BARTELSO ELEMENTARY SCHOOL DISTRICT NO. 57
2019-2020 SCHOOL EMERGENCY FORM

Student's Name: ______________________________ *Grade:* __________

Date of Birth: ________________ **Allergies:** ______________________________

Address: (please include P.O. Box) Street ______________________________

P.O. Box ______________ **e-mail** ______________________________

Home Telephone: ______________________________

cell phone (mom) ______________________________ *(dad)* ______________________________

Mother's Name: ______________________________ *Work phone* ______________________________

Place of Employment: ______________________________

Father's Name: ______________________________ *Work phone:* ______________________________

Place of Employment: ______________________________

In case of an emergency, please provide two other names of people we can call:

1. ______________________________ **Telephone** ______________________________

Relationship: ______________________________

2. ______________________________ **Telephone** ______________________________

Relationship: ______________________________

Family Physician: ______________________________ **Telephone:** ______________________________

Family Dentist: ______________________________ **Telephone:** ______________________________

Hospital or Medical facility choice: ______________________________

Does your child take any medication on a regular basis?

____

Sister and/or Brothers in Attendance: ______________________________

LOCAL FIELD TRIP PERMISSION (In Bartelso Community)

___ YES, my child has permission to attend local field trips throughout the school year.

___ NO, my child does not have permission to attend local field trips throughout the school year.

Parent Signature ______________________________

In the event of a serious injury or illness, and the school is unable to reach a responsible adult, the paramedics will be contacted. I authorize the school to transport my child to the medical facility of my choice which is listed above. School employees will administer first aid as needed.

Date: ______________ Parent/Guardian signature ______________________________

Does the student ride the bus? ______________________________

COMMENTS THAT MAY HELP US IN CASE OF AN EMERGENCY:

____

____

By mandate of the Illinois State Board of Education, the Board of Education of Bartelso Elementary School District #57 is required to be able to prove that the students attending its schools are truly residents of this School District or are paying tuition. The only exception is for homeless children as defined by law. If parents/guardians wish to challenge the District's determination of non-residency, they may do so in accordance with the policies adopted for such challenges which determination is final. Therefore, it is required that you provide the following residency verification.

VERIFICATION OF IN-DISTRICT RESIDENCY

I/We, the undersigned parent/guardian of the student provide the following information to Bartelso Elementary School District #57 (hereinafter the District) to support our representation that the student is a legal resident of the District, and is entitled to attend the school as a resident without charge of tuition, but with a charge for certain fees.

STUDENT'S NAME ______________________________

Student's Address: ______________________________

____

Student Telephone: ______________________________

Name of Adult(s) with whom student resides in District ____________________

Relationship of adult(s) named above to the student (mark one and explain, if necessary)

_____ Parent (includes natural and adoptive parents)

_____ Legal Guardian with Court Order (attach Court Order)

_____ Other (explain in detail why student is living with adult, and attach all relevant documentation)

Please submit the following required documentation from **Categories I and II**

Category I (one document establishing property within the District)

a. Most recent property tax bill (homeowners) **b.** Mortgage papers (homeowners) **c.** deed
d. Signed and dated lease and proof of last two months' payments if lease is not at its inception (canceled check or receipts required) (Renters) **e.** Housing letter (military personnel)
f. Letter from manager and proof of last two months' payments (canceled checks or receipts required) (Renters or trailer park residents) **g.** An agreement of sale for a residential property located within the District, signed by the seller and parent/custodian as buyer, which recites a closing date prior to the first day of attendance (new residence) **h.** Notarized affidavit of residency from the resident owner of property within the District where the parent/custodian of the child is living with the owner at no cost (those living with relatives or others)

Category II (one document establishing an address within the District)

a. Driver's license b. Vehicle registration c. Current Public Aid card
d. Current library card e. Voter registration
f. Most recent gas, electric, water, cable television and/or credit card bill
g. Current homeowners/renters insurance policy and premium payment receipt

If student does not live with the parent/guardian, please list parent's/guardian's residence.

If the student's parents/guardians are not residing together, where does the other parent/guardian reside?

Attach any court order, decree, or other document establishing the custody and/or residency of the student.

