2021-2022 School Year

Kindergarten registration is accepted by appointment only at

Oakwood School
1130 Kim Place Street, Lemont.

To schedule an appointment contact Rachel at rrode@sd113a.org or

630/257-2286 extension 1100.

Registration packet and required documents are below.

Lemont-Bromberek Combined School District 113A
Kindergarten Registration

Registration is accepted at Oakwood School (1130 Kim Place, Lemont). Contact Rachel Rode at (630) 257-2286 extension 1100 or rrode@sd113a.org to schedule an appointment. Please provide the required forms/documents during your registration appointment.

REQUIRED:
- ☐ ORIGINAL Certified Birth Certificate
- ☐ Completed Registration Forms
- ☐ Proof of Residency

Student's Name _____ Grade Level: _____

PROOF OF RESIDENCY

As initial proof of residency, the person with legal custody of the student and with whom the student lives in Lemont-Bromberek CSD 113A must provide **ONE** document from Category A and **TWO** documents from Category B. Documents must show Your Name, Address (within District 113A boundaries) and Current Month or Year.

Do you: ☐ Own ☐ Rent ☐ Live in another's household*
Are you currently living in the house which you are proving residency? ☐ Yes ☐ No
If No, please explain: _____

CATEGORY A (ONE document required)	AND	CATEGORY B (TWO documents required)
☐ Current real estate tax (property tax) bill showing you as the taxpayer at your Lemont address ☐ Current home closing documents with proof of closing date (within 3 months AFTER closing) ☐ Current mortgage statement ☐ Lease/rental contract with signatures, dates and address PLUS current paid rent receipt (current, NOT EXPIRED) ☐ Letter of residence form in lieu of lease ☐ *Letter of residence (Affidavit) – when the person seeking to enroll a student is living with a District resident (along with proof of residency) ☐ Housing letter (military)		☐ Driver's license/State identification (current) ☐ Bank statement (current month) ☐ Cable/internet bill (current month) ☐ Cancelled check with imprinted name and address ☐ Credit card statement (current month) ☐ Homeowners/rental insurance (current year) ☐ Library card with name and address ☐ Paycheck or pay stub with imprinted name and address ☐ Public aid card ☐ Utility bill: electric, gas, phone or water **(can only use 1 from this category)** ☐ Vehicle registration (current year) ☐ Voter registration (current year)

☐ None of the documents in Categories A or B above is applicable because the student is homeless and eligible for enrollment under the Illinois Education for Homeless Children Act and/or McKinney-Vento Act.

GROUNDS FOR LEGAL CUSTODY

Check one of the following as applicable. If none is applicable, check one of the "Exceptions".

- ☐ Custody is exercised by a natural or an adoptive parent with whom the student resides.
- ☐ Custody has been granted by court order to a person with whom the student resides for reasons other than to have access to the educational programs of the District (attach copy of court order).
- ☐ Custody is exercised under a court approved short-term guardianship (attach copy of court order).
- ☐ Custody is exercised by a caretaker adult relative who is receiving aid under the Illinois Public Aid Code for the student who resides with that caretaker for purposes other than to have access to the educational programs of this District (attach copy of Public Aid documents).
- ☐ Custody is exercised by an adult who demonstrates that, in fact, he or she has assumed and exercises legal responsibility for the student and provides the student with a regular fixed nighttime dwelling for purposes other than to have access to the educational programs of this District (attach Evidence of Non-Parent's Custody, Control and Responsibility of a Student form).

EXCEPTIONS

- ☐ The student is homeless.
- ☐ The student is a foreign exchange student.
- ☐ The student has been placed with a foster parent or childcare facility by the Department of Children and Family Services outside the District, but the DCFS has determined it to be in the best interests of the student to maintain attendance in the District (attach copy of DCFS determination).

_____ Initial I understand that knowingly and willfully providing false information to a school district regarding the residency of a child for the purpose of enabling that child to attend any school of the district without payment of nonresident tuition is a crime; a Class C misdemeanor 105ILCS5/10-20.12b. The District will seek prosecution, to the full extent of the law, of any person who the District believes has committed any residency-related crime. Additionally, a civil lawsuit may be initiated by the District.

