South Holland School District 150

District Office
848 East 170th Street
South Holland, Illinois 60473
Phone: 708.339.4240 – Fax: 708.339.4244
www.sd150.org

HEALTH PACKET

Dear Parents/Guardians:

Students entering Pre-K, Kindergarten, 6th grade and students newly transferred into Illinois are required by Illinois Regulation Code 27-8.1 to have updated immunization shots and a current physical. Illinois Public Act 95-671 requires all students entering **Kindergarten** and any student enrolling for the first time to have an eye examination by a licensed eye doctor or an optometrist.

Newly mandated by the State of Illinois, all students entering the 6th grade must receive 1 dose of Meningococcal vaccine. Also, students entering Kindergarten, 1st grade or 6th, 7th, and 8th grades must show proof of having 2 doses of the Varicella vaccine. Lastly, students entering 6th, 7th and 8th grades will be required to show proof of receipt of one dose of Tdap vaccine (combined tetanus, diphtheria, pertussis).

As for all Illinois mandated health requirements, enclosed are the necessary papers that must be fully completed before your child enters the 2018-2019 school year. This packet includes the following:

- Certificate of Child Health Examination Form
- Health Rules and Regulations Form; listing required immunizations
- State of Illinois Eye Examination Report Form
- The Lead Risk Assessment Questionnaire (Pre-K, Kindergarten or 1st grades)
- Dental Examination Form (Completed by May 1, 2019 for Kindergarten, 2nd and 6th grades)
- Permission to give Prescription and Non-Prescription Medication Form
- Medication Policy
- Immunizations clinics

Bring a copy of your child's current immunizations records when visiting clinics. After obtaining your child's updated health records, you may turn his/hers records in during school registration in August. I highly recommend that you have your child immunized now to avoid the last-minute rush and make a copy of your child's physical and immunizations forms for your records prior to turning them in to the school.

As dictated by law, your child will not be allowed to participate in gym and may be excluded from school, if the required documents are not provided.

If you have any questions, please call the nurse's office at 339-8500 or 339-4433.

Thank you in advance.

Respectfully,

District School Nurse

Cc: Dr. Denise Julius, Superintendent
Mrs. Carla Cunningham, Principal of Greenwood
Dr. Jerome Ferrell, Principal of McKinley

HEALTH RULES & REGULATIONS

According to Section 27-8.1 of the Illinois School code, all students entering school for the first time (Preschool, Kindergarten or 1st grade) and again before entering the 6th & 9th grades, are required to have a physical examination. The health exam must be performed by a physician. The results of the exam and the full immunization record are to be recorded on the required state form which is the **CERTIFICATE OF CHILD HEALTH EXAMINATION FORM**. The physician must date and sign the physical exam portion and the immunization section.

Out of state or country transfer students must present a health exam on a comparable Illinois form that was completed within 1 year prior to entering an Illinois school for the first time.

In addition to the physical exam, every student in school is required by state law to show proof of immunization against the following diseases:

1. **DPT** (Diphtheria, Pertussis, Tetanus) – 4 Doses – 3 doses prior to entering Pre-K, booster dose after 4th birthday, before entering Kindergarten.
2. **T-DAP** (Diphtheria, Pertussis, Tetanus) --- 1 Dose prior to entering 6th, 7th and 8th grades
3. **TOPV** (Trivalent Oral Polio Vaccine) – 4 Doses – 3 doses prior to entering Pre-K, booster dose after 4th birthday, before entering Kindergarten.
4. **MEASLES** (10 day/hard) – 2 Doses – 1st dose prior to entering Pre-K, 2nd dose after 4th birthday, prior to entering Kindergarten.
5. **MUMPS** – 2 Doses – 1st dose prior to entering Pre-K, 2nd dose after 4th birthday, prior to entering Kindergarten.
6. **RUBELLA** – (German or 3 day Measles) – 2 Doses – 1st dose prior to entering Pre-K, 2nd dose after 4th birthday, before entering Kindergarten.
7. **MENINGOCOCCAL—1** Dose—prior to entering 6th grade or after the 10th birthday
8. **HEPATITIS B** – Required for all Pre-K and 6th grade students. Required 3 doses (1st and 2nd dose minimum of 4 wks. Apart. Third dose minimum 2 months after 2nd dose).
9. **HiB** – (Haemophilus Influenza)-Required for entrance to Pre-K. Dosage according to pediatrician schedule.
10. **VARICELLA**-(Chickenpox) – 2 Doses—The first dose after 12 months, the 2nd dose before entering Kindergarten. Students in older grades, 2nd dose prior to entering 6th, 7th, and 8th grade; or proof of disease.
11. **LEAD SCREENING** – Required for children entering Pre-K and Kindergarten. The Lead Risk Assessment Questionnaire must be completed. Any single "Yes" or "Don't know" answer requires a blood lead test.
12. **DIABETES SCREENING** – State law requires diabetes screening to be completed on all school physicals. Testing is not required.