If this student's parents/guardians have students enrolled in other districts, please list those districts.

Certificate of Residency

I/We certify that the above information is accurate, and that the student is a resident of the Bartelso Elementary School District #57. I/We understand that the District may request additional information from us. I/We agree to notify the District within 7 days of any changes of residence or change of address. I/We understand that should any information on this form, or any information otherwise provided the District be wrong, or if it is determined that the student is not a resident of the District, the student may be dismissed immediately from the District's school, and the student and responsible adults shall reimburse the District for costs, including tuition for the time during which the student attended the District's schools. I/We recognize that any person who knowingly registers or attempts to register a student known by that person to be a non-resident of the District shall be subject to criminal prosecution.

DATED: ______________________________

Signatures of Student's Parents/Guardians

Bartelso Community School District #57

306 South Washington Street
Bartelso, Illinois 62218
Phone: 618-765-2164
Fax: 618-765-2712
www.bartelsobraves.com

Publicity Release
2019-2020

Throughout the school year, Bartelso School District No. 57 may conduct activities that may be publicized by the school district and/or through local news media. Please indicate by checking below whether you consent or do not consent to the release of publicity information concerning your child/children. This form *must be returned* with your signature in the packet of registration materials. If this form is **NOT** returned, Bartelso School District No. 57 will assume that you **have NOT given** your consent to the release of publicity information concerning your child/children.

___ ***I grant permission*** for Bartelso School District No. 57 to include my child/children's picture in school sponsored events that may be published in the newspaper and on the district website.

___ ***I grant permission*** for my child/children's picture to be printed **ONLY** in the newspaper for School News **BUT NOT** the school district website.

___ My child/children ***may not*** have their picture published in the newspaper or district website by Bartelso School District No. 57.

______________________________ ______
Child's Name (please print) Grade

______________________________ ______
Child's Name (please print) Grade

______________________________ ______
Child's Name (please print) Grade

______________________________ ______
Child's Name (please print) Grade

______________________________ ______________________
Parent or Guardian's Signature Date

Bartelso Community School District #57

306 South Washington Street
Bartelso, Illinois 62218
Phone: 618-765-2164
Fax: 618-765-2712
www.bartelsobraves.com

Tom Siegler
Superintendent

Dear Parent or Guardian:

In fall 2007, the U.S. Department of Education issued new guidance on the collection and reporting of race and ethnicity data for public school students and staff. The guidance implements new federal race and ethnicity categories that were developed to obtain a more accurate picture of the nation's diversity. The new data collection process requires respondents to answer a two-part question, indicating ethnicity first and then one or more of five races. (In the past, individuals were allowed to choose only one race or ethnicity category.)

The Illinois State Board of Education (ISBE) started using the new categories with data to be reported for the 2010-2011 school year. This requires school districts to re-identify race and ethnicity for all students—and the identification is to be done by parents or guardians. If a student's parents or guardians decline to indicate race and/or ethnicity, observer identification by school district staff is required.

The new race and ethnicity data will be used in the same manner as previously collected data, e.g., in reporting and analyzing test results by race and ethnicity. The information will not be used to check immigration status, and the confidentiality of individual student information will be protected.

Enclosed is the form that parents or guardians need to complete to identify race and ethnicity for their children. Please complete one form per child, and be sure to answer both parts of the two-part question. (Remember that school district staff is required to provide any missing information by observer identification.) Return the completed form to your child's school by **August 16, 2019.**

Thank you for your cooperation in providing the needed data. Please direct any questions you may have to the office.

Sincerely,

Tom Siegler
Superintendent

Bartelso Community School District #57

306 South Washington Street
Bartelso, Illinois 62218
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www.bartelsobraves.com

Student's Name:__________________________ SIS ID:_______________

INSTRUCTIONS: This form is to be filled out by the student's parents or guardian, and both questions must be answered. Part A asked 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 the question 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 maintain 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 other peoples of Europe, the Middle East, or North Africa.)

Note: Data collected on this form must be maintained by the school district for three years. However, when there is litigation, a claim, an audit, or another action involving this record, the original responses must be retained until the completion of the action.

