



## Glenbard East High School Enrollment Checklist

Today's Date: \_\_\_\_\_ Student Name: \_\_\_\_\_

Has student ever attended a Glenbard School? YES / NO

Has student withdrawn from current school? YES / NO

These items must be turned in *before* an enrollment appointment with the counselor can be arranged. If you have any questions, please contact the Guidance Office at 630-424-7150.

**To be completed by staff:**

<u>Initials</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**Birth Certificate**

**Parent/Guardian ID**

**Proof of Residency (see next page)**

**Custody Documentation (if applicable)**

- |   |   |
|---|---|
| <input type="checkbox"/> Divorce Decree     | <input type="checkbox"/> Notarized Custody/Control papers |
| <input type="checkbox"/> Court Guardianship | <input type="checkbox"/> Exhibits A and B                 |

**ISBE Student Transfer Form (public schools in Illinois only)**

**School Records**

- |   |  |
|---|--|
| <input type="checkbox"/> Grades in Progress | <input type="checkbox"/> Transcripts (official/unofficial) |
| <input type="checkbox"/> Report Cards       | <input type="checkbox"/> Teacher Recommendations           |

**Test Scores**

- |                                  |                                      |
|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Explore | <input type="checkbox"/> ISAT        |
| <input type="checkbox"/> PSAE    | <input type="checkbox"/> Access/WAPT |

**Health Records**

- |  |   |
|--|---|
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> IL 9 <sup>th</sup> Grade Physical Exam |
|--|---|

**ELL Services (if applicable)**

- Contact ELL staff Appt Date: \_\_\_\_\_

**Current/Prior Special Ed Services (if applicable)**

- |   |                          |
|---|--------------------------|
| <input type="checkbox"/> IEP (if currently Special Ed) *              |                          |
| <input type="checkbox"/> Record release form sent to Special Ed Dept. | Date _____               |
| <input type="checkbox"/> IEP sent to Special Ed                       | Date _____ Signed: _____ |

\*(FOR SPECIAL ED STUDENTS WHO **DO NOT** HAVE A CURRENT IEP - A STAFFING IS REQUIRED PRIOR TO COMPLETING A COURSE SCHEDULE AND STARTING SCHOOL.)

**Guidance Enrollment Forms**

- |       |  |
|-------|--|
| _____ | Authorization to <b>Release Student Records</b>                                    |
| _____ | New Student & Parent Statistical <b>Data</b> Record (pink-2 sided)                 |
| _____ | Home <b>Language</b> Survey (if <b>yes</b> checked, Native Language form required) |
| _____ | US Dept. of Education <b>Race and Ethnicity</b> Data Collection Sheet              |
| _____ | Glenbard Community <b>Notification</b> System Sheet                                |

Date/time of enrollment conference \_\_\_\_\_ Counselor \_\_\_\_\_



# GLENBARD TWP HIGH SCHOOL DISTRICT 87 RESIDENCY VERIFICATION

East \_\_\_\_\_ West \_\_\_\_\_ North \_\_\_\_\_ South \_\_\_\_\_

ALL students must verify residency in the Glenbard School District before they register for the 20\_\_ - 20\_\_ school year.

Name of Student \_\_\_\_\_ ID # \_\_\_\_\_

Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

Names of current Glenbard siblings:

Name \_\_\_\_\_ ID# \_\_\_\_\_

Name \_\_\_\_\_ ID# \_\_\_\_\_

Name \_\_\_\_\_ ID# \_\_\_\_\_

Evidence of proof of residency presented:

Please provide 1 (one) document from Category I **and** 2 (two) documents from Category II.

### CATEGORY I (ONE document)

- Most recent property tax bill
- Signed and dated lease and proof of last month's payment
- Letter of residency from landlord and proof of last month's payment
- Affidavit from local resident attesting registrant is living with the owner at no cost
- Mortgage papers
- An Agreement of sale
- Letter from manager and proof of last month's payment

### CATEGORY II (TWO documents showing proper address)

- Driver's License
- Voter Registration
- Home/Apartment Insurance Papers
- Gas or Electric Bill (Telephone Bill not acceptable)
- Auto Registration
- Credit Card Bill
- Library Card
- Public Aid Card
- Other \_\_\_\_\_

Military Personnel (must provide one of the following within 60 days after the student's initial enrollment)

- Postmarked mail addressed to military personnel
- Lease agreement for occupancy
- Proof of ownership of residency

I cannot provide the required evidence for the following reason(s):

\_\_\_\_\_

\_\_\_\_\_

By \_\_\_\_\_ I will provide the following evidence of my residency.  
(date)

**“A person who knowingly or willfully presents to any School District any false information regarding the residency of a pupil for the purpose of enabling that pupil to attend any school in that District without the payment of a non-resident tuition charge shall be guilty of a Class C Misdemeanor.” (105 ILCS 5/10-20.12b)**

This proof of residency form is to attest that the above child(ren) is/are not enrolling in the District solely for school purposes and is living on a permanent basis with the person having complete custody and control. Registration of a student who is not a resident is a fraudulent act. Any student found to have fraudulent registration will be subject to the payment of retroactive tuition charges for non-resident students, not to exceed 110% of the per capita cost.

