School District 105
School Health Office

GURRIE PHONE: (708)482-2720 FAX: (708)482-2724
HODGKINS PHONE: (708)482-2740 FAX: (708)482-2728
IDEAL PHONE:(708)482-2750FAX: (708)482-2729
SEVENTH AVENUE PHONE: (708)482-2730FAX: (708)482-2726
SPRING AVENUE PHONE: (708) 482-2710FAX: (708)482-2725

Dear 5th Grade Parents/Guardians,

A physical exam and immunizations are required for your student's entry into 6th grade. Students are not able to start 6th grade without these. Don't wait! You can start getting these done now. Turn them in to your school's nursing office as soon as they are completed.

Health Examination & Immunizations

- The attached physical examination form must be *fully* completed. **Parents, make sure to fill out the Health History section on the top of the back page.**
- Dates of all immunizations your child has received must be recorded on the front page with health care provider signature and date.
- The additional required immunizations for 6th grade students are:
  - **Tdap – Proof of 1 dose on or after the 11th birthday**
  - **Varicella (chickenpox)-2 doses**
  - **Meningococcal (meningitis)-1 dose on or after the 11th birthday**

If your child is medically exempt from any immunizations, a note from your doctor with an explanation is required. If a religious objection exists, an Illinois Certificate of Religious Exemption is required.

Dental Examination

- The attached state form is due to the school by May 15th of the school year your student attends 6th grade.

Please call the nursing office if you have any questions at all.

Queridos Padres/ Guardianes de Quinto Grado,

El examen físico y vacunas son requeridos para la entrada de su hijo a sexto grado. Los estudiantes no pueden empezar sexto grado sin estos requisitos. No espere! Usted puede empezar a completar estos documentos ya mismos. Entréguelos a la enfermera de su escuela tan pronto estén completos.

Examen de Salud y Vacunas

- El formulario del examen físico adjunto tiene que ser completado en su *totalidad*. **Los Padres deben asegurarse de llenar la sección de Historia de la Salud en la parte superior de la página de la parte de atrás.**
- Fechas de todas las vacunas que su niño ha recibido deben ser registradas en la primera página con la firma del doctor y la fecha.
- Las vacunas adicionales que son requeridas para estudiantes de sexto grado son:
  - **Tdap – Prueba de 1 dosis o después del 11 cumpleaños**
  - **Varicella (chickenpox)-2 dosis**
  - **Meningocócica (meningitis) -1 dosis en o después del 11 cumpleaños**

Si su hijo está médicamente exento de alguna vacuna, una nota de su médico con una explicación es necesaria. Si existe una objeción religiosa, un certificado de exención religiosa de Illinois es necesaria.

Examen Dental

- La forma del Estado que esta adjunto con esta nota tiene que ser mandada a la escuela antes 5/15 del año escolar su estudiante asiste sexto grado.

Por favor llame a la oficina de la enfermera si tiene alguna pregunta.

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.

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

Nombre del Estudiante			**Fecha de Nacimiento**	**Sexo**	**Escuela**	**Grado / Núm. De Ident.**
Apellido	Nombre	Inicial	Mes / Dia / Año			

HISTORIAL DE SALUD **PARA SER COMPLETADO Y FIRMADO POR EL PADRE / TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD**

ALERGIAS (Alimentos, drogas, insectos, otro)				**MEDICINAS** (Anote todas las recetadas o tomadas con regularidad.)			
¿Diagnosis de Asma? ¿Niño(a) despierta tosiendo en la noche?	Sí Sí	No No	Indique Severidad	¿Pérdida de las Funciones de uno de los pares de Órganos? (Ojos /Oídos / Riñones / Testículos)	Sí	No	
¿Defectos de Nacimiento?	Sí	No		¿Hospitalizaciones? ¿Cuándo? ¿Para Qué?	Sí	No	
¿Retrasos del Desarrollo?	Sí	No					
¿Problemas De La Sangre? Hemofilia, Glóbulos Falciformes, Otro Explique	Sí	No		¿Cirugía? (Anótelas Todas) ¿Cuándo? ¿Para Qué?	Sí	No	
¿Diabetes?	Sí	No		¿Heridas Graves o Enfermedad?	Sí	No	
¿Herida de la Cabeza / golpe / desmayo?	Sí	No		¿Prueba positiva de la piel para el TB (Pasado o Presente)?	Sí *	No	*Si contestó sí, referencia al departamento de salud local
¿Convulsiones? ¿Cómo Se Manifiestan?	Sí	No		¿Enfermedad de TB (Pasado o Presente)?	Sí *	No	
¿Problemas Cardiacos / Falta de Respiración?	Sí	No		¿Uso de Tabaco (Tipo, Frecuencia)?	Sí	No	
¿Soplo Cardiaco / Presión Arterial Alta?	Sí	No		¿Uso de Alcohol / Drogas?	Sí	No	
¿Mareos O Dolor De Pecho Al Hacer Ejercicio?	Sí	No		¿Historial Familiar de Muerte Repentina antes de los 50 años? (¿Causa?)	Sí	No	
¿Problemas con los Ojos / Visión? Lentes • Lentes de Contacto • Ultimo Examen _____ ¿Otras Preocupaciones? (bizco, párpados caídos, entrrecerrar los ojos, dificultad cuando lee)				Dental • • Ganchos • • Puente • • Placas Otro ¿Otras Preocupaciones?			
¿Problemas de Audición?	Sí	No		La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.			
¿Problemas de los huesos / Articulaciones / Heridas / Escoliosis?				**Firma del Padre / Tutor**		Fecha	