_____ Initial I understand that any student found to have been fraudulently registered will be immediately withdrawn from the district and the parent/guardian will be assessed the current per capita tuition for the time the student had been enrolled with District 113A.

_____ Initial I affirm that I live within the boundaries of Lemont-Bromberek CSD 113A, unless one of the exceptions above applies, and that the information presented in the Affidavit and in connection with any investigation of my residency or the residency of the student is true, complete and accurate and that I understand the penalties for fraudulent registration.

_____ _____
Signature of Parent/Guardian Date

Lemont-Bromberek Combined School District 113A
Enrollment Form

Grade _____
Student ID _____
SID_____
Fees _____

STUDENT INFORMATION – Please Print	
LAST Name of Student	FIRST Name of Student
MIDDLE Name	SUFFIX
GRADE	BIRTHDATE / /
GENDER ☐ Female ☐ Male	BIRTH COUNTRY
The State of Illinois requires for any student born outside the United States the district has to enter in the date of their first enrollment in a U.S. school. If your child was born outside the United States, is this the first time enrolling them at a school district inside of the United States? ☐ Yes ☐ No ☐ N/A If NO, what was the date of their first enrollment at a U.S. school? Date: _____/_____/_____	

HOME LANGUAGE SURVEY The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency.	
What is the child's native language? _____ _____	
Is a language other than English spoken in your home? ☐ Yes ☐ No If YES, what language? _____	Does your child speak a language other than English? ☐ Yes ☐ No If YES, what language? _____
If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.	

ETHNICITY AND RACE This information is to be filled out by the student's parents or guardians and both questions must be answered. The first question asks about the student's ethnicity and the second asks about the student's race. If you decline to answer either question, the school district is required to provide the missing information by observer identification.	
Part A: Is student Hispanic or Latino? (must check one) ☐ No, Not Hispanic or Latino ☐ Yes, Hispanic or Latino	**Part B: What is the student's race? (check one or more)** ☐ White ☐ Black or African American ☐ Asian ☐ Hawaiian or Pacific Islander ☐ American Indian or Alaskan Native
_____ Parent/Guardian Signature	_____/_____/_____ Date

PREVIOUS SCHOOL ATTENDED	
Full School Name	
City	State

STUDENT SERVICES This information is collected for students new to the district who may have had special services provided to them from a previous school district.	
Did your child have an Individualized Education Plan (IEP)?	☐ Yes ☐ No
Did your child have a 504 Plan?	☐ Yes ☐ No
Did your child receive English Language Learner Services?	☐ Yes ☐ No
Did your child receive Math Intervention?	☐ Yes ☐ No
Did your child receive Reading Intervention?	☐ Yes ☐ No

Lemont-Bromberek Combined School District 113A
Parent/Guardian/Emergency Information

PARENT 1/GUARDIAN 1 – Primary Contact

FIRST and LAST Name of Parent/Guardian

Address (including "Street", "Drive", etc.)	Apt. #/Unit #	City	State	Zip

Phone Number
Cell Phone (_____) _____-_____

Work Phone (_____) _____-_____

Home (_____) _____-_____

Does the child reside with this parent/guardian?
☐ Yes ☐ No

Is this parent/guardian currently serving in active duty in the military?
☐ Yes ☐ No

E-mail Address

Relationship to student

Parent/Guardian Status
☐ Married ☐ Divorced ☐ Other

Indicate any restrictions on release of the child to the non-custodial parent, as authorized in an Order of Protection, a legible copy of which must be submitted. NOTE: a divorce decree is NOT an Order of Protection.

