



Central Community Unit School District 301

Department of Student Support Services – Health Services Division

State of Illinois and District 301 Health Requirements

This information is provided to inform you of the medical requirements for all students enrolled in this district.

All documents are requested in the Health Office before the student's first day of attendance unless specified.

Early Childhood Special Education (ECSE)

- Complete physical exam*
- **PARENT** to complete and sign health history on page 2 of the physical exam form

Kindergarten

- Complete physical exam*
- **PARENT** to complete and sign health history on page 2 of the physical exam form
- Complete Vision exam by a licensed eye care professional
- Dental exam

2nd Grade

- Dental exam

5th Grade

- Documented evidence of completed Hepatitis B vaccine series

6th Grade

- Complete physical exam*
- **PARENT** to complete and sign health history on page 2 of the physical exam form
- Dental exam

9th Grade

- Complete physical exam*
- **PARENT** to complete and sign health history on page 2 of the physical exam form

NEW students (to Illinois schools)

- D301 New Student Health Questionnaire for each student
- Complete physical exam*
- **PARENT** to complete and sign health history on page 2 of the physical exam form
- Complete Vision exam by a licensed eye care professional

TRANSFER Students (within the state of Illinois) need to provide copies of the most recent complete physical, vision and dental exams that are needed to meet the state requirements in the grades outlined above and a D301 New Student Health Questionnaire for each student

Medications at School

Over the counter medications as well as prescription medications will only be administered in school when a District 301 "Meds A" Form is on file in the Health Office. Specific forms exist for asthma medications and epinephrine. One form needs to be completed for each medication. Both, the doctor and the parent/legal guardian need to complete and sign these forms.

Privacy Practices

Please be advised that state law now mandates strict privacy rules. As a result, school personnel will no longer contact a doctor, dentist, nurse or pharmacist about a student, health records or health exams unless the parent or legal guardian gives written consent. It is a parent / guardian responsibility to be sure all required documents are turned in to the school in the required time frames. If desired, a consent form permitting communication between health care professionals can be obtained in the school office.

* An IHSA Sports physical does not fulfill the physical requirement



NEW STUDENT HEALTH QUESTIONNAIRE

Child's Name _____ Birth date _____ Grade _____

In an effort to help us provide optimum health services for your child and keep your child's school health record complete and up to date, we ask your cooperation in providing the following information. Please circle responses and provide specifics.

1. Does your child have any allergies? No Yes: Please specify: _____
Type of past reaction: Swelling Itching Hives Rash Difficulty breathing Other _____
Please specify treatment to be done at school: _____

2. Does your child have asthma? No Yes How often are asthmatic episodes? _____ Activity Restrictions? No Yes
What causes episodes? Allergies Colds/URIs Weather Exercise Emotional situations Other _____
List any medications, including dose & frequency _____
Please specify treatment to be done at school _____

3. Does your child take any medications regularly? No Yes: at Home at School Please specify the medicine, its purpose, dose, frequency and any other pertinent information. _____

*NOTE: Additional forms must be completed by the parent/guardian and doctor before any medications can be given at school.

4. Does your child have any vision problems? No Yes Glasses? No Yes Contacts? No Yes Surgeries? No Yes
Please explain problem(s) & treatment(s) _____

5. Does your child have any hearing problems or frequent ear infections? No Yes Which ear? Right Left Both
Please explain problem(s) & treatment(s) _____

6. Does your child have a history of seizures? No Yes What type of seizures? _____ How often? _____
List any medications, including dose & frequency _____
Please specify actions to be taken at school _____

7. Does your child have a history of any emotional / psychological concerns? No Yes Is this a current concern? No Yes
Please explain _____
List any medications, including dose & frequency _____
Please specify actions to be taken at school _____

8. Has your child had any serious illness, operations, or injury? No Yes Please specify: _____

9. Is there anything else about your child's health, physical or emotional background that you would like the nursing staff to know?
Please specify: _____

Authorization: I hereby authorize CCUSD #301 health personnel to release my child's health information / records to teachers, administration, transportation and food service personnel for the purpose of treating or preparing for a medical situation for my child. This authorization is valid for one calendar year. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school District may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I prefer not to sign, it will not interfere with my child's ability to obtain health care.

Signature of Parent / Guardian who completed form: _____ 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 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 October 15 of the year the child enters an Illinois school.