Home Language Survey
English

Home Language Survey

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 need for bilingual and English as a Second Language education services in the schools.

Child's Name________________________________ Grade________

Please answer the questions below and return this survey to your child's school.

1. Does anyone in your home speak a language other than English?

_____Yes

What language? ____________________

_____No

2. Does your son/daughter speak a language other than English?

_____Yes

What language? ____________________

_____No

If the answer to either question is yes, the school will assess your child's English speaking skills and, for students in grades 2 through 12, reading and writing skills.

Signed ________________________________

Parent or Guardian

Date ________________________

Bartelso Community School

District No. 57

306 South Washington Street - Bartelso, Illinois 62218
Phone: 618-765-2164 - Fax: 618-765-2712

MILITARY CHILDREN REGISTRATION FORM

Dear Parent or Guardian,

Please take a few moments to answer these voluntary questions.

This information will help identify Illinois military families.

Your participation will help schools get U.S. Department of Defense assistance for children struggling with their parent's or guardian's military deployment.

Name(s) of child(ren)/School:

____

____

Does the child(ren)'s parent or guardian serve in the military, including National Guard or Reserve?

☐ Yes

☐ No

Is the parent or guardian currently serving on active duty or expect to be deployed this year?

☐ Yes

☐ No

Has a parent or guardian returned from deployment in the last 6 months?

☐ Yes

☐ No

Return form to your school. Thank you!

BARTELSO SCHOOL DISTRICT #57
STUDENT/PARENTAL INTERNET CONSENT FORM
2019-2020 School Year

______________________ ______________ ______________
Student's last name First name Middle name

____
Grade

I realize the primary purpose of the Bartelso School Internet Connection is educational, and that as such, educational purposes shall take precedence over all others. I know that if I follow the stated policies, I may have access to the Bartelso School Internet Connection. I understand that if I lose my Internet Connection privileges, there will be no second chance. I release Bartelso School and all other organizations related to the Bartelso School Internet Connection from any liability or damages that may result in any way from my use of the Internet Connection. In addition, I will accept full responsibility and liability for the results of my actions with regards to the use of the Internet. I release the school and related organizations from any liability relating to consequences resulting from my use of the Internet.

______________________ ______________ ______________
Student's last name First name Middle name

I understand the policies and parameters outlined in the document. Bartelso Elementary School has my permission to allow my child to have access to the Internet through Bartelso School's Internet Connection. The purpose of the Acceptable Use Policy is to provide information not to exclude anyone.

____________________________ __________
Parent or guardian signature Date completed

PARENT PORTAL

Student(s) name:____

Please provide an email address for the Parent Portal. This will be needed in order to view your child's grades and lunch account online. School announcements/information is also sent to the email address provided as well.

____

____

Bartelso Community School District #57

306 South Washington Street
Bartelso, Illinois 62218
Phone: 618-765-2164
Fax: 618-765-2712
www.bartelsobraves.com

Dear Parents/Guardians of Bartelso School District #57 Student:

As noted in the Bartelso School District #57 Student Handbook, the Board of Education has adopted an Integrated Pest Management Plan. Our use of pesticides will be limited but will be necessary on occasion and will not be administered during school hours.

In accordance with state law, if you wish notification of such usage, you must complete a parent/guardian notification form. This form is available in the school office. By being placed on the roster of parents/guardians to notify, you will be contacted 48 hours in advance of pesticides being used.

Please call the school if I can be of additional assistance in regards to this matter.

Sincerely,

Tom Siegler
Superintendent

Bartelso Community School District #57

306 South Washington Street
Bartelso, Illinois 62218
Phone: 618-765-2164
Fax: 618-765-2712
www.bartelsobraves.com

PESTICIDE USAGE NOTICE

AS PARENT/GUARDIAN OF THE FOLLOWING STUDENT(S) I WISH TO HAVE THE SCHOOL NOTIFY ME FORTY-EIGHT (48) HOURS IN ADVANCE OF PRESTICIDE USAGE AT BARTELSO SCHOOL DISTRICT #57.