PARENT 2/GUARDIAN 2 – Secondary Contact

FIRST and LAST Name of Parent/Guardian

Address (including "Street", "Drive", etc.) If different from parent/guardian 1	City	State	Zip

PHONE NUMBER
Cell Phone (_____) _____-_____

Work Phone (_____) _____-_____

Home (_____) _____-_____

Does the child reside with this parent/guardian?
☐ Yes ☐ No

Is this parent/guardian currently serving in active duty in the military?
☐ Yes ☐ No

E-mail Address

Relationship to student

ADDITIONAL EMERGENCY CONTACT/STUDENT RELEASE

List additional emergency contacts who would have permission to pick your child up and assume temporary care of your child if you cannot be reached during an emergency. These contacts cannot be the same as the parents or guardians listed above.

FIRST and LAST Name of Emergency Contact

Phone Number
(_____) _____-_____

Relationship to student

ADDITIONAL EMERGENCY CONTACT/STUDENT RELEASE

FIRST and LAST Name of Emergency Contact

Phone Number
(_____) _____-_____

Relationship to student

CHILDREN UNDER 18

Please list all children 18 years of age and under living in the household.

Name _____ Birthdate _____/_____/_____ Age _____

Name _____ Birthdate _____/_____/_____ Age _____

Name _____ Birthdate _____/_____/_____ Age _____

Name _____ Birthdate _____/_____/_____ Age _____

Lemont-Bromberek Combined School District 113A
Health Form

Student's Name (please print) _____ **Birthdate** _____/_____/_____ **Grade** _____

This questionnaire is designed to aid school staff in anticipating any health concerns that might affect your child's safety or learning.

Have you ever been told by a physician or health care professional that your child has:
☐ ADD/ADHD ☐ Asthma ☐ Bleeding disorder ☐ Bone/muscle problems ☐ Diabetes ☐ Ear/hearing problems.
☐ Eye/vision problems ☐ Heart condition ☐ Hospitalizations ☐ Learning disability ☐ Mental health condition (i.e., anxiety, depression, eating problems) ☐ Pans/Pandas ☐ Physical restrictions ☐ Serious injuries ☐ Seizures
☐ Skin condition ☐ Surgery

☐ Other _____

Does your child use an inhaler or nebulizer? ☐ Yes ☐ No

Does your child experience any of the following?
☐ Emotional concerns ☐ Fainting spells ☐ Frequent headaches ☐ Frequent stomach aches ☐ Nose bleeds
☐ Physical disability ☐ Poor appetite ☐ Tires easily

☐ Other _____

Will any of the above condition(s) limit/affect your child at school? _____
_____

Does your child have a life-threatening health condition?
☐ Yes ☐ No ☐ Describe: _____

Allergies
☐ Animals ☐ Bees ☐ Food ☐ Medications ☐ Mold ☐ Plants

☐ Other _____

Are any of the allergies life-threatening? ☐ Yes ☐ No Has your child been prescribed an Epi-Pen? ☐ Yes ☐ No

Please describe the allergic reaction and the treatment of each checked allergy:
_____

Does your child take any medication(s)?
☐ Yes* ☐ No

If yes, name of medication(s): _____

Purpose: _____

Will medication be needed at school? ☐ Yes** ☐ No Does your child wear hearing aids? ☐ Yes ☐ No

* If yes, a district nurse will contact you for further information if needed.
** If your child needs to take medication at school, please contact the school nurse for the necessary authorization form. This form must be completed prior to any medication being brought to school.

Oakwood – Mrs. Earnest (630) 257-2286 ext. 1102 River Valley – Mrs. Dellaportas (630) 257-2286 ext. 2102
Old Quarry – Mrs. Iazzetto (630) 257-2286 ext. 4102

☐ **My child has no health conditions at this time.**

I understand the information given above will be shared with appropriate school staff to provide for the health and safety of my child.

