil who is required to take medication during the regular school day must comply with the school regulations. If you have any questions about these regulations, please contact our school nurse. These regulations include the following:

1) Notify the school nurse through the school secretary or teacher that your child must take medication while at school.
2) Written orders from the physician detailing the name of the drug, dosage, and directions for administering the medication must be on file at the school prior to administration of the medication.
3) Written permission is required from the parent or guardian of the pupil requesting that the school comply with the physician's order.
4) Medication must be brought to school in the pharmacy prescription bottle labeled with the child's name, name of medication, directions for taking, and the doctor's name who ordered it. It must be left at school and not transported back and forth between home and school. An extra labeled-bottle may be obtained from the pharmacy at a very small cost. Over-the-counter medication must be brought to school in the original container.
5) Any medication taken three times per day will be given at home unless specifically ordered at noon by the physician.
6) Medication is to be kept in the school office. Your child should be instructed by you to report to the office at the time he/she is to take the medication.

TO BE COMPLETED BY THE PHYSICIAN

Student Name _____ Grade _____

Prescription _____ Dosage _____

Time Taken at School _____ # of Days Given _____ to _____

Please note any reactions to this prescription to which nurse or teacher should be alert:

_____

Disease or illness for which medication is prescribed: _____

Comments: _____

Doctor's Signature _____ Date _____

TO BE COMPLETED BY THE PARENT

I request that the Forrestville Valley School District make a provision for my child to receive the medication prescribed according to the instructions above. I acknowledge that FVV School District and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the administration of the medication above and I indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of the medication above.

Parent/Guardian Signature _____ Date _____

PRINCIPAL'S APPROVAL

Principal Signature _____ Date _____