School Enrollment Form

Chicago Public Schools

Please print or type:

Student Information

SCHOOL NAME

STUDENT ID#	**School Use Only:** Prevent duplicate student records. Search in SIS for an existing Student ID before creating a new one.	REGISTRATION GRADE LEVEL *(when first entering CPS)*

LEGAL LAST NAME	LEGAL FIRST NAME	LEGAL MIDDLE NAME

GENERATION (Jr., etc)	BIRTH DATE *(mm/dd/yyyy)*	LEGAL SEX (F/M/X/N)

*AFFIRMED GENDER (F/M/N)

***Optional.** For more information regarding affirmed gender and affirmed name, please visit: **Supporting Gender Diversity Toolkit**

*AFFIRMED FIRST NAME

*AFFIRMED MIDDLE NAME

*AFFIRMED LAST NAME

STUDENT'S SIBLINGS' NAMES IF CURRENTLY ENROLLED IN CPS:

Personal Information

BIRTH CERTIFICATE ON FILE ☐ YES ☐ NO

BIRTH VERIFICATION TYPE

*BIRTH COUNTRY	BIRTH STATE	BIRTH CITY

*Complete if student was not born in the United States (US) or one of its Territories:

DATE OF FIRST ENROLLMENT IN ANY US SCHOOL:

FULL YEARS COMPLETED SCHOOL IN US:

School Use Only: Note that *"Date of first enrollment in any US School"* becomes a required field in SIS if *"Birth Country"* is not the US or one of its Territories.

Student Address/Phone

PHYSICAL (HOME) ADDRESS (include unit number if applicable) City State Zip HOME PHONE #

MAILING ADDRESS (include unit number if applicable) (if different than Home) City State Zip

Included Information

FEDERAL ETHNIC AND RACE CATEGORIES: *(Enter information into SIS from the Race and Ethnicity Survey form)*

HOME LANGUAGE SURVEY: *(Enter information into SIS from the Home Language Survey form)*

PARENT/GUARDIAN CONTACTS: *(Enter information into SIS from the Request for Emergency and Health Information form)*

EMERGENCY/HEALTH INFORMATION: *(Enter information into SIS from the Request for Emergency and Health Information form)*

Enrollment

*SCHOOL TRANSFERRING FROM (if not a Chicago Public, Charter or Contract School)

CITY AND STATE

*IS THE STUDENT IN GOOD STANDING? ☐ YES ☐ NO

(Instructions to school: for out-of-state public school or any private school students, a certification of "good standing" should be received from the Parent/Guardian. Refer to CPS Policy 21-0728-P01 for more information.)

LAST CHICAGO PUBLIC, CHARTER, OR CONTRACT SCHOOL ATTENDED

IS THE STUDENT RECEIVING ANY TYPE OF SPECIAL EDUCATION SERVICES? ☐ YES ☐ NO

(Instructions to school: if yes, please notify the Case Manager.)

STUDENT ENROLLED BY (Print Name and Relationship)

Enrollment Status Codes:

01 – No Former School
02 – Chicago Public School (to Incl. Charter/Contract)
03 – Chicago Private School
04 – IL Public Schl, not Chicago
05 – IL Private Schl, not Chicago
06 – US Public Schl, not Illinois
07 – US Private Schl, not Illinois
08 – Not in USA

Signature of Parent/Guardian
Must have an original signature; an electronic signature is not acceptable

Date of Enrollment

School Use Only:	ENROLLMENT STATUS CODE *(insert a # from the left)*	GRADE LEVEL	HOMEROOM/DIVISION #

Request for Emergency and Health Information

Chicago Public Schools

PARENTS/GUARDIANS: The school must have on file emergency information that can be used to contact you. Please print clearly.
Whenever there is a change in this information, immediately notify the school in writing.

SCHOOL NAME	STUDENT ID#

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

STUDENT HOME ADDRESS (include unit number if applicable) City State Zip

BIRTH DATE (mm/dd/yyyy)	HOMEROOM #	STUDENT HOME PHONE #

CONFIDENTIAL INFORMATION BOX 1

Complete this box only if (1) it reflects your child's current living situation; OR (2) it reflects your living situation if you are a youth not living with a Parent or Guardian. (Your answer will help school staff with enrollment and may enable the student to receive additional services.) Check one box:

- ☐ in a car/park/other public place
- ☐ doubled-up
- ☐ in a hotel/motel
- ☐ in a shelter
- ☐ in transitional housing

School Note: If any box is checked, see the CPS Policy 702.5.