Student Name _____ (Last) _____ (First) _____ (Middle Initial)

Birth Date _____ Sex _____ 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

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 _____



State of Illinois Eye Examination Report

Recommendations

1. Corrective Lenses: No Yes, glasses should be worn for:
 Constant Wear Near Vision Far Vision
 May Be Removed for Physical Education

2. Preferential seating recommended: No Yes

Comments _____

3. Recommend re-examination: 3 months 6 months 12 months
 Other _____

4. _____

5. _____

Print name _____
Optometrist or Physician who provides eye examinations

Address _____

Phone _____

Signature _____
Optometrist or Physician who provides eye examinations

Date _____

<p>Consent of Parent or Guardian</p> <p>I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p>_____</p> <p style="text-align: center;">(Parent or Guardian's Signature)</p> <p>_____</p> <p style="text-align: center;">(Date)</p>
--

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



State of Illinois Department of Public Health Eye Examination Waiver Form

Please print:

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Sex _____ School _____ Grade _____
(Month/Day/Year)

Address _____
(Number) (Street) (City) (ZIP Code)

Phone _____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All KIDS).

My child is enrolled in Medicaid/All KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to see the child and accepts Medicaid/All KIDS.

My child does not have any type of medical or vision/eye care insurance coverage, and there are no low-cost vision/eye clinics in our community that will see my child.

Signature _____ Date _____

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



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

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011



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

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 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 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	
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps			COMMENTS:								
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

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 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 result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN															
Date														Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
Age/Grade															
Vision	R	L	R	L	R	L	R	L	R	L	R	L	R		L
Hearing															

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	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the night	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.			
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)				Parent/Guardian Signature _____ Date _____		
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		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.						
Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ (Blood test required if resides in Chicago.)						
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. 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					Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>			Genito-Urinary	LMP
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 Antagonist) <input type="checkbox"/> 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: <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 (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>			
Print Name			(MD,DO, APN, PA) Signature		Date	
Address			Phone			

(Complete both sides)

Section 665.240 Basic Immunization

- a) Diphtheria, Pertussis, Tetanus
 - 1) Any child two years of age or older entering a school program (defined as nursery schools, pre-school programs, early childhood programs, Head Start, or other pre-kindergarten child care programs offered or operated by a school or school district) shall show proof (see Section 665.250(b)) of having received four or more doses of Diphtheria, Tetanus, Pertussis (DTP or DTaP) vaccine. The first three doses in the series shall have been received no less than four weeks (28 days) apart. The interval between the third and fourth or final dose shall be at least six months.
 - 2) Any child entering kindergarten or first grade for the first time shall show proof (see Section 665.250(b)) of having received four or more doses of Diphtheria, Tetanus, Pertussis (DTP or DTaP) vaccine, with the last dose being a booster and having been received on or after the fourth birthday. The first three doses in the series shall have been received no less than four weeks (28 days) apart. The interval between the third and fourth or final dose shall be at least six months. Children 6 years of age and older may receive Tetanus, Diphtheria (Td) vaccine in lieu of DTP or DTaP vaccine.
 - 3) Any child entering school at a grade level not included in subsection (a)(1) or (2) of this Section shall show proof (see Section 665.250(b)) of receiving three or more doses of DTP, DTaP, pediatric DT or adult Tetanus, Diphtheria (Td) with the last dose being a booster and having been received on or after the fourth birthday. The first two doses in the series shall have been received no less than four weeks (28 days) apart. The interval between the second and third or final doses shall be at least six months.
 - 4) Receipt of pediatric Diphtheria Tetanus (DT) vaccine in lieu of DTP or DTaP is acceptable only if the pertussis component of the vaccine is medically contraindicated. Documentation of the medical contraindication shall be verified as specified in Section 665.520.
 - 5) Beginning with school year 2011-12, any child entering sixth grade shall show proof (see Section 665.250(b)) of receiving one dose of Tdap (defined as tetanus, diphtheria, acellular pertussis) vaccine regardless of the interval since the last DTaP, DT or Td dose.
 - 6) Students entering grades seven through 12 who have not already received Tdap are required to receive 1 Tdap dose regardless of the interval since the last DTaP, DT or Td dose.

What's the Difference Between DTaP and Tdap?

