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_____

Revised: 6/2/17

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: _____

(Both sides of this registration form must be completed.)

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
- *Diphtheria, 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
- *Varicella (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.

If you have any questions or concerns, please call the school nurse at 618-635-3831 x253.

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. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 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						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments:

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

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

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

Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

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

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

Last	First	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)	Yes No	List:	**MEDICATION** (Prescribed or taken on a regular basis)	Yes No	List:		
Diagnosis of asthma?	Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No			
Child wakes during night coughing?	Yes No						
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 if <2-3 years old **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. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **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		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	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 Agonist) ☐ 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** **Yes** ☐ **No** ☐ **Modified** ☐

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

Address **Phone**

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

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 _____

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

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: 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

Printed by Authority of the State of Illinois
P.O.#346085 5M 10/05

Macoupin County Public Health Department

Maple Street Clinic

Dear Parents,

A **FREE** Dental program and other services are being provided by Maple Street Clinic, Macoupin Co. Public Health Dept., and the Illinois Department of Healthcare and Family Services for **ALL** children in your school. Dental services may include an exam, cleaning, fluoride treatment, and sealants(a protective coating to seal out food and bacteria that cause decay). Other services include school and sports physicals, immunizations, sick/urgent care, and counseling. In order for your child to receive these services, please fill out this form **completely** and return to your child's school nurse.

Please print **in ink** and answer all of the following questions:

SCHOOL: _____ TEACHER _____ GRADE _____

CHILD'S NAME: _____ BIRTHDATE: _____ GENDER: M / F

ADDRESS: _____ CITY/ZIP _____

PHONE: _____ HOUSING: €**Public Housing** €**Rent** €**Own**

RACE: Please check all that apply for your child

€Asian €Black €Hispanic €Native American €White

Your child does not have to be enrolled in free/reduced lunch or Medicaid to receive dental services at school

Does your child qualify for free or reduced lunch? €**Yes** €**No**

Is your child enrolled in the "All Kids" or Medical Card program? €**Yes** €**No**

If **YES**, what is your child's recipient number (9 digits): ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____ - ____

HEALTH HISTORY

Has your child had any serious health problems? €**YES** €**NO**

If **YES**, please explain _____

Does your child have any allergies? €**YES** €**NO**

If **YES**, please explain _____

Is your child taking any medications at this time? €**YES** €**NO**

If **YES**, please list _____

Emergency Contact: _____ Phone number: _____

FREE transportation to Maple Street Clinic or MCPHD in Carlinville provided by MCPT for your next visit

please call 1-877-600-0707 for a ride

The above is true and correct to the best of my knowledge. All clients have the right to treatment by Macoupin County Public Health Department and Maple Street Clinic without discrimination to age, race, color, religion, sex, sexual orientation or national origin. I accept full responsibility for my care and treatment and release Maple Street Clinic and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment. I authorize Macoupin County Public Health Maple Street Clinic to provide service to me and to release necessary information to bill, process, and receive payment of Medical/Behavioral/Dental Benefits (private insurance, Medicare, Medicaid, etc), for Professional Services rendered. I give permission for IDPH, QA audits to be performed and providers to return to check my child's sealants and for the school nurse and providers access to the child's dental record.

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____

Parent/Guardian Date of Birth: _____ Relationship _____

Staunton Community Unit School District #6

Student Medical History – 2017-2018

Name: Last _____ First_____ D.O.B. _____ Grade_____

A. MEDICAL HISTORY: Check the ones that apply and describe under the comments section.

B.

- o ADD/ADHD
- o Asthma
- o Color Deficiency
- o Diabetes
- o Digestive Problems
- o Emotional Concerns
- o Headaches
- o Hearing Problems
- o Heart Condition
- o Seizures
- o Urinary Problems
- o Vision Problems
- o Other _____

COMMENTS:

_____

_____

C. ALLERGIES: Food/Insect/Latex/Medications/Other

Allergy to:	Treatment:

Students with life threating allergies must complete additional forms – please see nurse

D. PRESCRIPTION MEDICATION (please include dosages)

E. GLASSES _____ CONTACT LENSES _____

F. OPERATIONS/INJURIES/HOSPITALIZATIONS (please include date)

G. CURRENT PRIMARY PHYSICIAN: _____

H. MEDICAL EMERGENCY: In case of emergency, please provide at least two contacts:

1.) Name: _____ Phone Number: _____

2.) Name: _____ Phone Number: _____

I, _____, give permission to the nurse/staff of Staunton CUSD#6 to:

Please Circle

YES NO Transport and admit my child to a medical facility in the event of a medical emergency.