CONFIDENTIAL INFORMATION BOX 2

Is there a current Order of Protection or No Contact Order which concerns this student? ☐ YES ☐ NO

School Note: If "Yes," follow CPS Policy 704.4 procedures. Enter information in *Legal Alert* field and update contact information, as needed, in SIS.

Parent/Guardian and Emergency Contact Information: *Add extra contacts on additional page, if needed.*

	PARENT/GUARDIAN CONTACT	PARENT/GUARDIAN CONTACT
Contact Name		
Relationship to Student		
Check all that apply:	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pick up	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pick up
Home Address, ***If different from student's*** ***(include unit number if applicable)***		
Cell Phone Number		
Email Address		
Name and Address of Employer		
Work Phone Number		
* Communication Language		

* CPS communicates via phone calls. Select the language that should be used to communicate with you. Languages available for mass communication at this time are English and Spanish (note: other languages upon availability).

List the name of a relative or neighbor who can also be notified in an emergency and has permission to pick up the student:

NAME	RELATIONSHIP	TELEPHONE #

ADDRESS

Family Doctor's Name, Address, and Phone Number: ☐ *I authorize you to call my family doctor, if necessary, in an emergency.*

NAME	ADDRESS (include unit number if applicable) City State Zip
TELEPHONE #	

STUDENT HEALTH INSURANCE: (select only one of the three)

- ☐ Illinois Medical Card/All Kids: provide student's medical ID # _____ *(9-digit number located on back of card).*
- ☐ No Insurance: are you interested in applying for the Illinois Medical Card/All Kids? ☐ YES ☐ NO
- ☐ Private/Employer Health Insurance: no additional information needed.

CHILDREN OF MILITARY PERSONNEL (optional)

As the Parent or Guardian, are you a member of a branch of the armed forces of the United States? ☐ YES ☐ NO

If yes, are you either deployed to active duty or expect to be deployed to active duty during the school year? ☐ YES ☐ NO

_____ _____

Parent/Guardian Signature **Date**

Must have an original signature; an electronic signature is not acceptable.

Home Language Survey 2022

07.2022 | Office of Language and Cultural Education

Chicago Public Schools

Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.
This form must be kept in the student's folder.

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency and may be eligible for English Learner services.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

SCHOOL NAME

STUDENT ID #	NETWORK	ROOM #

English — If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

1. Is a language other than English spoken in your home? ☐ Yes ☐ No Language
2. Does the student speak a language other than English? ☐ Yes ☐ No Language

Spanish/Español — Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la competencia de su niño en inglés.

1. ¿Se habla algún otro idioma que no sea inglés en su hogar? ☐ Sí ☐ No Lenguaje
2. ¿Habla el estudiante algún otro idioma que no sea inglés? ☐ Sí ☐ No Lenguaje

Chinese / 中文 — 如果兩個問題中有任何一題的答案為 "是"，根據法律要求，學校將評測您子女的英語水平。

1. 您的家庭是否說英語之外的其他語言？ ☐ 否 ☐ 是 語言
2. 您的子女是否說英語之外的其他語言？ ☐ 否 ☐ 是 語言

Arabic / العربية — إذا كانت الإجابة على أي من السؤالين نعم، فإن القانون تطلب من المدرسة تقييم إتقان طفلك للغة الإنجليزية.

هل تُستخدم لغة أخرى غير اللغة الإنجليزية في منزلك؟ ☐ نعم ☐ لا اللغة

هل يتحدث الطالب لغة أخرى غير اللغة الإنجليزية ؟ ☐ نعم ☐ لا اللغة

Polish/Polski — Jeśli udzielili Państwo twierdzącej odpowiedzi na którekolwiek z pytań, przepisy wymagają aby szkoła sprawdziła poziom znajomości języka angielskiego waszego dziecka.

1. Czy mówi się w domu językiem innym niż angielski? ☐ Tak ☐ Nie Język
2. Czy uczeń mówi innym językiem niż angielski? ☐ Tak ☐ Nie Język

Signature of School Official _____ Date _____ Parent/Guardian Signature _____ Date _____

Must have an original signature; an electronic signature is not acceptable.

OFFICE USE ONLY

Please make sure both questions are answered completely and that the parents/guardians sign and date the form.

