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MERIDIAN COMMUNITY UNIT 223
STATE HEALTH REQUIREMENTS FOR STUDENTS

Dear Parents:

The required physical examination form is enclosed for your student. Section 7-8, Chapter 122 of the Illinois School Code requires that all pupils entering PreK or K, 6th and 9th grades must have completed the following before being admitted to school:

1. A physical examination on the specified state form. Physical exams must be completed within one year prior to school entry.
2. Immunizations required for DPT, Polio, Measles, Mumps, Rubella, and Td Booster every 10 years, Varicella and Hepatitis B Vaccine Series.
3. Physician's documentation indicating lead assessment and/or screening (for high risk zip code areas) is required at kindergarten or first entrance to a program (i.e. Early Childhood or Pre-K).
4. Physician's documentation indicating diabetes risk assessment (PreK or K, 1, 6, and 9).

KINDERGARTEN HEALTH NEEDS:

1. Required physical and recommended dental exam.
2. DPT and Polio Boosters must be given after the 4th birthday.
3. MMR (Measles, Mumps, Rubella) 2 doses of measles vaccine required:
   1st dose **on** or **after** 12 months of age
   2nd dose at least **one month** later
4. Varicella vaccine (Chickenpox) –1 dose **on or after** 12 months of age.
5. If the above immunizations have not been completed at the time of the physical exam, a written schedule from your physician to complete the required doses must be presented with the physical exam at the time of registration.
6. Proof of dental exam (or waiver) prior to May 15th of the school year.
7. Proof of a vision exam (or waiver) by October 15 of the school year.

2ND GRADE HEALTH NEEDS:

1. Proof of dental exam prior to May 15th of the school year.

6TH GRADE HEALTH NEEDS:

1. Required physical and recommended dental exam. Be sure physician designates approval for participation in physical education and interscholastic sports by checking the appropriate boxes on the physical form. ***This DOES fulfill the sports physical requirement for 6th grade.***
2. Hepatitis B Vaccine series completed.
3. Required immunizations current.
4. Proof of dental examination (or waiver) prior to May 15th of the school year.

9TH GRADE HEALTH NEEDS:

1. Required physical and recommended dental exam. Be sure physician designates approval for participation in physical education and interscholastic sports by checking the appropriate boxes on the physical form. ***This DOES fulfill the sports physical requirement for 9th grade.***
2. Tetanus (Tdap) Booster
3. Required immunizations current.

I urge you to make your medical, dental and vision exam appointments now to avoid difficulty obtaining an appointment later this summer. **According to the Illinois School Code, students are subject to exclusion from school on and after October 15th if the physical examination and immunization requirements have not been completed and returned to the school.**

Sincerely,

Dr. Robert Morelan
Superintendent

Kim Glendenning, RN, BSN
Director of Health Services

Revised 07/11

DHS

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

Please Print

Student's Name Last First Middle	Birth Date Month/Day/ Year	Sex	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	1 DA	1 YR	2 MO	2 DA	2 YR	3 MO	3 DA	3 YR	4 MO	4 DA	4 YR	5 MO	5 DA	5 YR	6 MO	6 DA	6 YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										Comments								
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23		
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

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

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

ALTERNATIVE PROOF OF IMMUNITY

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

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

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

Date of Disease Signature Title Date

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

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																					Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/ Contacts
Age/Grade																					
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																					
Hearing																					

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(Complete Both Sides)

IL444-4737 (R-01-05)

** THIS FORM IS INTENDED FOR NEW STUDENTS ENTERING THE DISTRICT AND FOR MANDATORY KINDERGARTEN, 6TH GRADE AND 9TH GRADE PHYSICALS.

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? Child wakes during the night coughing	Yes No Yes No	Indicate Severity	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 Other concerns?		
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				

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

PHYSICAL EXAMINATION REQUIREMENTS HEIGHT WEIGHT BMI B/P

DIABETES SCREENING BMI>85% age/sex Yes ☐ No ☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes ☐ No ☐
Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ At Risk Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Blood Test Result (Blood test required in Chicago and other high risk zip codes.)

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

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

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 ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name Signature Date

Address Phone

(Complete both sides)

** THIS FORM IS INTENDED FOR NEW STUDENTS ENTERING THE DISTRICT AND FOR MANDATORY KINDERGARTEN, 6TH GRADE AND 9TH GRADE PHYSICALS.

Illinois Department of Public Health
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: ☐ Male ☐ 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 ______________

Address ______________________ Telephone ______________
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health, 535 W. Jefferson St., Springfield, IL 62761
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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P.O.#346085 5M 10/05

** THIS FORM IS INTENDED FOR KINDERGARTEN, 2ND GRADE AND 6TH GRADE STATE REQUIRED EXAMS.

Illinois Department of Public Health
DENTAL EXAMINATION WAIVER FORM

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: ☐ Male ☐ Female
Parent or Guardian:		Address (of parent/guardian):	

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/KidCare).

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

☐ My child is enrolled in Medicaid/KidCare, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/KidCare.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature ______________________________ Date ____________________

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** IF YOU ARE UNABLE TO FULFIL THE STATE REQUIRED EXAM, PLEASE COMPLETE THIS WAIVER AND SUBMIT TO YOUR BUILDING.