Both vaccines contain inactivated forms of the toxin produced by the bacteria that cause the three diseases. Inactivated means the substance no longer produces disease, but does trigger the body to create antibodies that give it immunity against the toxins. DTaP is approved for children under 7. Tdap, which has a reduced dose of the diphtheria and pertussis vaccines, is approved for adolescents starting at the age of 11 or 12 and adults ages 19 to 64.

Here's a hint to help you remember. The pediatric formulations usually have 3-5 times as much of the diphtheria component than what is in the adult formulation. This is indicated by an upper-case "D" for the pediatric formulation (i.e., DTaP, DT) and a lower case "d" for the adult formulation (Tdap, Td). The amount of tetanus toxoid in each of the products is equivalent, so it remains an upper-case "T."

QUESTIONS & ANSWERS REGARDING SCHOOL HEALTH RECORD ISSUES

Compiled in consultation with, IDHS, ISBE and IDPH programs impacted by the Child Health Examination Code

September 2011

- 1. Can a nurse practitioner or physician's assistant sign the "Child Health Examination form"?**

RESPONSE: Section 27-8.1 in the School Code of Illinois was amended on July 19, 2002 (Public Act 92-0703) to allow advanced practice nurses (APNs) and physician assistants (PAs) who perform a health examination to sign the health exam form. The APN or PA must have signed the health examination form on or after the effective date of the Act (7/19/02) for it to be acceptable.

- 2. If a person other than an APN or PA has sign-off authority from the physician, can they sign the physician's name and then their name on the health exam form?**

RESPONSE: No. Section 27-8.1 in the School Code of Illinois states, that if anyone other than a physician, APN or PA performs any part of a health examination, then a physician must review and sign all required forms.

- 3. If the "Certificate of Child Health Examination" form has a physician stamp instead of an actual signature, is this acceptable?**

RESPONSE: Yes, if a physician signature stamp is used.

- 4. Who can sign the Immunization History portion of the "Certificate of Child Health Examination" form?**

RESPONSE: Physician, nurse in physician's office, school nurse, record keeper in schools, local health agency, etc.

- 5. Is a local health department stamp acceptable?**

RESPONSE: No. A local health department stamp will ONLY be acceptable if the Immunization History portion of the health form was stamped prior to the 2002-2003 school year (i.e. health forms stamped during or before the 2001-2002 school year will be "grandfathered" in).

- 6. Can the school require the physician conducting the physical exam to complete the immunization history section of the Certificate of Child Health Examination form?**

RESPONSE: No. Section 665.250 in the Child Health Examination Code provides that

“Proof of immunity shall consist of documented evidence of the child having received a vaccine (verified by a health care provider, defined as a physician, child care or school health professional or health official) or proof of disease (as described in subsections (c) through (f))”. It should be recognized that the physician may not always have knowledge of the child’s immunization history.

- 7. Is it acceptable to the State Board of Education and the Illinois Department of Public Health Immunization Section to attach an immunization record (i.e. immunization record from a local health department, Cornerstone report) to the “Certificate of Child Health Examination” form and indicate in the Immunization “Comments” section of the form to “see attached immunization history documentation”?** (Some schools are hesitant about transferring immunization dates from another health record to the Certificate of Child Health Examination form.)

RESPONSE: Yes, if there is a notation in the Immunization section of the form that refers to the attached documentation and the person attaching the documentation makes it known by signing their name in the health care provider verifying the immunization history signature space and on the attachment verifying the dates.

- 8. Will the State Board of Education “cite” a school if the parent does not sign the health history section of the “Certificate of Child Health Examination” form?**

RESPONSE: The health history section is a required part of the “Certificate of Child Health Examination”.

- 9. If the parent does not complete the health history section of the form, can I ask them to complete one and attach it to the physical?**

RESPONSE: Yes, a health history can be completed, dated and signed by the parent and attached to the physical examination form.

- 10. Can I still accept physicals done on the old 01-05 version of the form?**

RESPONSE: Yes, for fall 2012-2013 school year **only** you can accept the previous 01-05 version of the form. The new 01-12 form will be required for fall 2013-2014. (In spite of efforts to distribute the form to all necessary parties in usually takes 2 years to be successful in getting full compliance with use of the new form.)

The Child Health Examination Code requires that all mandated school physicals “shall be reported on the uniform forms that the Department of Public Health and the Illinois State Board of Education prescribe for statewide use.