If the language spoken by the parent/guardian is not included on either page of this form, please visit the OLCE Employee Intranet Page, Forms, and click on "Home Language Survey in Additional Languages" which will take you to ISBE's HLS page.

If the parent/guardian does not speak English and the school does not have staff who speaks the parent/guardian's language, identify the language spoken by the parent/guardian through any assistance available in the school, i.e. using interpretation services from a vendor.

ASPEN REGISTRATION PROCESS

All five fields have to be entered on Aspen: date, answer to question 1, Home language, answer to question 2, and Native language.

When a language other than English is reported for only one of the questions on the form, that Non-English language has to be listed as both Home and Native Language in Aspen.

If there are two different languages other than English listed, enter the language identified in question 2 as both Home and Native language. If there is more than one language listed in question 2, check with the family, since only one of the languages can be entered on Aspen.

English can be entered as the Home language ONLY if both questions are answered No and English is listed for both questions.

If the language is not included on the list of languages available on Aspen, enter "Other" temporarily, but contact OLCE as soon as possible so that the district can ask ISBE to add the new language. An SRR will have to be submitted to OLCE to correct the language at a later date.

Home Language Survey 2022

07.2022 | Office of Language and Cultural Education

Chicago Public Schools

Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.
This form must be kept in the student's folder.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

SCHOOL NAME

STUDENT ID #	NETWORK	ROOM #

Bosnian/Serbian(Latin) Bosanski/Srpski Ukoliko ste na bilo koje od ovih pitanja odgovorili sa „Da", škola će biti zakonski dužna da procijeni nivo znanja engleskog jezika kod vašeg djeteta.

1. Da li se u kući govori na stranom jeziku (različitom od engleskog)? ☐ Da ☐ Ne Jezik
2. Da li učenik govori neki drugim jezikom (različit od engleskog)? ☐ Da ☐ Ne Jezik

Romanian/Română Dacă ați răspuns afirmativ la oricare dintre întrebări, prin lege, instituția de învățământ trebuie să evalueze cunoștințele de limbă engleză ale copilului dvs.

1. In familia dvs. se vorbește și altă limbă decât engleza? ☐ Da ☐ Nu Limba
2. Studentul vorbește și altă limbă decât engleza? ☐ Da ☐ Nu Limba

Urdu / اردو اگر کسی بھی سوال کا جواب ہاں میں ہے تو ، قانون کے تحت اسکول سے آپ کے بچے کی انگریزی زبان کی مہارت کا اندازہ لگانا پڑتا ہے ۔

کیا آپ کے گھر میں انگریزی کے علاوہ کوئی دوسری زبان بولی جاتی ہے ؟ ☐ ہاں ☐ نہیں زبان

کیا طالب علم انگریزی کے علاوہ کوئی دوسری زبان بول سکتا ہے ؟ ☐ ہاں ☐ نہیں زبان

Assyrian ܐܢ ܡܓܘܒܘܬܐ ܚܕ ܡܢ ܫܘܐܠܐ ܐܝܬܘܗܝ ܐܝܢ، ܒܢܡܘܣܐ ܒܝܬ ܣܦܪܐ ܩܢܘܢܐܝܬ ܠܡܦܬܟܝܢ ܡܠܝܘܬܐ ܐܢܓܠܝܙܝܐ (ܐܢܓܠܝܙܝܐ) ܕܝܠܟܘܢ.

ܐ. ܐܝܬܘܗܝ ܠܫܢܐ ܗܘܝܐ ܡܢ ܐܢܓܠܝܙܝܐ ܡܡܠܠܐ ܒܒܝܬܐ ܕܝܠܟܘܢ؟ ☐ ܐܝܢ ☐ ܠܐ ܠܫܢܐ

ܒ. ܐܝܢ ܬܠܡܝܕܐ ܡܡܠܠ ܠܫܢܐ ܗܘܝܐ ܡܢ ܐܢܓܠܝܙܝܐ؟ ☐ ܐܝܢ ☐ ܠܐ ܠܫܢܐ

Gujarati / [ગુજરાતી] તમારા બાળકના અંગ્રેજી ભાષાના કૌશલ્ય માટે આકારણી કરાવવા માંગે છે. જો બન્નેમાંથી કોઈ એક પ્રશ્નનો જવાબ પણ હા માં હોય તો, કાયદો શાળા પાસે

