Annual Health History Year 2019 - 2020 School District 308

TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name Last First Middle			**Birth Date** Month Day Year	**Parent Name**	
				Parent Phone #	
Grade	**Sex** M ☐ F ☐		**Physician**	**Phone**	
School		**Comments**	**Hospital** (circle) Copley Mercy Edward		**Comments**
Allergies? Specify. Allergies to Medication/ Environmental / Food / Stinging Insects (circle)	Yes ☐ No ☐	Indicate severity & treatment:	Loss of Function of one of paired organs? Eye / Ear / Kidney / Testicle (circle)	Yes ☐ No ☐	
Diagnosis of Asthma? Wakes during night coughing?	☐ ☐	Indicate severity:	Hospitalizations? When? What for?	☐ ☐	
Birth Defect?	☐ ☐	Type:	Serious injury/illness? When? What?	☐ ☐	
Blood Disorders? Hemophilia, Sickle Cell, Other? Explain	☐ ☐		Surgery? (List all) When? What for?	☐ ☐	
Diabetes? Type I or Type II (circle)	☐ ☐		Diagnosis of migraine headaches? Explain treatment used.	☐ ☐	
Head Injury/Concussion When?	☐ ☐		Mental Health Concerns? Depression, Bipolar Disorder, other? Explain.	☐ ☐	
Diagnosis of seizure disorder? Type? How long do they last? Please describe.	☐ ☐		Shunt? Right or Left (circle) What type?	☐ ☐	
Heart Problem / Current heart murmur? (circle)	☐ ☐		Dental: Braces / Bridge / Plate (circle)	☐ ☐	Last dental exam?
High Blood Pressure?	☐ ☐		Pre K - K only Developmental Delay?	☐ ☐	
Dizziness or chest pain with exercise?	☐ ☐		Is your child potty trained (daytime)?	☐ ☐	
Bone/Joint Problems/Scoliosis?	☐ ☐		If NO, are you interested in assistance with toilet training during the school day?	☐ ☐	
Ear/Hearing Problem/Frequent Ear Infections? Explain.	☐ ☐		**Additional Comments?**		
Medically-related dietary restrictions? Explain.	☐ ☐		**Medications (List all prescribed or taken on a regular basis.)**		
Eye/Vision Problems? Glasses/Contacts? (circle)	☐ ☐	Last eye exam?			
This information is shared with 911 providers in case of an emergency.			**Parent/Guardian Signature**	**Date**	

Rev January 2014

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

In the event reasonable attempts to contact me at the locations listed below are unsuccessful, I, as parent or legal guardian of **(name of student)** _____, so hereby authorize: (1) the treatment by a licensed medical physician of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed with the purpose of authorizing medical treatment under emergency circumstances in my absence. *(please print)*

Guardian name:	**Relation to student:**
Address:	**City:**
Home phone:	**Business phone:**
Cell phone:	**Other phone:**

This information is shared with 911 providers in case of emergency.

_____ _____

Parent/Guardian Signature Date

AUTHORIZATION TO RELEASE HEALTH RECORDS

I hereby authorize my child's health care provider and previous school to release my child's most recent physical, immunization, and other pertinent health information to CUSD 308 for completion of student health records. This authorization is valid while the student is enrolled in CUSD 308.

_____ _____

Parent/Guardian Signature Date

PESTICIDE NOTIFICATION REQUEST

School District #308 practices Integrated Pest Management, a program that combines preventive techniques, non-chemical pest control methods, and the appropriate use of pesticides with a preference for products that are the least harmful to human health and the environment. The term "pesticide" includes insecticides, herbicides, rodenticides, and fungicides.

This school district is establishing a registry of people who wish to be notified prior to pesticide applications. To be included in this registry, please sign below.

If you have any questions or comments, please contact the, Director of Buildings and Grounds at 630-636-3171.

I would like to be notified two days before the use of pesticides at the school. I understand that if there is an immediate threat to health or property that requires treatment before notification can be sent out, I will receive notification as soon as possible.

_____ _____

Parent/Guardian Signature Date

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

DCFS

State of Illinois
Certificate of Child Health Examination

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

IMMUNIZATIONS: To be completed by health care provider. 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)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)						
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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 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																						
Age/ Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																						
Hearing																						

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

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

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

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

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

HEAD CIRCUMFERENCE HEIGHT WEIGHT BMI B/P

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

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ 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 ☐ Test performed ☐
Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value _____

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes		Amblyopia Yes☐ No☐	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

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

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

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

Yes ☐ No ☐ If yes, please describe.

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

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

Address Phone

(Complete both sides)