Facility preferred: _____

Parent Signature: _____ Date: _____

STAUNTON COMMUNITY UNIT SCHOOL DISTRICT NO. 6

801 North Deneen St. • Staunton, IL 62088
(618) 635-2962 • Fax (618) 635-2994 • www.stauntonschools.org

Staunton Community Unit School District #6 Expects Everyone's Best
**LEAD *CHALLENGE *ACHIEVE*

REQUEST FOR THE ADMINISTRATION OF MEDICINE

STUDENT'S NAME: _____ Date of Birth: _____

School: _____ Grade / Teacher: _____

PART I – LICENSED PRESCRIBER'S AUTHORIZATION

1. Name / type of medication: _____
2. Dosage / amount to be given: _____
3. Route of administration: _____
4. Frequency and time of administration: _____
5. Duration (week, month, indefinite, etc.): _____
6. Diagnosis a) _____
   b) _____
7. Intended effect, and anticipated reaction to medication:
   a) _____
   b) _____
8. Other medication child receives: _____
9. Other requirements: _____

_____ _____
Licensed Prescriber's Signature (required) Date Signed

_____
(Print) Licensed Prescriber's Name

PART II – PARENT'S REQUEST / APPROVAL

I, _____, hereby request and grant permission for Staunton CUSD#6 school nurse or trained personnel to administer above stated medication to my child. (Medication will be stored in locked medication cabnit)

I understand that an individual other than a school nurse may perform this administration, and I specifically consent to this. I further waive any claims against Staunton CUSD#6, members of the Board of Education, its employees, and / or agents arising out of the administration of said medication and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees, and / or agents, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorney fees, resulting from or arising out of the administration, or self-administration of medication to my child.

I may be reached at the following phone # in the event of a reaction to the medication or an emergency:

Parent/Guardian (s) Signature _____ Phone # _____ Date _____

School Nurse Signature _____ Date Received _____

NANCY M. WERDEN
Elementary/Jr. High Principal
(618) 635-3831
Fax (618) 635-4637

DAN W. COX
Superintendent
dcox@stauntonschools.org

BRETT T. ALLEN
High School Principal
(618) 635-3838
Fax (618) 635-2834

STAUNTON COMMUNITY UNIT SCHOOL DISTRICT NO. 6

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Staunton Community Unit School District #6 Expects Everyone's Best
**LEAD *CHALLENGE *ACHIEVE*

Medication Policy and Procedures:

When absolutely necessary, students may require medication during school hours. Staunton CUSD#6 has policies and procedures in place to allow for this to happen safely. If your child needs to take medication at school, please contact the school nurse at (618) 635 – 2962 x 253. There are medication order forms that must completed and turned in. In accordance to School Board policy 7:720, **Physician orders are required for all medicine administered at school, including over-the-counter(OTC) medicines such as Tylenol and Ibuprofen.** Parents/guardians are responsible for obtaining the physician's order and returning it and the medication to school.

- The medicine must be brought to school in the original bottle/container(OTC) or with a pharmacy label (for prescription medications). **Students may not transport their own medication, for safety reasons a parent/guardian should perform this task.**
- All medication(s) are to be stored in a locked cabinet. A refrigerator is available if required.
- At the end of the year or medication regime, it is the parent/guardians responsibility for removing the unused medication from the school. If the parent/guardian does not pick up the medication, the school nurse will dispose of the medication.
- New medication forms must be filled out each year.
- Students are not allowed to carry any medication on them at any time. The only exceptions to this are inhalers, epi-pens, and diabetes supplies/medications. There are special forms for students to carry these medications. These forms are available from the school nurse. Physician's signature is not required for students carrying and administering their own asthma inhalers, although an Asthma Action Plan is. For all students with a diagnosis of asthma, a new Asthma Action Plan should be completed by the physician and turned in to the school nurse yearly.
- Schools are required to follow Illinois licensing laws as well as Illinois School Code when administering medicine for the safety of your child and others.
- See Staunton CUSD #6 handbook (page 35) for additional policy information under Administering Medicines to Students (School Board Policy 7:270)

    - According to School Board policy 7:270, Students should not take medication during school hours or during school-related activities unless it is necessary for a student's health and well-being. When a student's licensed health care provider and parent(s)/guardians(s) believe that it is necessary for the student to take a medication during school hours or school-related activities, the parent/guardian must request that the school dispense the medication to the child and otherwise follow the District's procedures on dispensing medication. No School District employee shall administer to any student, or supervise a student's self-administration of, any prescription or non-prescription medication until a completed and signed "School Medication Authorization Form" is submitted by the student's parent(s)/guardian(s).

NANCY M. WERDEN
Elementary/Jr. High Principal
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Staunton Community Unit School District #6 Expects Everyone's Best
**LEAD *CHALLENGE *ACHIEVE*

Dear Staunton Families,

This letter is to inform you that a student in your child's classroom has **severe food allergies** to Peanuts and Tree Nuts. Exposure to these allergens could cause a life-threatening reaction.

It is our goal to ensure that every student in our school is safe. Our District has adopted a policy for managing students with food allergies. Our policy is in compliance with Public Act 96-0349 and meets the guidelines created by the Illinois State Board of Education and the Illinois Department of Public Health.

Because these students cannot be in contact with foods containing these allergens, we are requesting that you DO NOT send these foods containing these ingredients to school for snacks or treats. Even trace amounts of these allergens could result in a severe allergic reaction. Sometimes these elements may be hidden in processed foods. Please read food labels carefully before sending a treat/snack to school. We ask that treats be pre-packaged and store bought with ingredients list to ensure all products are nut free.

Please discuss the following with your child:

- Do not offer, share, or exchange any foods with other students at school.
- Hand washing with soap and water, after eating, is necessary to decrease the chance of cross-contamination of surfaces at school.
- If your child rides the bus, remind them that there is a "no eating on the bus" policy.

Thank you for your consideration and help in this matter. The safety of our students is of utmost priority. Please do not hesitate call if you have any questions or concerns.

Sincerely,

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