Some electronic forms have been approved for use and a statement denoting that

approval will appear on the form. These forms will closely resemble the State mandated form. Healthcare providers using an electronic form will have until January 2013 to implement the use of the 01-12 version of the form.

If you have additional questions contact Vyki Jackson, 217-785-4525, for further assistance.

11. What types of “out-of-state” physical exam forms are acceptable? (i.e. many “out-of-state” health examination forms do not include sufficient information to determine compliance with the Physical Examination Requirements section on the “Certificate of Child Health Examination” form.)

RESPONSE: Out-of-state forms are only accepted for students transferring into Illinois schools for the first time. The exam must have been completed within one year prior to the date of entry into an Illinois school and must cover all “required” elements as listed on the Certificate of Child Health Examination form. See section 665.150 b. of the Child Health Examination code.

12. When did the change requiring physicals for entry into 6th grade instead of 5th grade take affect?

RESPONSE: Beginning school year 2009-2010, all students entering sixth grade need to present a physical examination that was performed within one year prior to the date of entry.

13. Who is responsible for reviewing physician notes?

RESPONSE: Physician notes which state that a child is “adequately immunized” or which indicate “no additional vaccine is needed” **must** be sent to regional IDPH Immunization Staff for review (Section 665.280).

The IDPH rules and regulations **do not** acknowledge the “4 day grace period” that many providers apply. When physicians administer vaccinations “off schedule,” they will need to submit notes on these circumstances for review by IDPH.

During the time physician notes are under review by IDPH staff, students will be considered “In Compliance, but Unprotected.”

14. Are children entering kindergarten required to be vaccinated against hepatitis B?

RESPONSE: No, hepatitis B vaccination is required for children attending preschool and for the 2011-2012 school year, all children entering grades 5 through 12 should be vaccinated. This would include any student who transfers in from an out-of-state school that would be entering those grades that are required to comply.

15. Will varicella vaccination requirements be progressive like hepatitis B requirements?

RESPONSE: Yes, the varicella vaccine requirement **is** a progressive requirement and grades will continue to be added until 2014, when all students enrolling will be expected to have protection. Varicella vaccination requirements for school year 2011-12 will include children who attend Preschool, Kindergarten, 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 8th and 9th grades. Any student who transfers in from out-of-state in any of those grades is required to comply with varicella vaccination requirements.

When counting intervals for all vaccines, especially with hepatitis B, day one is the day after the vaccine was administered. The day vaccine was administered is considered Day Zero, you count from the next day and day 28 can be the earliest the next dose is given.

16. If a non-immunized child is excluded from school because of a measles outbreak, does the school district have to provide homebound tutoring?

RESPONSE: If the child is non-immunized because of a medical objection they may be eligible for homebound tutoring.

17. When a school transfers a record to another school, should they keep the original record or keep a copy?

RESPONSE: ISBE does not have an official position. It is recommended that the original follow the student and a copy be kept at the school the student transferred from.

18. Who is responsible for maintaining the “Certificate of Child Health Examination” form for students attending out-of-district classes (i.e. special education students)?

RESPONSE: Both districts. The original should be maintained by the district in which the child resides. Copy should be kept by the school where the child attends out-of-district classes. Questions should be directed to ISBE at 217/782-3950.

19. For record keeping purposes, is medical records (containing physical exam and immunization information) part of the student’s “permanent record”?

RESPONSE: Yes. The Certificate of Child Health Examination form is part of the permanent record and must be kept for a period of 60 years.

20. Can Immunization Program staff recommend that schools keep the medical record (containing the student’s immunization history) separate from the student’s cumulative record?

RESPONSE: Staff can recommend it be kept separate, but can't require it.

21. Who is required to be screened for lead?

RESPONSE: Children six months through six years of age entering day care, preschool or kindergarten shall provide a statement from a physician or health care provider that the child has been screened or assessed for lead poisoning. A doctor or nurse must administer and sign the IDHP, Lead Risk Assessment Questionnaire. The law adheres to the recommendations of the American Academy of Pediatrics. The IDPH, Lead Poisoning Prevention Code and Lead Risk Assessment Questionnaire may be found on the IDPH website, www.idph.state.il.us. Questions should be addressed to the IDPH, Illinois Lead Program at 217/782-3517.

22. Is lead screening required?

RESPONSE: The Child Health Examination code says, "Lead screening is a required part of the health examination for children age six years or younger prior to admission to kindergarten or first grade.

