



FORRESTVILLE VALLEY SCHOOL DISTRICT #221

2023 – 2024 School Year

Dear Parents/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 a completed dental form.

2nd grade: A completed dental form.

6th grade: Completed Illinois Physical Exam form including physician verification of having received all required immunizations including: a Td booster and Meningococcal vaccine. A completed dental form.

9th grade: Completed Illinois Physical Exam form including physician verification of having received all required immunizations including: a Td booster and one dose of Meningitis vaccine. A completed dental form.

12th grade: Proof of 2 meningococcal vaccinations.

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 15, 2024. Students must have been seen by a dentist in the previous 18 months of the deadline to complete the requirement, anytime on or after November 15, 2022.

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



State of Illinois Certificate of Child Health Examination

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

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)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> 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
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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 <small>Month/Day/Year</small>			Sex	School			Grade Level/ ID			
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER																			
ALLERGIES <small>(Food, drug, insect, other)</small>		Yes	No	List:															
MEDICATION (Prescribed or taken on a regular basis)		Yes	No	List:															
Diagnosis of asthma?				Yes	No	Child wakes during night coughing?				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	Surgery? (List all.) When? What for?				Yes	No		
Developmental delay?				Yes	No	Serious injury or illness?				Yes	No	TB skin test positive (past/present)?				Yes*	No		
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.				Yes	No	TB disease (past or present)?				Yes*	No	Tobacco use (type, frequency)?				Yes	No		
Diabetes?				Yes	No	Alcohol/Drug use?				Yes	No	Family history of sudden death before age 50? (Cause?)				Yes	No		
Head injury/Concussion/Passed out?				Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other													
Seizures? What are they like?				Yes	No	Information may be shared with appropriate personnel for health and educational purposes.													
Heart problem/Shortness of breath?				Yes	No	Parent/Guardian Signature				Date									
Heart murmur/High blood pressure?				Yes	No														
Dizziness or chest pain with exercise?				Yes	No														
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____																			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																			
Ear/Hearing problems?				Yes	No														
Dental/Orthodontic 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 <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>																			
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 <input type="checkbox"/> No <input type="checkbox"/>				Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/>				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 <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read _____ Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported _____ Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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																
Skin			Endocrine				Normal	Comments/Follow-up/Needs											
Ears			Screening Result:				Gastrointestinal												
Eyes			Screening Result:				Genito-Urinary	LMP											
Nose			Neurological																
Throat			Musculoskeletal																
Mouth/Dental			Spinal Exam																
Cardiovascular/HTN			Nutritional status																
Respiratory			<input type="checkbox"/> Diagnosis of Asthma				Mental Health												
Currently Prescribed Asthma Medication:																			
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																			
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																			
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>						INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>													
Print Name						(MD,DO, APN, PA) Signature						Date							
Address						Phone													



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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Last Name		First Name	
Student's Race/Ethnicity:				
<input type="checkbox"/> White	<input type="checkbox"/> Black/African American	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Asian	
<input type="checkbox"/> Native American	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> Multi-racial	<input type="checkbox"/> Unknown	
<input type="checkbox"/> Other _____				

To be completed by dentist:

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

- | | |
|--|----------------------------------|
| <input type="checkbox"/> Restorative Care — amalgams, composites, crowns, etc. | Appointment Date: _____ |
| <input type="checkbox"/> Preventive Care — sealants, fluoride treatment, prophylaxis | Appointment Date: _____ |
| <input type="checkbox"/> Pediatric Dentist Referral Recommended | Treatment Completion Date: _____ |

Additional comments: _____

Signature of Dentist _____ License #: _____ 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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____



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 _____)