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:______________

Estado de Illinois
Departamento de Salud Publica

FORMULARIO COMPROBANTE DEL EXAMEN DENTAL ESCOLAR

La ley de Illinois (Child Health Examination Code, 77 Ill. Código Administrativo 665) índice que todos los niños en kínder, segundo, sexto, y noveno grados en escuela pública, privado, o parroquial adquieran examinación dental. La examinación se tiene que haber hecho entre 18 meses antes de 15 Mayo del año escolar. Un dentista licenciado tiene que hacer el examen, firmar y ponerle fecha a esta Formulario Comprobante de Examen Dental Escolar. Si no puede obtener este examen requerido, completa el Formulario de Renuncia Voluntaria del Examen Dental Escolar

Este examen importante le dejara saber si hay algún problema que requiere atención de un dentista. Los Niños necesitan buena salud bucal para habla con confianza, expresar se, ser saludables y ser listos para aprender. La salud bucal malo ha sido relacionado con bajo actuación escolar, malas relaciones sociales, y menos éxito más adelante in la vida. Por esta razón, le damos gracia por su contribución al salud y bien estar de su niño.

Para ser completado por el padre/madre (por favor impresión):

Nombre del Estudiante:	Apellido	Nombre	Inicial	Fecha de Nacimiento: (Mes/Dia/Año)
Dirección:	Calle	Ciudad		Código Postal
Nombre de la Escuela:		Código Postal	Grado:	Sexo: □ Masculino □ Femenino
Nombre del padre/madre o encargado				
Raza/Etnicidad del Estudiante: □ Blanco □ Nativo de Alaska o Indio Americano □ Nativo de Hawái o otras islas del Pacífico	□ Hispano/Latino □ Afroamericano	□ Asiático □ Multirracial	□ Otro ____________ □ Desconocido	

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: ____________

Health Community Resources for Families

If you have Medicaid and need to find a health care provider:

- Call the Health Care Benefits Helpline at (866)468-7543.
- Or the customer service number on the back of your medical card.

If you have Medicaid and need to find a dental care provider:

- Call DentaQuest: (888)286-2447.

If you have Medicaid and need transportation assistance to appointments:

- Call First Transit: (877) 725-0569.

If you do not have medical insurance:

- To Apply for Illinois AllKids (comprehensive healthcare for kids): 1-866-All-Kids (1-866-255-5437) or https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/default.aspx
- Pillars Community Health (formerly Community Nurse Health Center) can help families find plans and apply for benefits and offers a sliding fee scale for uninsured persons. Call:708-PILLARS (708-745-5277) pillarscommunityhealth.org

Recursos de Salud de la Comunidad para las Familias

Si usted tiene Medicaid y necesita encontrar un proveedor de salud:

- Llame a la línea de ayuda de Beneficios de Salud al (866)468-7543.
- O, al número de servicio al cliente en el respaldo de su tarjeta médica.

Si usted tiene Medicaid y necesita encontrar un proveedor de salud dental:

- Llame a DentaQuest: (888)286-2447.

Si usted tiene Medicaid y necesita asistencia para transporte para ir a las citas:

- Llame a "First Transit": (877) 725-0569.

Si usted no tiene Seguro médico:

- Para aplicar al Illinois AllKids (cuidados de salud comprensivos para niños): llame al 1-866-All-Kids (1-866-255-5437) o ingrese a: https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/default.aspx
- Salud Comunal Pillars (que es ahora el nuevo nombre de Community Nurse Health Center), puede ayudar a las familias a encontrar planes y aplicar por beneficios y ofrece costos de escala menores para personas sin seguro. Llame a: 708-PILLARS (708-745-5277) pillarscommunityhealth.org

01/08/18