

Oak Lawn-Hometown School District 123
Health Guidelines 2009-2010
Forms available on-line at www.d123.org

Entrance into Preschool or PreK

- Certificate of Child Health Examinations
- Lead Assessment (Oak Lawn)
- Blood Test for Lead (Hometown 60456)

Entrance into Kindergarten

- Certificate of Child Health Examination
- Dental Examination Form
- Lead Assessment (Oak Lawn)
- Blood Test for Lead (Hometown 60456)
- Eye Examination Form

Entrance into Second Grade

- Dental Examination Form

Entrance into Sixth Grade

- Certificate of Child Health Examination
- Dental Examination Form

Transfer Student

- ALL transfers must have an Illinois Certificate of Child Health Examination form
- ALL transfers from **out of state** must have an Eye Examination
- If the student is entering Kindergarten, Second or Sixth grade, they must comply with the above requirements

Medication Form

- Any student receiving medication, inhalers, or nebulizers at school, whether by prescription or over-the-counter, must have the doctor complete the medication form.

ALL parents must complete the **emergency information sheet** in the registration packet and indicate whether or not there is a medical issue, medication, glasses, hearing aids etc.



**STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

Student's Name			Birth Date	Sex	School	Grade Level /ID#
Last	First	Middle	Month/Day/ Year			

Address			Parent/ Guardian	Telephone #		Work
Street	City	ZIP code		Home		

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given after the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.

VACCINE/DOSE	1			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningo-coccal, etc.)																		

Comments

Health care provider (MD, DC, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying 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 Date

3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA																		
Pre-school - annually beginning at age 3; School age - during school year at required grade levels																		
Date																		
Age/Grade	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																		
Hearing																		

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Printed by Authority of the State of Illinois
(Complete Both Sides)

Student's Name			Birth Date	Sex	School	Grade Level/ID #
Last	First	Middle	Month/Day/Year			

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

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

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING BMI > 85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/>	Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>			

LEAD RISK QUESTIONNAIRE * Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

Blood Test Indicated? Yes No Blood Test Date _____ Blood Test Result _____ (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read / / Result _____ min

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results	Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)	
Urinalysis			Other	

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____ Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optomestrist Yes <input type="checkbox"/> No <input type="checkbox"/>			Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	

NEEDS/MODIFICATIONS required in the school setting	DIETARY Needs/Restrictions
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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 **PHYSICAL EDUCATION** Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited (If No or Modified, please attach explanation.)

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name _____ Signature _____ Date _____

Address _____ Phone _____

(Complete both sides)

**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
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- | | |
|---|-------------------|
| 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 of 10 mcg/dL or higher? | Yes No Don't Know |
| 3. Does this child live in or regularly visit a home that was 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 |

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 _____

Please discuss any questions or concerns with your child's health care provider. For more information call:

Illinois Department of Public Health
Childhood Lead Poisoning Prevention Program
800-545-2200 or 217-782-0403
TTY (hearing impaired use only) 800-547-0466

Signature of Doctor/Nurse

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 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: _____ Birth Date: _____ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: _____ Phone: _____
(Last) (First) (Area Code)

Address: _____ County: _____
(Number) (Street) (City) (Zip Code)

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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (media, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Integrity (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and Vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IOP (glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other: _____

Recommendations

- Corrective Lenses: No Yes, glasses should be worn for: Constant Wear Near Vision Far Vision
 May Be Removed for Physical Education
- Preferential seating recommended: No Yes Comments: _____
- Recommend re-examination: 3 months 6 months 12 months Other _____
- _____
- _____

Print Name: _____
Optometrist or Physician Who Provides Eye Examinations

Address: _____

Signature: _____
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)

Phone: _____

Oak Lawn Hometown School District 123
4201 W. 93rd Street
Oak Lawn, Illinois 60453
Phone: 708-423-0150
Fax: 708-423-0160

For School Use Only
Medication Exp. Date: _____
Dosage: _____

PHYSICIAN'S ORDER
Medication Authorization Form

Student's Name _____ Date of Birth _____

Address _____ Telephone _____

Medication _____ Diagnosis _____ Prescribed Dosage _____ Route _____

Purpose of Medication _____

Specific Time/Instructions _____

Possible Side Effects _____

Other Medications Prescribed for this student _____

Possible Drug Interactions _____

FOR PHYSICIAN USE ONLY (Choice must be initialed by Physician)	
<input type="checkbox"/>	Student may carry this medication on his/her person. It is recommended that "back-up" medication be stored in the school's health office. _____ Physician's Initials
<input type="checkbox"/>	Student may self-administer medication. I have instructed the student on the administration of this medication and find that he/she is able to independently self-administer. _____ Physician's Initials
<input type="checkbox"/>	Student may not self-administer medication. _____ Physician's Initials

