Staunton Community Unit District #6
Registration Form

Date_____, 20____ Grade_____ Age_____

STUDENT INFORMATION

Full Name_____ Male_____Female_____
(Last Name) (First) (Middle)

Date of Birth_____ Place of Birth _____ Student email _____
(Month/Day/Year) (City)

Residence Address _____
(Street) (City) (State) (Zip)

Mailing Address_____
(If different from residence) (Street) (City) (State) (Zip)

Student Cell #_____ Distance to School_____

Last school attended_____ Eligible to ride Bus (Circle One) YES NO

CHILD LIVES WITH: (check one)

_____Both Mother and Father _____ Mother and Stepfather
_____Father and Stepmother _____ Mother Only
_____Father Only _____ Relatives other than Parent
_____Foster Parents _____ Independently
_____ Other _____

HEALTH CONCERNS (circle one)

Asthma Inhaler ADD Seizures Diabetes Allergies
Other/Explain _____
_____
Family Physician _____
Physician Phone # _____

PARENT/GUARDIAN INFORMATION (Household where child resides)

Father/Guardian_____ Relationship to Child_____ Marital Status _____

Home Phone #_____ Cell Phone #_____

Employer_____ Work #_____

Email Address_____
Mother/Guardian_____ Relationship to Child_____ Marital Status_____
Home Phone #_____ Cell Phone #_____
Employer_____ Work #_____

ADDITIONAL FAMILY INFORMATION (Child does not reside in this household) Receive a report card at this address (circle one) YES NO

Parent/Guardian_____ Relationship to Child_____ Marital Status_____
Address _____
(Street) (City) (State) (Zip)
Home Phone #_____ Cell Phone #_____
Employer_____ Work #_____

Parent/Guardian_____ Relationship to Child_____Marital Status_____
Home Phone #_____ Cell Phone #_____
Employer_____ Work #_____

EMERGENCY CONTACT (Designate TWO individuals other than yourself.)

1. Name_____ Relationship to Child_____
Primary Phone #_____
2. Name_____ Relationship to Child_____
Primary Phone #_____

If in the judgment of the school authorities immediate treatment is urgent, and neither parent can be reached, I authorize Staunton Community Unit School District #6 to call 911 and transport my child for treatment. I authorize the school nurse to share information with appropriate staff as necessary.

Parent /Guardian Signature_____ Date_____

STAUNTON COMMUNITY UNIT SCHOOL DISTRICT #6
801 N. DENEEN ST.
STAUNTON, IL 62088

STUDENT NAME: _____ SIS ID #: _____

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, 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? Choose one or more.

- ☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains 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 original peoples of Europe, the Middle East, or North Africa.)

_____ _____
Parent/Guardian's Signature Date

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.

School Use Only: _____

Race and ethnicity verified by: _____ Date verified: _____

KINDERGARTEN MEDICAL REQUIREMENTS

Welcome to Kindergarten! This will be an exciting, fun-filled year for you and your child. This note is to inform you of the requirements for students entering Kindergarten. In order for your child to be in compliance with state law, the school nurse will need the following:

- *Physical Exam* – Must be on the State of Illinois Child Health Examination form
- *Diptheria, Pertussis, and Tetanus* – A series of 4 or more doses, with the booster dose being given on or after the 4th birthday
- *Polio* – A series of 3 doses or more with the booster dose being given on or after the 4th birthday
- *Measles, Mumps, and Rubella* – Two doses required
- *Hepatitis B* – Three doses required
- *Varivax (Chickenpox)* – Two doses required
- *Lead Test* – Required for all children 6 months to 6 years
- *Diabetes Screening* – Questionnaire on exam form to be completed by the physician
- *Vision Exam* – Due by October 15th of the Kindergarten year
- *Dental Exam* – Due by May 15th of the Kindergarten year

A complete list of immunizations and a physical exam **must** be turned in within one month of entry into Kindergarten. Also, please notify the nurse of any significant health problems your child may have. If your child requires medication during the school hours, we will need a doctor's order before it can be administered at school.

I look forward to serving your child during the next school year. If you should have any questions, please call me at 618-635-3831 Ext. 253.

Sincerely,
Sherry Semanek R.N.

KINDERGARTEN REQUIREMENTS

In order for your child to be in compliance with Illinois State law, he/she will need the items checked below:

_____Physical Exam

_____D.P.T.

_____ Polio

_____Measles, Mumps, and Rubella

_____Hepatitis B series

_____Haemophilus Influenzae B (HIB)

_____Varicella (Chickenpox – 2 doses - new law in 2014)

_____Lead Test (Past lead tests will fulfill this requirement)

_____Booster D.P.T.

_____Booster Polio

_____Booster Measles, Mumps and Rubella

_____Diabetes Screening-questionnaire completed by doctor

_____Dental Exam due by May 15th of Kindergarten year

_____Vision Exam due by Oct. 15th of Kindergarten year

_____List of past immunizations

Please turn these records in to the School Nurse.

Certificate of Child Health Examination

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

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)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
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																						
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

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 QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionairre 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)

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 _____ (Month/Day/Year) Sex ____ Grade K

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)	☐	☐	☐	_____
Internal Exam (media, lens, fundus, etc.)	☐	☐	☐	_____
Neurological Integrity (pupils)	☐	☐	☐	_____
Binocular Function (stereopsis)	☐	☐	☐	_____
Accommodation and Vergence	☐	☐	☐	_____
Color Vision	☐	☐	☐	_____
IOP (glaucoma)	☐	☐	☐	_____
Oculomotor Assessment	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other _____

Continued on back

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 _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____
Optometrist or Physician who provides eye examinations

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

Printed by Authority of the State of Illinois
5/08

IISG08-1048

Illinois Department of Public Health
PROOF OF SCHOOL DENTAL EXAMINATION FORM

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: K		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
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

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