1. શું આપના ઘરમાં અંગ્રેજી સિવાયની ભાષા અન્ય કોઈ ભાષા બોલ આવે છે? ☐ ના ☐ હા ભાષા
2. શું વિદ્યાર્થીઓ અંગ્રેજી સિવાયની કોઈ ભાષા બોલે છે? ☐ ના ☐ હા ભાષા

Yoruba / Yorùbá Tí ìdáhùn sí ìbéèrè nàá bá jẹ́ Bẹ́ẹ̀ni, òfin bèèrè pé kí ilé-ẹ̀kọ́ nàá ṣe ìgbéléwọ̀n bí ọmọ rẹ ṣe gbọ́ èdè Gẹ̀ẹ́sì si.

1. Njẹ́ ẹ n sọ èdè miran yatọ sí Èdè-Gẹ̀ẹ́sì ninu idile yin bí? ☐ Bẹ́ẹ̀kọ́ ☐ Bẹ́ẹ̀ni Èdè
2. Ṣe akẹ́kọ̀ọ́ nàá n sọ èdè miran yatọ sí èdè-Gẹ̀ẹ́sì bí? ☐ Bẹ́ẹ̀kọ́ ☐ Bẹ́ẹ̀ni Èdè

Korean / [한국어] 위 질문 중 하나라도 "예"로 답하신 경우에는, 관련법에 따라 학교는 귀 자녀의 영어 언어 능력평가해야 합니다.

1. 가정에서 사용하는 언어 중에서 영어를 제외한 다른 언어가 있습니까? ☐ 아니오 ☐ 예 언어
2. 학생이 영어 이외에 다른 언어를 구사합니까? ☐ 아니오 ☐ 예 언어

Tagalog Ayon sa batas, kung "Oo" ang sagot sa parehong tanong, kailangan suriin ng paaralan ang kakayahan at kaalaman na mag-aaral sa wikang Ingles.

1. May iba pa bang lengguwahe bukod sa Ingles na ginagamit sa iyong tahanan? ☐ Oo ☐ Hindi Lengguwahe
2. May ginagamit ba na ibang lenggguwahe ang mag-aaral bukod sa Ingles? ☐ Oo ☐ Hindi Lengguwahe

Signature of School Official ______ Date ______ Parent/Guardian Signature ______ Date ______

Race and Ethnicity Survey

Chicago Public Schools

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER	SCHOOL NAME
BIRTH DATE	**SCHOOL ID#**

Instructions

Please answer the questions below. Both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

PART A

Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) Choose only one.

- ☐ **No, not Hispanic/Latino**
- ☐ **Yes, Hispanic/Latino**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to PART B below by marking one or more boxes to indicate what you consider this student's race to be.

PART B

What is the student's race? Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- ☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- ☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- ☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- ☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

School Messaging Consent Form

Chicago Public Schools

Dear Parent/Guardian/Student:

If age 18 or older, your school and the district will periodically want to send information regarding school or district events, updates or initiatives. We will utilize a phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, COVID-19 information and screenings, and more. To ensure you receive periodic school- or district-related notifications and reminders, your consent is needed below.

In the event of an emergency, whether or not consent is on file, you will be informed through all contact information provided. Emergency calls include weather closures, health risks, threats, unexcused absences, and other situations affecting the health or safety of students and faculty. Emergency calls will be sent to all phone numbers, including cellular numbers, listed on the student's record. Please make sure these numbers are updated with your school.

Please fill out and return this form to ensure you receive informational calls and texts.

By signing this form, you are authorizing Chicago Public Schools to use an automated system to periodically deliver automated informational calls or text messages to the phone number(s) provided below. If you change your phone number or no longer wish to receive automated calls and texts, you agree to inform Chicago Public Schools immediately. By signing below, you agree that this consent will remain valid and you will continue to receive automated phone calls and text messages unless or until you revoke your consent. Standard messaging rates and data may apply.

☐ **I CONSENT as outlined in the above section.**

☐ **I DO NOT CONSENT as outlined in the above section.**

please print or type:

Student's Name _____ Name of Parent/Guardian/Student if age 18 or older _____

School _____ Date _____

Signature of Parent/Guardian/Student if age 18 or older _____ Student ID # _____

Phone Number 1 for Messages _____ Phone Number 2 for Messages _____

E-mail Address _____

Must have an original signature; an electronic signature is not acceptable.