_____ _____
Signature of Parent or Guardian Date

STATUS OF PHYSICAL AND IMMUNIZATION, DENTAL AND VISION RECORDS FOR NEW STUDENTS

I understand that my child is being admitted to school on a temporary basis awaiting the completion of his/her health file. Physical and immunization records along with dental and vision records must be provided by the previous school attended or by the parent/guardian. Thirty calendar days from the enrollment date (first day child starts school), he/she must have a physical, dental and vision exam and complete record of immunizations on file at school in order to remain in attendance (Illinois School Code, 5/27-8:1; District 113A Policy 7:100). I also understand that it is my responsibility to check with school authorities to determine what, if anything, may be required to bring my son's or daughter's records into compliance. Forms can be found at www.sd113a.org - Parents – Health Services.

_____ _____
Signature of Parent or Guardian Date

Lemont-Bromberek Combined School District 113A
Transportation Form

Student's Name _____ **Birthdate** _____/_____/_____ **Grade Level** _____

A transportation form must be completed for each student. Students that live 1.5 miles or further from their school will be eligible for free bus service. If a student lives within 1.5 miles from school parents should contact Pat Crean, Director of Operations, at pcrean@sd113a.org or (630) 257-2286 extension 2803 to inquire if they qualify for bus service.

District 113A School: ☐ Oakwood School (Early Childhood) ☐ Oakwood School (Grades K-2)
☐ River Valley School (Grades 3-5) ☐ Old Quarry Middle School (Grades 6-8)

Non-Public School: ☐ St. Al/St. Pat ☐ SS Cyril ☐Everest

LAST Name of Student	FIRST Name of Student
GRADE	BIRTHDATE / /
GENDER ☐ Female ☐ Male	PHONE NUMBER
ADDRESS (including "Street", "Drive", etc.)	CITY STATE ZIP

If eligible, will your child require bus service for the school year?

☐ Yes ☐ No

If yes, please complete the sections below.

Parent/Guardian Name	Email Address
Emergency Contact Name	Emergency Contact Phone Number

If the morning pickup location or afternoon drop off location is different from your home address complete the section below. Transportation services will be provided to one address only 5 days a week.

Daycare/Babysitter Address: _____

BUS ASSIGNMENTS WILL BE MAILED IN EARLY AUGUST
ALL REQUESTS SHOULD BE MADE BY EMAIL TO pcrean@sd113a.org

*****WE WILL NOT ACCEPT ADDITIONS OR CHANGES ONE WEEK PRIOR TO AND THREE WEEKS AFTER THE BEGINNING OF THE SCHOOL YEAR*****

Office Use Only

☐ New Student ☐ Address Change

☐ EC-AM ☐ EC-PM ☐ K-AM ☐ K-PM

Student Start Date _____

Student ID _____

Sent/Emailed to Transportation _____

KINDERGARTEN

Your child will receive a name/desk tag, please indicate how you would like his/her name printed on their place marker. This is the name your child will be called and learn to print.

_____
First Name Last Name

To help us to get to know our child, please take a few minutes to answer this questionnaire. Please print your responses. Thank you.

Child's Full Name:						
Birth Date:						
My child is the:	oldest	middle	youngest	only	twin	triplet
Number of sisters:			Number of brothers:			

Did your child attend pre-school:	yes	no
Length of day:	full-day	half-day
Please list the name of the pre-school:		

Did your child receive Early Intervention Services?	yes	no
If yes, please tell us where:		
Please check any/all services your child received for Early Intervention:		
_____ Academic Support	_____ Speech/Language	
_____ Behavior Support	_____ Other	
_____Occupational Therapy	_____Wrap-Around Services	
_____Physical Therapy	Agency:	

What is the most important thing you would like us to know about your child?

_____

_____

Does Dyslexia and/or significant reading difficulties run in your family? (Yes/No/Unsure/NA)

_____

If you have other specific information that you would like to share please contact Kate Kwasny or Ryan Talaga via email at kkwasny@sd113a.org or rtalaga@sd113a.org.

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				**Comments:** * indicates invalid dose		
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.

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** **BMI PERCENTILE** **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

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City		ZIP Code
Name of School:	ZIP Code	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name		

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other_____

To be completed by dentist:

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ 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 **Urgent Treatment —** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Additional comments: _____

Signature of Dentist _____ License #:_____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

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

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

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

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

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

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
6/09

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