Please list the name(s) of student(s) attending Bartelso School District #57 below:

____

____

____

____

Please place my name on the pesticide notification roster:

Print name of parent/guardian ______________________________

Signature of parent/guardian ______________________________

Phone # where parent/guardian can be reached ____________________

Date signed ____________________

Bartelso Community School District #57

306 South Washington Street
Bartelso, Illinois 62218
Phone: 618-765-2164
Fax: 618-765-2712
www.bartelsobraves.com

TO: Parents

FROM: Tom Siegler, Superintendent

SUBJECT: Medication Policy

Due to state regulation, the district has an established medication policy. Under this policy, parents should not send prescription medication to school unless it is absolutely necessary for the health and well-being of the child. Therefore, for medication to be dispensed, the following must occur:

1. The doctor's prescription is listed on the medication listing the dosage and time or a note listing the dosage and time is sent by the parent.
2. The parent gives written permission for the school to dispense the medication.

All requests to dispense medication should be brought to the school office by the parent or the child. The medication will be stored in a secure place until it is dispensed to the child. It is the child's responsibility to come to the office to take medication home at the end of each day, if needed.

ADMINISTRATION OF MEDICATION AND TREATMENT

District #57 retains the right to reject requests for administration of medication or treatment.

Only in the case of prescribed medication or treatment necessary for the student to remain in daily attendance or where failure to take medication or treatment could jeopardize the student's health, should medication or treatment be administered in school.

All medication, including non-prescription drugs, or treatments given in school shall be prescribed by a licensed prescriber on an individual basis as determined by the child's health status.

Should the need for medication or treatment at school arise, the following is required:

a. Signed orders from the physician or dentist detailing the name of the student, medication or treatment, frequency of administration, dosage, anticipated reaction, side effects and illness or condition requiring medication or treatment.

b. Signed parental request for the school to administer prescribed medication or treatment.

c. Medication must be brought to the school in a container appropriately labeled by the physician or pharmacy. Parents/guardians will be responsible for providing all supplies and equipment needed to perform treatment.

The school nurse, her substitute, or a person designated by the principal will administer medication or treatment.

The medication will be stored in the office, with the exception of refrigerated medications.

A daily record of medication or treatment administration data will be kept.

A student's teachers, doctor or parents will be contacted as needed concerning the medication or treatment.

If the medication or treatment is changed, a new physician's order is required.

At the end of the school year unused medication left in the possession of the office will be appropriately disposed of by the principal in the presence of a witness.

Adopted 2001
Effective fall, 2001

REQUEST FOR MEDICATION/TREATMENT TO BE GIVEN AT SCHOOL INCLUDING PRESCRIPTION AND OVER-THE-COUNTER MEDICATION

Name of Student ______________________________ birthdate ______________

School ____

TO BE COMPLETED BY PHYSICIAN

Name/type of medication/treatment ______________________________________

Dosage and frequency of administration __________________________________

Illness or condition requiring medication/treatment, at school _________________

____

Anticipated reaction to medication/treatment, side effects, additional instructions

____

Duration of order (week, month, indefinite) ______________________________

Antibiotics require a six month renewal order. All other medications/treatments will need a new order each school year.

Doctor, do you wish a report from the school? ____________________________

____

Physician's Signature Date Phone

TO BE COMPLETED BY PARENT/GUARDIAN

I hereby request and give my permission for the above named school to administer the medication/treatment prescribed on this form to my child. I will notify the school in writing if the order is discontinued. Also, I will obtain a written doctor's order if the medication dosage of treatment is changed.

____

Parent/Guardian Signature Date Phone

Bartelso Community School District #57

306 South Washington Street
Bartelso, Illinois 62218
Phone: 618-765-2164
Fax: 618-765-2712
www.bartelsobraves.com

HEALTH, DENTAL, AND VISION EXAM REQUIREMENTS

ALL EXAMS ARE DUE ON OR BEFORE THE FIRST DAY OF SCHOOL

KINDERGARTEN EXAM REQUIREMENTS

The following exams are required for students entering Kindergarten:
- Health Physical Exam / Immunizations
- Vision Exam
- Dental Exam

2ND GRADE EXAM REQUIREMENTS

The following exam is required for students entering 2nd grade:
- Dental Exam

6th GRADE EXAM REQUIREMENTS
- Health Physical Exam / Immunizations
- Dental Exam

The exam forms are included in the registration packet, available in the school office and can also be found on the school website at www.bartelsobraves.com.