Physician's Name (Please Print) _____

Address _____ Telephone _____

Physician's Signature _____ Date _____

PARENT/GUARDIAN AUTHORIZATION

Oak Lawn Hometown School District 123 and its employees and agents, are hereby authorized to administer to the above named student or to allow the self-administration of the lawfully prescribed medication described above. I further acknowledge and agree that when the lawfully prescribed medication is so administered I waive any claims against the School District and its agents and/or employees, which might arise out of the administration of said medication. In addition, I agree to indemnify and hold harmless the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries, including reasonable attorneys fees and costs expended in defense thereof, except for willful and wanton conduct, incurred or resulting from the administration of said medication.

Signature of Parent/ Guardian _____ Date _____

Please Note:
Over-the-counter medication must be in the manufacturer's labeled container. Prescription medication must be in container labeled by a physician or pharmacist. A separate form must be completed for EACH medication that is to be administered during school hours by SD123 personnel.

Oak Lawn Hometown School District 123

STUDENT MEDICATION AUTHORIZATION FORM

(To Be Completed by Parent/Guardian)

Student's Name: _____ Birthdate: _____ Date: _____

PLEASE CHECK APPLICABLE SECTION:

ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

The undersigned, being the parent/guardian of the above-named student, hereby requests that appropriate Oak Lawn Hometown School District 123 personnel administer prescription medication ordered by the student's physician or licensed prescriber in accordance with the letter that accompanies this form.

I understand that I am to bring the medication to the school office in a pharmaceutical container labeled with the student's name, name of medication, dosage and all pertinent instructions.

I hereby release Oak Lawn Hometown School District 123, its officers, directors, agents, employees and assigns from any and all liability arising from the administration of medication to the above-named student.

SELF-ADMINISTRATION OF MEDICATION BY STUDENTS

Pursuant to the School Code, Oak Lawn Hometown School District 123 will permit the self-administration of medication by a student with asthma or other medical condition, if the student demonstrates appropriate use of the medication and if the following documents are provided by the student's parent/guardian:

1. A Student Medication Authorization form to be completed and signed by the parent/guardian.
2. A Physician's Order form completed and signed by the physician and the parent/guardian.

I acknowledge that the School District and its employees and agents will incur no liability, except for willful and wanton conduct, as a result of any injury arising from the student's self-administration of the medication. I agree to indemnify and hold harmless the School District and its employees and agents against any and all claims, except claims based on willful and wanton conduct, arising out of the self-administration of medication by the student.

Signature of Parent/Guardian Date

Name of Parent/Guardian (Please Print)

Street Address

City/State Zip Code

Phone Number During School Hours

Emergency Phone Number

WORTH TOWNSHIP CLINIC A PREVENTATIVE CLINIC

• 11601 SOUTH PULASKI ROAD • ALSIP, ILLINOIS 60803 • PHONE: 708-371-3393 FAX: 708-371-2542

- SCHOOL and SPORT PHYSICALS *
- DENTAL SCREENING, CLEANING & SEALANTS *
- IMMUNIZATIONS
- BLOOD PRESSURE CHECKS
- FASTING BLOOD SUGAR & FASTING CHOLESTROL *
- PODIATRY SERVICES (preventative)*
- FLU (October)



* Appointments Required

A parent must accompany all children under the age of 18. If coming in for an immunization, please bring a record of all previous immunizations or a letter from the school specifying what immunizations need to be given.

CLINIC RATES

Dental Screening	\$ 5.00	Children's Immunizations	\$ 5.00
Dental Cleaning/Fluoride	\$15.00	TB Skin Test	\$ 5.00
Dental Sealant/per tooth	\$10.00	Flu Shots	To be determined
School / Sport Physicals	\$20.00		
Extra Forms	\$ 3.00		

CLINIC HOURS

Tuesday, Thursday, Friday: 9:00 am - 3:30 pm
Monday 9:00 am - 7:30 pm
Wednesday 9:00 am - 6:30 pm

Any child with a medical condition or history such as, but not limited to: **ASTHMA, SEIZURES, A.D.D., DIABETES, HEART CONDITIONS, OR FRACTURES** must have written clearance from their doctor prior to examination at Worth Township clinic.

These services are available to all residents of Worth Township with proper identification such as a current utility bill that shows the name and address.

The Township Clinic does not accept Public Aid, All Care, or any other type of insurance. We do not perform dental x-rays, and therefore suggest you follow up with your family dentist. We will be happy to refer clients to the appropriate Health Care Facility.

Carol Murphy, R. N., Clinic Director