

Bartelso Elementary School District # 57

School Emergency Form

STUDENT INFORMATION					
Student Legal Last Name	Student Legal First Name	Student Middle Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Grade Level Please Choose
Primary Address		PO Box	City	State	Zip Code
Sister(s) and/or Brother(s) in attendance				Primary Custody Please Choose	
PARENT/GUARDIAN INFORMATION # 1 (Lives with student)					
Guardian Last Name	Guardian First Name	Cell Phone	Home Phone		
Relationship to student Please Choose	Place of Employment	Work Phone	Extension		
Guardian Email Address (Parent Portal Access)					
PARENT/GUARDIAN INFORMATION # 2 (Lives with student)					
Guardian Last Name	Guardian First Name	Cell Phone	Home Phone		
Relationship to student Please Choose	Place of Employment	Work Phone	Extension		
Guardian Email Address (Parent Portal Access)					
ALTERNATE PARENT/GUARDIAN INFORMATION # 2 (Does NOT Live with student) Request Mailings <input type="checkbox"/> Yes <input type="checkbox"/> No					
Guardian Last Name	Guardian First Name	Cell Phone	Home Phone		
Relationship to student	Place of Employment	Work Phone	Extension		
Mailing Address		City	State	Zip Code	
Email Address (Parent Portal Access)					
EMERGENCY CONTACTS – OTHER THAN GUARDIANS					
Contact Name	Relationship to Student	Cell Phone	Work/Other Phone		
Contact Name	Relationship to Student	Cell Phone	Work/Other Phone		
MEDICAL INFORMATION					
Allergies			Wears Glasses or Contacts <input type="checkbox"/> Yes <input type="checkbox"/> No		
List any medications your child takes on a regular basis					
Family Physician		Phone Number	Family Dentist		Phone Number
Hospital or Medical facility choice					
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 Signature _____					

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:

Home 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)

You MUST submit the following required documentation from Categories I and II BEFORE the first day of school.

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 [Click here to enter a date.](#)

Signatures of Student's Parents/Guardians

**Please submit the two proofs of residency to the school office
BEFORE the first day of school.**



Bartelso Community School District #57

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

Publicity Release

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



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Student's Name:

INSTRUCTIONS: This form is to be filled out by the student's parents or guardian, and 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 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? PLEASE CHECK ALL THAT APPLY.

- 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

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	Choose a grade.
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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.

Parent or Guardian Signature:	
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Date Click or tap to enter a date.



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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 of Child:	
Name of Child:	
Name of Child:	
Name of Child:	
Name of Child:	

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!

BARTELSON SCHOOL DISTRICT #57
ACCEPTABLE USE POLICY FOR INTERNET/TECHNOLOGY

The Internet is a vast, global network, linking computers at universities, high schools, science labs, and other sites. Through the Internet, one can communicate with people all over the world through a number of discussion forums, as well as through electronic mail. In addition, many files are available for downloading on the Internet, many of which are of educational value. Because of its enormous size, the Internet's potential is boundless. It is possible to speak with anyone from prominent scientists to world leaders to a friend at college. However, with such great potential for education also comes some potential for abuse. It is the purpose of these guidelines, as well as the consent form for Internet use, to make sure that all who use the Internet, both students and faculty, use this valuable resource in an appropriate manner.

The primary purpose of Bartelso School Internet Connection is to support and enhance the school system's educational program. It is essential that everyone who uses this connection understand that purpose. Therefore, anyone using the Bartelso School Internet Connection for other purposes shall immediately be told to disconnect. In addition, people connecting to Bartelso School Internet Connection from remote locations, such as homes, must follow the guidelines and purposes stated in this policy. Failure to abide by these regulations shall result in suspension of their Bartelso School Internet privileges.

Network storage areas will be treated like school lockers. Network administrators will review files and communications to maintain system integrity and insure that users are using the system responsibly. Users should not expect that files stored on district servers will always be private. Within reason, freedom of speech and access to information will be honored. During school time, teachers of younger students will guide them toward appropriate materials. Outside of school, families bear the same responsibility for such guidance as they exercise with information sources such as television, telephones, movies, radio and other potentially offensive media.

Bartelso School strongly condemns the illegal distribution of software, otherwise known as pirating. Any students caught transferring such files through the Internet, and/or whose accounts are found to contain such illegal files, shall immediately have their Internet accounts and privileges revoked. In addition, all users should be aware that software piracy is a federal offense and is punishable by fine or imprisonment. It is a policy that all computers and electronic devices used at Bartelso School are to be used in a responsible, efficient, ethical and legal manner. Specifically, failure to adhere to the policy and guidelines for the use of Bartelso School Internet Connection, as described below, will result in the revocation of access privileges.