Each parent or legal guardian shall provide a statement from a physician or health care provider that the child has been risk assessed using the Lead Risk Assessment Questionnaire if the child resides in an area defined as low risk by the Department, or screened (Blood Lead Tested) for lead poisoning if the child resides in an area defined as high risk. (Section 7.1 of the Lead Poisoning Prevention Act)"

23. What is Lead Program's expectation for completion of the lead section on the health exam form?

RESPONSE:

1. Completion of the section "Blood Test Indicated? Yes or No."

If the lead section of the form is not completed by the child's health care provider, a nurse can administer the questionnaire and mark that section "yes or no", refer for the blood test if indicated and note the date of the referral on the form.

3. There is no requirement that the school obtain the actual blood test results.

If the lead section of the health examination is not completed by the health care provider or nurse, the form is incomplete and cannot be accepted for school enrollment.

24. Do students need to have a TB skin test?

RESPONSE: There are no IDPH rules and regulations that require the initial or routine

skin testing of school children for TB. However, the local health department, TB board or IDPH may, after considering community factors, institute routine, periodic testing when a community, school, or school district has a higher than expected prevalence of infection.

The TB Control Program recommends that children be assessed individually and skin tested by the Mantoux method if they are

- in a high risk group such as children who are immunosuppressed due to HIV infection or other conditions,
- recent immigrants from high prevalence countries-see CDC Travelers Health Yellow Book on website, or
- exposed to adults in high-risk categories (see CDC guidelines).

Some school districts require TB skin testing as part of the school health examination.

TB skin testing requirements for federal Head Start programs are decided by local Health Services Advisory Committees.

The Department of Children and Family Services requires that children in licensed day care centers receive a Mantoux skin test if the child is in a high-risk group as determined by the examining physician.

Questions should be directed to the TB Control Program at (217) 785-5371.

25. Is diabetes risk assessment a required component of the physical examination?

RESPONSE: Yes. Public Act 93-0530 requires that diabetes screening shall be completed as a required part of each mandated health examination. The Consensus Panel of the American Diabetes Association (ADA) suggests that if an individual is overweight and has any two of the risk factors listed below, they are at risk of developing type 2 diabetes.

Overweight is defined as **BMI>85th percentile** for age and sex

Risk Factors:

1. Family history of type 2 diabetes in first/second-degree relatives.
2. Belonging to a certain race/ethnic groups including American Indians, African-Americans, Hispanic Americans, Asian/South Pacific Islanders.
3. Showing signs of insulin resistance or conditions associated with insulin resistance including: acanthosis nigricans, hypertension, dyslipidemia, polycystic ovarian syndrome.

Results of the diabetes risk assessment must be documented on the Certificate of Child Health Examination form. Beginning school year 2006-07, schools will be cited

if risk assessment is not documented on mandated school physicals. Questions should be directed to Vyki Jackson, 217/785-4525 or victoria.jackson@illinois.gov.

26. What are the mandated grades/age for vision and hearing screening?

RESPONSE: Vision and hearing screening are required annually beginning at age 3 in all licensed daycare/preschool programs. Once a child begins school, vision screening is required at grades K, 2 and 8. Hearing screening is required at grades K, 1, 2, and 3. Screening for both vision and hearing must be completed annually on ALL children in special education, children new to the district, and teacher referrals. Screening performed by the doctor's office as part of the school physical does not fulfill the mandate. If there is documentation in the child's file of an eye examination having been done by an optometrist or ophthalmologist within the last 12 months, he/she does not have to be screened.

27. Who can provide mandated vision and hearing screening?

RESPONSE: Screeners who are trained and certified by the IDPH may perform mandated screening.

28. Does the new vision requirement apply to early childhood classes?

RESPONSE: No, the law does not apply to ECE children. The law applies to children entering Illinois schools for the first time at kindergarten or after. So, if a child came from another state or was home schooled and entered the Illinois school system in grade 3 (or 5 or 4 or 9 whatever), then the eye examination requirement would apply to that child.

29. What does "enrolling for the first time" mean?

RESPONSE: Any child entering the Illinois school system at the kindergarten level or higher for the first time is required to have the eye examination regardless of grade level. If a child transfers in from another school in Illinois, it would not be first entry into the Illinois school system. If they transfer in from out of state, out of country, or from home schooling, and have never before been in the Illinois school system, then the eye examination would be required. The children receiving the mandated eye examination are NOT included on the vision conservation annual report of screening activity. Children who are non-compliant with the eye examination requirement would still be screened and counted on the vision conservation annual report to IDPH.