Media Consent Form and Release

Chicago Public Schools

Consent/Release

I hereby consent to have my child photographed, digitally recorded, video taped, audio taped and/or interviewed by the Board of Education of the City of Chicago (the "Board") or the news media when school is in session, either in person or hosted remotely, or when my child is under the supervision of the Board. Further, I consent for these photos, digital recordings, video tapes, audio tapes and/or interviews to be shared with third parties who have received written approval from the Office of Communications. I understand in the course of the above described activities that the Board might like to celebrate my child's accomplishments and work. Therefore, I further consent for the Board's release of information on my child's name, academic/non-academic awards and information concerning my child's participation in school-sponsored activities, organizations and athletics.

I also consent to the Board's use of my child's name, photograph or likeness, voice or creative work(s) on the Internet or on a CD or any other electronic/digital media or print media electronic which may include honorary banners/signs displayed in, near, or around the school building or community.

As the child's parent or legal guardian, I agree to release, indemnify and hold harmless the Board, its members, trustees, agents, officers, contractors, volunteers and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child's name, photograph or likeness, voice or creative work(s), on television, radio or motion pictures, or on the Internet, or on a CD, or any other electronic/digital media or print media or in connection with my child's participation in virtual school events and/or celebratory activities.

It is further understood and I do agree that no monies or other consideration in any form, including reimbursement for any expenses incurred by me or my child, will become due to me, my child, our heirs, agents, or assigns at any time because of my child's participation in any of the above activities or the above-described use of my child's name, photograph or likeness, voice or creative work(s).

I understand that I may cancel this consent by providing written notice to the principal. I also understand that my consent is valid for one school year, including the following summer.

Instructions: Check Box #1 or Box #2

☐ **1. I consent as outlined in the above consent/release section.**

☐ **2. I DO NOT consent as outlined in the above consent/release section.**

please print or type:

Student's Name _____

Name of Parent/Guardian/Student if age 18 or older _____

School _____

Date _____

Signature of Parent/Guardian/Student if age 18 or older _____

Student ID # _____

I understand that I have the right to inspect and copy my student's records, challenge the contents of such records; and limit my consent to the designated records or designated portions of information within the records.

Must have an original signature; an electronic signature is not acceptable.

Student's Name Grade Room Parent's Name Phone No.

Address and Zip Code

Parent's Email Address

State of Illinois
Certificate of Child Health Examination

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

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				Comments: * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes / No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	List:	
Diagnosis of asthma?	Yes / No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes / No		
Child wakes during night coughing?	Yes / No						
Birth defects?	Yes / No			Hospitalizations? When? What for?	Yes / No		
Developmental delay?	Yes / No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes / No			Surgery? (List all.) When? What for?	Yes / No		
Diabetes?	Yes / No			Serious injury or illness?	Yes / No		
Head injury/Concussion/Passed out?	Yes / No			TB skin test positive (past/present)?	Yes* / No	*If yes, refer to local health department.	
Seizures? What are they like?	Yes / No			TB disease (past or present)?	Yes* / No		
Heart problem/Shortness of breath?	Yes / No			Tobacco use (type, frequency)?	Yes / No		
Heart murmur/High blood pressure?	Yes / No			Alcohol/Drug use?	Yes / No		
Dizziness or chest pain with exercise?	Yes / No			Family history of sudden death before age 50? (Cause?)	Yes / No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Ear/Hearing problems?	Yes / No			Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature**		**Date**	
Bone/Joint problem/injury/scoliosis?	Yes / No						

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____
Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		
NEEDS/MODIFICATIONS required in the school setting			**DIETARY** Needs/Restrictions		

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

State of Illinois
Illinois Department of Public Health

Dentist must complete form, parents please return to your child's school or send to Katheryn Hudson healthforms@cps.edu, or fax 773-535-8677

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

Doctor must complete report, parents please return report to your child's school or

State of Illinois Eye Examination Report

send report to Katheryn Stafford-Hudson, kgstafford-h@cps.edu or fax 773-535-8677

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 15th 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 child beginning school.

Student Name: _____ (Last) _____ (First) _____ (Middle Initial) Birth Date: _____ (Mo.) (Day) (Yr.) 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: _____

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: _____

_____

Signature: _____ Phone: _____
Optometrist or Physician Who Provides Eye Examinations

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)