Unacceptable use of Bartelso School Internet Connection and electronic devices includes but is not limited to:

- Violating individuals' right to privacy.
- Using profanity, obscenity or other language that may be offensive to others.
- Reposting personal communication without the author's prior consent.
- Copying commercial software in violation of copyright laws.
- Using the network for financial gain, commercial activity or any illegal activity.

Because access to the Internet provides connections to other computer systems located throughout the world, users (and parents of student users) must realize that neither Bartelso School nor any district staff member control the content of the information available on the Internet. Some of the information available is controversial and, sometimes, may be offensive. Bartelso School does not condone such materials. In an effort to limit access to such offensive material, a filtering program will be put in place. Staff will also monitor all student use.

Bartelso School Internet Connection Acceptable Use Policies:

- Use of the Internet is free to users.
- It is a privilege to use the Internet facilities.
- A responsible user of the Bartelso School Internet Connection may have access as long as the user is a staff member or a student of Bartelso School.

A responsible user may:

- Use the Internet to research curriculum projects.
- Use the Internet to send electronic mail (e-mail) to other users, within the guidelines written below.
- Use the Internet to explore areas of interest within Bartelso School curriculum.
- Use the Internet under the supervision of Bartelso School staff to enter non-specific personal data (e.g. age, gender) in order to access educational information.

A responsible user may NOT:

- Use the Internet for any illegal or inappropriate purpose.
- Use impolite or abusive language, or access obscene or pornographic materials.
- Violate the rules of common sense or etiquette.
- Delete or alter computer files that do not belong to the user.
- Send or receive material that would violate the copyright and/or trademark laws of the United States.

- Share a password, when issued, with anyone.
- Vandalize the Internet system. (Students will be legally liable for any damage they might create.)
- Send messages that are likely to result in the loss of recipients' work or systems, send "chain letters," or "broadcast" messages to lists or individuals.
- Create conditions which cause congestion of the networks or otherwise interfere with the work of others.
- Enter any information that may be used to specifically identify the student (e.g. name, address, date of birth, social security number) without the approval of Bartelso School professional staff.

Electronic Mail (E-Mail) Use (when available)

- The person to whom an e-mail account is issued may use the Internet to send mail (e-mail) to other users.
- The holder of an e-mail account is responsible at all times for its proper use.
- Users of Bartelso School e-mail Internet Connection are advised to change their password frequently.
- Users must not give a password to another user.

Bartelso School reserves the right to examine all data stored in local machines, on servers, and on disks in the Internet link to make sure that all users are in compliance with these regulations.

In the event school-owned devices are allowed to be removed from the building and used in students' home, the families of students with a device become responsible for its condition and are financially liable if a device is damaged, broken, lost, or stolen.

By signing this Acceptable Use Policy, you acknowledge that you:

- Understand the policies and procedures of the Bartelso School's Acceptable Use Policy.
- Realize that, if the rules are broken (or if you develop a record of unacceptable behavior in the library media center or classroom), that your Internet Access Privilege will be canceled.
- Realize that there will be no second chances once privileges are denied.
- Understand the foregoing list is not all-inclusive and that Bartelso School reserves the right to notify a user of any other impermissible action regarding the use of the internet.
- **Understand the financial responsibility of replacing or paying for repairs to a school device used outside of school.**

Acknowledgements: Sections of this document were adapted from the Internet Acceptable Use Policy of the South Shore Educational Collaborative which also acknowledged:

The Net: User Guidelines and Netiquette, Arlene Ranaladi, Florida Atlantic University
 The Lexington Public Schools Acceptable Use Policy, Lexington, Massachusetts
 The Bellingham Public Schools District Internet and E-Mail Rules, Bellingham, Massachusetts

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.



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Tom Siegler
Superintendent

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



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Tom Siegler
Superintendent

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 BARTELSON SCHOOL DISTRICT #57.

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

Name of student		Grade	Choose Grade
Name of student		Grade	Choose Grade
Name of student		Grade	Choose Grade
Name of student		Grade	Choose Grade
Name of student		Grade	Choose Grade

Please place my name on the pesticide notification roster:

Parents' Name		Phone number	
Parents' Name		Phone number	

Date signed Click or tap to enter a date.



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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.

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



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Tom Siegler
Superintendent

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 / Immunization
- Vision Exam
- Dental Exam

2nd GRADE EXAM REQUIREMENTS

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

- Dental Exam

6th GRADE EXAM REQUIREMENTS

The following exams are required for students entering 6th grade:

- Health Physical Exam / Immunizations
- Dental Exam

Health Physical Exam / Immunizations - The physical exam and immunizations are to be up-to-date and returned to school **before the first day of school**. Parents, please remember to complete the parent questionnaire on the back and sign. Thank you.