ABSENCES: All parents are required to phone in their child's absence before 9:00 AM of each absent day.
GREENWOOD – 339-4433, McKINLEY ELEM. – 339-4748, McKINLEY JR. HIGH – 339-8500
All students (K-8) must return with a signed note from parent stating cause of illness if out for 3 days.
DOCTOR'S NOTE: If absence exceeds 3 days.

ILLINOIS DEPARTMENT OF PUBLIC HEALTH and THE CENTER FOR DISEASE CONTROL

Certain communicable diseases require specific amounts of isolation days from school. A doctor's note is **required** before a student may return to school for the following diseases:

1. Confirmed Strep throat and/or Scarlet Fever
2. Hepatitis
3. Mononucleosis
4. Whooping Cough
5. Ringworm (on medication for 24 hours before returning to school.
6. Diphtheria
7. Polio
8. Typhoid Fever
9. Any undiagnosed rash
10. "Pink-eye" (on medication 24 hours before returning. No doctor's note needed.)
11. Novel Influenza A {H1N1} virus (Swine Flu)

Listed are required days for exclusion:
1. Chickenpox – 6 days 2. Mumps – 9 days 3. Measles – 7 days 4. Influenza A {H1N1} - 7-10 days

INDOOR RECESS:
If a student has been ill, he/she may remain indoors for **2 days** only if a parent requests and a note is set to school. Extended indoor recess requires a note from the doctor.

GYM EXCLUSIONS:
If a student has been ill or injured, he/she may be excused from gym class for 2 days only if a parent requests and a note is sent to school. Extended exclusion requires a note from the doctor.

MEDICATIONS IN SCHOOL:
A permission request form for prescription and nonprescription medicine must be completed by both the physician and parent. Call school nurse for further information.

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:**		
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**

MEDICATION POLICY

School District 150, in accordance with PA#86-1441, established an Advisory Committee to develop a medication policy. The committee includes administrators, school nurses and parents. The purpose of administering medications in school is to help each child maintain an optimal state of health that may enhance his/her educational plan. The medications shall be those required during school hours that are necessary to provide the student access to the educational program.

The intent of these guidelines is to reduce the number of medications given in school, yet assure safe administration of medications for those children who require them. Any medications, including non-prescription drugs, given in school shall be prescribed by a licensed physician or healthcare provider.

A written order for prescription and non-prescription medications must be obtained from the child's licensed physician or healthcare provider.

THE ORDER SHALL INCLUDE:

Child's Name and Date of Birth
Licensed Prescriber and Signature
Licensed Prescriber Phone/Emergency Number
Name of Medication
- Dosage
- Route of administration
- Frequency and time of administration

Date of Prescription
Discontinuation Date
Diagnosis Requiring Medication
Other Medications Child is receiving

PRESCRIPTION MEDICATION SHALL DISPLAY:

Child's Name
Prescription Number
Medication Name/Dosage
Administration Route and/or Other Directions
Date and Refill
Licensed Prescriber's Name
Pharmacy Name, Address and Phone Number
Name of Initials of Pharmacist
Medication must be brought to school in the original package or an appropriately labeled container.

Over the Counter Medications (OTC) (non-prescription) medications shall be brought in with the manufacturer's original label with the ingredients listed and the child's name affixed to the container. In addition to the licensed prescriber's orders, a written request shall be obtained from

parent(s)/guardian requesting the medication be given during school hours. The request must include the parent(s)/guardian's name and phone number in case of emergency. It is the parent(s)/guardian's responsibility to assure that the licensed prescriber's order, written request and medication are brought to the school.

Medications will be stored in a separate locked cabinet. Medications requiring refrigeration will be refrigerated in a secure area.

Consistent with Senate Bill 90979, Asthma Inhalers may be carried and self-administered if written authorization is given on the Medication Authorization form by the physician and parent(s).

Consistent with Senate Bill 2898, Epinephrine Auto-Injector may be carried and self-administered if written authorization is given on the Medication Authorization form by the physician and parent(s).

The parent/guardian will be responsible at the end of the treatment regime for removing from the school any unused medication which was prescribed for their child. If the parent/guardian does not pick up the medication at the end of the school year, the nurse will dispose of the medication. If you have any questions, please call the nurse at Greenwood (339-4433) or McKinley (339-8500).

BOARD OF EDUCATION DISTRICT #150
SOUTH HOLLAND, COOK COUNTY, ILLINOIS

PERMISSION REQUEST FOR PRESCRIPTION AND NON-PRESCRIPTION MEDICATION

School District #150 requires that all students who need medication during the school hours **must do** the following:

1. This form must be completed by both the **PHYSICIAN** and **PARENT/GUARDIAN**, and returned to the Health or Principal's office.
2. **Parent/Guardians** must bring the medication in the original prescription bottle, properly labeled by the pharmacist, physician or manufacturer, to the Health or Principal's office.
3. **A PARENT/GUARDIAN** or **DELEGATED ADULT** must return to the school for the unused portion of the medication within ten (10) days or the medication will be disposed of by the nurse.

