Dear Kindergarten Parents:
A physical exam and immunizations are required for your student's entry into Kindergarten. Students are not able to start Kindergarten 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. A dental examination and vision examination are also required by the dates below.

1) **Current Physical Examination:**
   ***Physical must have documentation of all up-to-date immunizations. Parents, make sure to fill out the Health History section on the top of the back page.**

   ***BMI (body mass index), Diabetes Screening, and Lead Risk Questionnaire sections must be completed by the doctor's office (check these before you leave the medical office).**

2) **Dental Examination due by 5/15 of the year your student attends kindergarten**

3) **Vision Examination due by 10/15 of the year your student attends kindergarten**

Estimados Padres de Kindergarten:
Un examen físico y vacunas son requeridos para la entrada de su hijo a Kindergarten. Los estudiantes no pueden empezar Kindergarten sin estos documentos. No espere! Usted puede empezar a completar estos documentos ahora mismos. Entréguelos a la oficina de enfermería de su escuela tan pronto estén completos. Un examen dental y examen de la vista también son requeridos antes de las fechas mencionadas en la parte de abajo.

1) **Examen Físico Corriente:**

- **El examen físico debe tener la documentación de todas las vacunas actuales. Padres, asegúrense de llenar la sección marcada Historia de Salud en la parte superior de la página de atrás.**
  *** BMI(índice de masa corporal), Prueba para la Diabetes y de Riesgos de Plomo Secciones de preguntas deben ser completadas por el consultorio del médico (Por favor asegúrese que esta parte esté completa antes de salir del consultorio).**

2) **Examen Dental ,completo antes de 5/15 del año escolar su estudiante asiste Kinder.**

3) **Examen de la Vista,completo antes de 10/15 Del año escolar su estudiante asiste Kinder.**

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

Nombre del Estudiante			Fecha de Nacimiento	Sexo	Escuela	Grado / Núm. De Ident.
Apellido	Nombre	Inicial	Mes / Día / 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 • Último 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:_____

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

Printed by Authority of the State of Illinois

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: _____

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete 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 October 15 of the year the child enters an Illinois school.

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

Birth Date _____ (Month/Day/Year) Sex _____ 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

Refraction:	**Distance**			**Near**
	Right	Left	Both	Both
Unaided Visual Acuity	20/	20/	20/	20/
Best Corrected Visual Acuity	20/	20/	20/	20/

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	❑	❑	❑	_____
Internal Exam (media, lens, fundus, etc.)	❑	❑	❑	_____
Neurological Integrity (pupils)	❑	❑	❑	_____
Binocular Function (stereopsis)	❑	❑	❑	_____
Accommodation and Vergence	❑	❑	❑	_____
Color Vision	❑	❑	❑	_____
IOP (glaucoma)	❑	❑	❑	_____
Oculomotor Assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

Diagnosis

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

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses 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 who provides eye examinations

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 _____
Optometrist or Physician who provides eye examinations

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

Printed by Authority of the State of Illinois
5/08

IISG08-1048

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