30. How are children who receive the eye exam counted on the vision conservation annual report?

RESPONSE: The children receiving the mandated eye examination are NOT included on the vision conservation annual report of screening activity. Children who are non-compliant with the eye examination requirement would still be screened and counted on the vision conservation annual report to DPH.

31. Do you know if this will change the Vision screening requirements?

RESPONSE: This will not change the requirements of the II Child Vision and Hearing Test Act. The new law does not apply to pre-kindergarten. For kindergarten children, the same rules apply as before. If there is documentation of an eye examination having been done within the last 12 months in the child's file, he/she does not have to be screened.

32. What do I do if I receive an eye examination form that has not been completed in its entirety?

RESPONSE: According to ISBE, you should ask for another form that has all requested information completed, including the pieces of information that are missing on the form that has been received.

33. The parents are NOT signing the Consent of Parent or Guardian Box on the eye examination form. Does that matter?

RESPONSE: This is not an issue for the Illinois State Board of Education. It is the responsibility of the school district to decide whether it will accept an eye examination form without a parent/guardian signature (in the Consent of Parent or Guardian Box).

34. Who should I contact if I have vision and hearing screening questions?

RESPONSE: Questions should be directed to the IDPH Division of Health Assessment & Screening at 217/782-4733. **Vision and hearing questions can also be sent to the DPH.VisionandHearing@ILLINOIS.GOV mailbox. You can add your contact information for the listserv by sending an email to the address given above with a request to be added to the listserv.**

35. Who can give medications and sign the forms for medications to be given?

RESPONSE: Guidelines for medication administration are available on the DHS website at www.dhs.state.il.us/chp/ofh/SchoolHealth. Contact Vyki Jackson, 217-785-4525 with further questions.

36. Which questions should be referred to the Illinois State Board of Education (ISBE) and which ones to DHS School Health Program?

RESPONSE: Questions regarding the religious objection, enforcement of the rules, and general questions regarding the School Code should be referred to ISBE. Child health examination questions should be directed to Vyki Jackson, 217/785-4525 or victoria.jackson@illinois.gov. Questions regarding Vision and Hearing should be directed to IDPH Division of Vision & Hearing at 217/782-4733. Questions regarding ISBE reporting should be addressed to Gayle Johnson at 217-782-3950 or gjohnson@isbe.net.

37. When can a child be excluded from school for noncompliance with physical examination and immunization requirements?

RESPONSE: If a child does not comply by October 15, or by the earlier established date of the current school year, with **all** of the physical examination and immunization requirements, then the local school authority shall exclude that child from school until such time as the child presents proof of having had the **health examination as required** and presents proof of having received those required immunizations which are medically possible to receive. **Required components of the health examination include: health history, diabetes screening, lead risk assessment or testing, and complete physical examination.**

38. Can students who are enrolled in Special Education be excluded from school for noncompliance with health examination and immunization requirements?

RESPONSE: The requirements for health examinations and immunizations apply to all children except those who have been granted an exemption due to religious convictions or medical concerns. If an exemption has not been sought and granted, the district can exclude a special education student in the same manner as a regular education student.

39. Can a student who is "homeless" be excluded from school for failure to comply with physical examination and immunization requirements?

RESPONSE: The McKinney-Vento Homeless Assistance Act requires that schools provide support to homeless children in need of physicals and immunizations for school enrollment. The enrolling school must immediately refer the parent or guardian to the LEA homeless liaison, who must assist in obtaining the immunizations or records by helping to enroll the child in AllKids, arranging appointments for physicals and immunizations and providing transportation if necessary. If, after exhausting all efforts, the parent fails to keep appointments or complete paperwork such as that needed for AllKids enrollment the child may be excluded.

40. If excluded, does the school have to provide homebound tutoring?

RESPONSE: A district would only have to provide homebound tutoring to a child enrolled in special education who is excluded if they extended that service to a child enrolled in regular education.

41. Is dental examination required?

RESPONSE: Before May 15 of the school year, each child in kindergarten and the second and sixth grades shall present to the school proof of having been examined by a dentist in accordance with Section 27-8.1(1.5) of the School Code.