Name of Student _____ School _____

Date of Birth _____ Teacher _____ Grade _____

TO BE COMPLETED BY THE PHYSICIAN

Diagnosis: _____
Medication: _____
Dosage: _____ Specific time to be given: _____
Side Effects: _____
Date to be discontinued: _____
Other medications child is receiving: _____

_____ /X _____
Printed Name of Physician Physician's Signature

_____ /X _____
Physician's Telephone # & Emergency Number Date form completed

****

TO BE COMPLETED BY THE PARENT/GUARDIAN

I hereby authorize my child to receive the medication(s) prescribed above under the supervision of the school nurse or authorized staff member to give medication.

Parent/Guardian **X** _____ Date **X** _____

I can be reached at the following number in case of emergency: _____

****

Physician Authorization for Self-Administration of Asthma Medication or Epinephrine Auto Injector

In compliance with Senate Bill 90979 (August 17, 2001), I authorize this student to carry and self-administer the above mentioned asthma medication. **YES** _____ **NO** _____

In compliance with Senate Bill 2898 (May 19, 2006), I authorize this student to carry and self-administer the above named epinephrine auto-injector due to risk of anaphylaxis. **YES** ____ **NO** ____

_____/X_____

Printed Name of Physician Physician's Signature

_____/X_____

Physician's Telephone # & Emergency Number Date form completed

****

Parent/Guardian Agreement Authorizing Self-Administration of Asthma medication or Epinephrine Auto-Injector

In compliance with Senate Bill 0979 (August 17, 2001), I agree with the doctor statement above to authorize my child to carry and self-administer the above named asthma medication. **YES** _____ **NO** _____

In compliance with Senate Bill 2898 (May 19, 2006), I agree with the doctor statement above to authorize my child to carry and self-administer an epinephrine auto-injector. **YES** ____ **NO** _____

I/We understand that according to state statute the School District and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from self-administration or use of an epinephrine auto-injector and/or of the asthma medication by my/our child. I/we must indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration or use of an epinephrine auto-injector and/or of asthma medication by my/our child. I/we further understand that this permission for self-administration or use of an epinephrine auto-injector and/or of asthma medication is effective for this school year only and must be renewed each subsequent school year if desired. I/we understand that a copy of this permission will be kept in my /our child's medical file.

_____ _____ _____

Parent's Signature Date Parent's Emergency Phone number

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

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)

Address _____

_____

Phone _____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

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

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

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

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING (410 ILCS 45/6.2)

Name _____ Today's Date_____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes No Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher?	Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area?	Yes No Don't Know

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _____ Test 2: Blood Lead Result_____mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_____ _____

Signature of Doctor/Nurse Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

SOUTH HOLLAND SCHOOL DISTRICT 150

FOOD ALLERGY QUESTIONNAIRE

From the Nurse's Desk...

Dear Parent/Guardian, *Date*_____

If your child is allergic to any foods, please indicate the following:

*Your child's name*_____

*Grade*_____ *Homeroom teacher*_____

1. *What food(s) is your child allergic to?*

2. *When and how did you first become aware of the allergy?*

3. *When was the last time your child had a reaction?*

4. *Describe the signs and symptoms of the reaction?*

5. *What medical treatment was provided and by whom?*

6. *Is your child able to self administer Epi-pen or Benadryl? If so, where will he/she keep medication?*

7. *If no medication will be provided for child at school, please explain why?*

If medication is required while your child is in school, please contact the nurse's office to obtain the "PERMISSION TO GIVE PRESCRIPTION AND NON-PRESCRIPTION MEDICATION" form. The form must be completed by a licensed medical provider and parent/guardian and returned to school.

I understand, in the event my child has an allergic reaction, the parent and possibly 911 will be called.

Parent/Guardian Signature_____ Date_____
Contact phone numbers: _____
_____

School starts soon! Make sure your child's shots are up-to-date. Take your child to his or her pediatrician or visit a clinic providing LOW COST services for physicals and immunizations.

- **Aunt Martha's Health Center**
  52 W. 162nd Street, South Holland, Ill. Phone 596-2204

- **Family Christian Health Center**
  31 W. 155th Street, Harvey, Ill. (across the street from Ingalls Hospital)
  Phone 596-5177

- **CVS Pharmacy**
  14701 Pulaski Ave. Midlothian, Ill. Phone 239-2150

- **Walgreens' Take Care Clinic**
  522 Torrence Ave., Calumet City
  Phone 239-2150

- **Illinois Department of Public Health, Vaccines for Children call 217 785-1455 (no cost for low-income families)**

Be sure to bring your child's immunization records with you