Vision exam - The vision exam is to be completed within one year before the first day of Kindergarten. (between August 16, 2022 and August 16, 2023). This form must be turned into school **before the first day of school**.

Dental exam - The dental exam is to be turned into the office by May 15, 2024, however the exam is to be completed anytime between November 15, 2022 and May 15, 2024.

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

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: _____



**State of Illinois
Certificate of Child Health Examination**

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

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)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
E11b Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps Rubella																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Comments:

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

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

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

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

3. Laboratory Evidence of Immunity (check one) Measles* Mumps** Rubella Varicella Attach copy of lab result.
 *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
 **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

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

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

Last			First			Middls			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				Hospitalizations? When? What for?			Yes	No												
Birth defects?			Yes	No				Surgery? (List all.) When? What for?			Yes	No												
Developmental delay?			Yes	No				Serious injury or illness?			Yes	No												
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes	No				TB skin test positive (past/present)?			Yes*	No	*If yes, refer to local health department.											
Diabetes?			Yes	No				TB disease (past or present)?			Yes*	No												
Head injury/Concussion/Passed out?			Yes	No				Tobacco use (type, frequency)?			Yes	No												
Seizures? What are they like?			Yes	No				Alcohol/Drug use?			Yes	No												
Heart problem/Shortness of breath?			Yes	No				Family history of sudden death before age 50? (Cause?)			Yes	No												
Heart murmur/High blood pressure?			Yes	No				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other																
Dizziness or chest pain with exercise?			Yes	No				Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature			Date													
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____																								
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																								
Ear/Hearing problems?			Yes	No																				
Bone/Joint problem/injury/scoliosis?			Yes	No																				
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA																								
HEAD CIRCUMFERENCE if < 1-3 years old					HEIGHT					WEIGHT					BMI					B/P				
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) 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 required if resides in Chicago or high risk zip code.)																								
Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/>					Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/>					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 <input type="checkbox"/>					Test performed <input type="checkbox"/>					Skin Test: Date Read / /					Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____									
					Blood Test: Date Reported / /					Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>					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		IMP														
Nose								Neurological																
Throat								Musculoskeletal																
Mouth/Dental								Spinal Exam																
Cardiovascular/HTN								Nutritional status																
Respiratory			<input type="checkbox"/> Diagnosis of Asthma					Mental Health																
Currently Prescribed Asthma Medication:																								
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																								
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																								
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): <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>					INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>																			
Print Name _____					(MD, DO, APN, PA) Signature _____					Date _____														
Address _____					Phone _____																			



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: <input type="checkbox"/> Male <input type="checkbox"/> 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 _____
Street City ZIP Code

Telephone _____



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 word 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

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. Vehicles may form two lines and should park facing the North. After all students are in their vehicles, proceed one way from the south side of the school, moving northward behind the church to Highway 161 by the Bowling Alley. (Attached to this notice is a drawing showing where vehicles should park.)

Students who are walking, riding the bus or biking, will be dismissed from the front door exit.

If anyone has questions, please contact the school office at 765-2164.