42. Where can I find the most current dental examination report form?

RESPONSE: The form is available on IDPH website at www.idph.state.il.us. The date on the form is to be the actual date of the exam.

43. What are the consequences for failure to provide a report of dental examination?

RESPONSE: If a child in the second or sixth grade fails to present proof of having been examined by a dentist by May 15, the school may hold the child's report card until one of the following occurs:

- 1) the child presents proof of a completed dental examination. (Section 27-8.1(1.5) of the School Code) Submission of a completed examination form, in accordance with subsection (b), constitutes proof of a completed dental examination;
- 2) the child presents proof that a dental examination will take place within 60 days after May 15. (Section 27-8.1(1.5) of the School Code) A written statement or appointment card, prepared by a dentist, dental hygienist, or his or her designee and signed by the child's parent or guardian, indicating the name of the child and the date and time of the scheduled dental examination, constitutes proof that a dental examination will take place. The child must present proof of a completed dental examination at the beginning of the following school year; or
- 3) the child presents a dental examination waiver form, in accordance with Section 665.450

44. Can a school the student is transferring from refuse to send a copy of a physical and immunization record to a new school if there are outstanding fees due?

RESPONSE: It is the position of the Illinois State Board of Education that the school physical is the property of the parent and that the school may not withhold it. The school must also, at the minimum, provide an unofficial transcript of the student's grades.

Call the ISBE Educator and School Development Division at 217-782-2948 if you have questions.

Revised 8-1-11
Revised 1-6-12 vjj



Central Community Unit School District 301

Department of Student Support Services – Health Services Division

Dear Parents / Guardians:

Medications are defined as either prescription or over-the-counter drugs.

Over-the-counter medications as well as prescription medications will be administered in school only when a Meds-A form has been completed by the parent / guardian or an emancipated student **and** the healthcare provider. (*Specialized forms exist for asthma medications & epipens; ask your building nurse.*)

If you feel your child might require a prescription or over-the-counter medication, like Tylenol, Motrin or other such medication, there must be a Meds-A form on file (form attached).

One form must be completed for each medication and requires completion by the parent / guardian or the emancipated student **and** by the healthcare provider. When this form is completed and filed in the school health office, the child will be administered the identified medication. The order for medication and thus the Meds A form must be renewed by the healthcare provider/physician annually or whenever a medication or dosage is changed.

The Meds-A form needs to be completed and submitted when a medication is brought to school. All medications need to be brought to school or back home by an adult.

Minor students are not permitted to transport medications. (Exceptions: epipens and asthma medications if the proper documents have been completed; ask your building nurse for self-administration forms.)

These procedures are for the protection of your child and for those administering the medications to Central District #301 students. A complete guideline for medication administration at school can be found in your student handbook. We appreciate your cooperation with this process and hope it will benefit both you and your child in knowing that medications are being safely administered. If you have any questions, please feel free to call.

Respectfully,

A. Bryant RN CSN
PV 847-464-6014
Fax 847-464-6024

S. Ubelhart RN
LL 847-464-6011
Fax 630-365-2283

J. Lullo RN CSN
HBT 847-464-6008
Fax 847-464-6022

S. Dossey RN
CT 847-717-8000
Fax 847-717-8006

V. McFarland, RN
PKMS 847-717-8100
Fax 847-717-8105

A. Jones RN
CMS 847-464-6000
Fax 847-464-6023

M. Baumgartner RN
CHS 847-464-6027
Fax 847-464-6039



Central Community Unit School District 301

Meds A Form

Not the form for asthma medications, epipens, diabetes or seizure.
Please ask your building nurse for the correct form.

To be completed by parent/ legal guardian or emancipated student:

Student's Name _____ Birth date _____
Address _____ Phone # _____
School _____ Grade _____ Teacher _____
Healthcare Provider: _____
(Please print)
Provider's Phone # _____ Fax # _____

I hereby grant permission for the above named school to administer the medication routine described below for the above named child. I further give the district nursing staff permission to be in contact with the healthcare provider with regard to the medication order and the response my child has to the medication.

Signature of parent / legal guardian or emancipated student _____ Date _____

To be completed by Healthcare Provider:

Diagnosis _____

Name of medication _____

Dosage _____ Time / Frequency _____

Is this medication necessary in order to maintain the student at school? Yes No

Possible Side Effects: _____

Further instructional remarks: _____

Provider's Signature _____ **Date** _____