Please see attached for more information regarding the above examination requirements and immunizations.

State of Illinois
Illinois Department of Public Health

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
Illinois Department of Public Health

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 ______________________________
Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number ______________________________

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 ______________

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

Printed by Authority of the State of Illinois

IOCI 15-391

State of Illinois
Certificate of Child Health Examination

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

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

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

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

Signature Title Date

Signature Title Date

ALTERNATIVE PROOF OF IMMUNITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

No test needed ☐ Test performed ☐ Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm______

Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐

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

Address Phone

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

<table>
<tr><td colspan="2">Student's Name: Last First Middle</td><td>Birth Date: (Month/Day/Year)
/ /</td></tr>
<tr><td colspan="2">Address: Street City ZIP Code</td><td>Telephone:</td></tr>
<tr><td>Name of School:</td><td>Grade Level:</td><td>Gender:
☐ Male ☐ Female</td></tr>
<tr><td>Parent or Guardian:</td><td colspan="2">Address (of parent/guardian):</td></tr>
</table>

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

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School Year
2019-2020

ROOM PARENTS

At various times during the year, we need one or two mothers or fathers to help with room parties, to accompany classes on field trips, or to help make phone calls to other parents in case of emergency school dismissal. If you are willing to serve as a Room Parent, please sign your name below and return this letter to your child's teacher by September 8th. The classroom teacher will notify those who have been selected as a Room Parent.

VOLUNTEERS

Throughout the school year, teachers would appreciate having your help. Not only would this be a valuable service, but it would also be a way to keep parents informed and involved. (We welcome grandparents and other community members, too.)

Please check the boxes for areas in which you would be able to help and return this form to your child's homeroom teacher: (If you have more than one child, please return it with your youngest child in attendance or with the child in whose room you would be able to serve as a room parent.)

- ☐ Participating in school improvement activities (related to instruction)
- ☐ Serving as a Room Parent (List grade: _____)
- ☐ Duplicating papers
- ☐ Typing and/or wording processing
- ☐ Helping with art activities
- ☐ Being a guest speaker or sharing information about your career
- ☐ Helping with bulletin boards
- ☐ Assisting with special projects
- ☐ Helping at home (cutting, pasting, etc.)
- ☐ Other ____________________
- ☐ Not able to help

Your Name: ____________________

Your Telephone Number: ____________________ Date: ____________________

Names of Children: ____________________

Their Homeroom Teachers: ____________________

____

____
Signature

____________________ ____________________
Telephone Number Date

Notice

After School Student Pick-up Procedure

At the recommendation of Mark Etter, Chief Deputy from the Clinton County Sheriff's Department, the Board of Education approved to change the after-school student pick-up procedure. This pick-up procedure has been changed to address the hazardous condition we currently have. The goal is to keep our students safe and free from harm.

From **3:00 to 4:00 P.M.**, students who will be leaving school in an automotive vehicle will be dismissed from the computer lab exit. All vehicles will proceed one way from the south side of the school. Parked vehicles should park single file facing the North (end to end). Students who are walking, riding the bus or bike, will be dismissed from the same front door exit. Once the student(s) have been picked-up, vehicles will then move northward behind the church to Highway 161 by the Bowling Alley. (Attached to this notice is a drawing showing where vehicles should park.)

This procedure will be monitored and evaluated in order to keep our students safe. With your help and patience, we hope to have this new student pick-up procedure routine mastered very quickly. If anyone has questions, please contact the school office at 765-2164.

Tom Siegler, Superintendent

AUTOMOBILE TRAFFIC
After School Pick-Up

For **safety** purposes, parent/guardians need to park behind the school to pick-up their students.

Students who ride with parent/guardian will exit through the double doors by the computer lab.

Parents should: - enter the driveway by the gym from the south
- park in designated areas (see diagram)

Exit **slowly** out the drive behind the parish out past the bowling alley to the highway!