Tom Siegler,
Superintendent

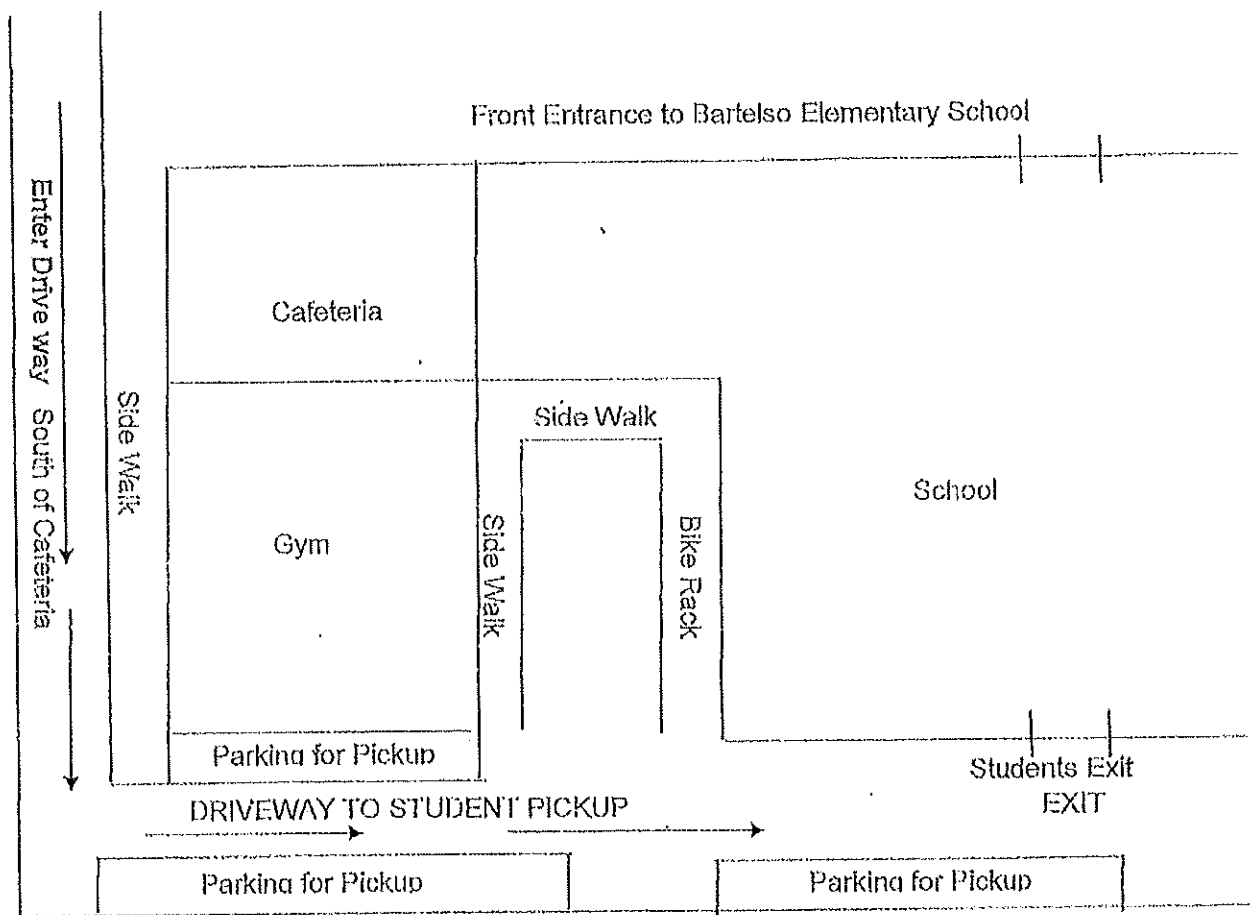
AUTOMOBILE TRAFFIC After School Pick-Up

For safety purposes, parents/guardians need to park behind the school to pick up their children.

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

Parents should:

- Enter the driveway by the gym from South Washington Street.
- Park in designated areas (see diagram)



St. Cecilia Catholic Church

School Year _____

Parish School of Religion (PSR) Registration

304 S. Washington St., Bartelso, IL 62218

stceciapsr@gmail.com

***Please fill in all lines**

Family Last Name:

Father's Name:

Mother's Name:

Home Address:

Home Phone Number:

Registered with St. Cecilia Parish? Yes (Envelope Number) No

Are you interested in volunteering in the PSR program? Yes No

Today's Date: Click or tap to enter a date.

Father's Cell:

Mother's Cell:

Primary Email:

Alternate Email:

Parish School of Religion Class Information

PSR Classes (Grades K-8) meets Monday through Friday during the schoolyear at Bartelso Elementary in student classrooms from **7:30 am – 8:20 am**. Students in grades 2 – 8 attend mass on Wednesday and Friday mornings.

Sacramental Preparation for Reconciliation, Eucharist and Confirmation will be during PSR classes. Students are expected to attend PSR regularly to be prepared for and receive the sacraments. Baptismal information MUST be provided for all students preparing for a sacrament this year (grades 2 and 8).

Student #1 Information –

Name: First: Middle: Last:

Grade in school next year: Allergies:

Baptismal Date: Church: (city) (state)

First Communion Date: Church: (city) (state)

THIS FORM HAS 2 SIDES. PLEASE FILL OUT BOTH SIDES.

Student #2 Information –

Name: First: Middle: Last:

Grade in school next year: Allergies:

Baptismal Date: Church: (city) (state)

First Communion Date: Church: (city) (state)

Student #3 Information –

Name: First: Middle: Last:

Grade in school next year: Allergies:

Baptismal Date: Church: (city) (state)

First Communion Date: Church: (city) (state)

Student #4 Information –

Name: First: Middle: Last:

Grade in school next year: Allergies:

Baptismal Date: Church: (city) (state)

First Communion Date: Church: (city) (state)

Tuition Information: Tuition is charged to partially defray some of the costs of textbooks and supplies. Please make payment **as soon as possible**, making the **check payable to ST. CECILIA CHURCH**, by way of collection basket, mail, or in the school office. Write "PSR" in the memo and **return the entire form along with payment** so it will be recorded in the correct account.

PSR Classes Fee - \$40 for one child **OR** \$60 per family (2 or more children)

Total number of children registered for PSR

Total Due \$

For Office Use Only – Updated 9/20

DATE _____ AMOUNT PAID _____ CHECK # _____