I certify that I understand the residency requirements and that I know the penalty for fraudulent registration.

\_\_\_\_\_  
Signature of Parent/Guardian/Custodian

\_\_\_\_\_  
Date

Relationship to student(s) \_\_\_\_\_

Address of Parent/Guardian/Custodian \_\_\_\_\_

Phone Number \_\_\_\_\_

Revised 07/23/12



# Glenbard East High School

1014 S. Main Street, Lombard, IL 60148

## REQUEST FOR STUDENT RECORDS

STUDENT NAME: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ YEAR IN SCHOOL: 9 10 11 12  
PARENT/GUARDIAN NAME: \_\_\_\_\_  
PARENT/GUARDIAN PHONE NUMBER: \_\_\_\_\_  
PREVIOUS SCHOOL NAME: \_\_\_\_\_  
SCHOOL STREET ADDRESS: \_\_\_\_\_  
SCHOOL CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_  
PHONE #: \_\_\_\_\_ FAX #: \_\_\_\_\_

I authorize the release of records for this student to:

Jessica Sauter, Registrar  
Glenbard East High School  
1014 South Main Street  
Lombard, IL 60148-3968

jessica\_sauter@glenbard.org  
Phone: 630-424-7142  
Fax: 630-627-4922

**Please fax or email the following records immediately:**

- Unofficial Transcript
- Date of Withdrawal and Grades in Progress
- ISBE Good Standing Form (Illinois residents only)
- Test Results (Explore, ISAT, PSAT, ACT, Plan)
- 9<sup>th</sup> Grade Physical and Immunization Record
- Special Education Records (if applicable)
- ELL Records (ACCESS and/or WAPT Scores, Exit Letter, etc)

Please mail an Official Transcript and any other pertinent records as soon as possible.

\_\_\_\_\_  
(signature of parent, guardian, or student over the age of 18)

\_\_\_\_\_  
(date)

*This information is considered and kept confidential. According to new Federal Law 99.31, no parent or student signature is required for educational records sent to another educational agency.*

Emailed/faxed on \_\_\_\_\_ 2<sup>nd</sup> request \_\_\_\_\_ 3<sup>rd</sup> request \_\_\_\_\_ Records received \_\_\_\_\_



# New Student & Parent Statistical Data Record

Glenbard High School District #87

Legal Name: [Last] [First] [Middle] Gender:  Male  Female

Date of Birth: [Month] [Day] [Year] Birthplace: [City] [State] [Country]

Mother's Maiden Name: [ ] Attended another Glenbard? North  East  South  West

### STUDENT IS LIVING WITH OR IS IDENTIFIED

- (1) Both  (2) Mother  (3) Father  (4) Mother & Stepfather  (5) Father & Stepmother  (6) Grandparents  (7) Foster  
 (8) Legal Guardian  (9) Other  (A) Alone  (E) Emancipated  (S) Spouse  (W) Ward of State  (J) Joint Custody

Address of Parent(s) or Guardian(s) with whom this student is living and where school items are to be mailed (Primary Mailing Address)  
 P.O. boxes are not accepted.

[Street Address] [Apt.] [City] [Zip Code] ( ) [Home Phone]  Phone # Unlisted

Previous school attended (if any): [ ]

City, State, Zip: [ ]

Street Address: [ ]

First Date of Entry into a U.S. School? [Month] [Day] [Year] Where was the student born? [City] [State] [Country]

**Special Services:** Has this student ever received Special Education, 504 or other special services? If yes what program?  Yes  No

### Name of Parent(s) or Guardian(s) ONLY with whom this student is living:

Parent or Guardian Name: [Title] [Last] [First] Relationship: [ ]  
 Parent / Guardian's E-Mail Address: [ ]

( ) [Ext.] Work / Day Phone  
 ( ) [Ext.] Cell Phone  
 ( ) [Ext.] Other

Parent or Guardian Name: [Title] [Last] [First] Relationship: [ ]  
 Parent / Guardian's E-Mail Address: [ ]

( ) [Ext.] Work / Day Phone  
 ( ) [Ext.] Cell Phone  
 ( ) [Ext.] Other

### Warning and Affirmation:

Illinois law has made it a crime, punishable by imprisonment and fine, to knowingly or willfully present any false information regarding the residency of a student for the purpose of enabling that student to attend on a tuition-free basis or to knowingly enroll a student on a tuition-free basis when the student is known to be a non-resident of the District. The District will seek prosecution to the full extent of the law on any persons that District believes

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

### School Use Only

ID # [ ] Class Of [ ] Counselor [ ] Dean [ ] Locker [ ]

87 Transfer  New Student  Re-Entry [ ] Entry Date

Student Last Name: \_\_\_\_\_ First: \_\_\_\_\_

**Contact**

**Attendance Phone Number**  
*Number may be used for automated attendance phone calls (if left blank the home number will be used)*

Primary Attendance Number  
( ) \_\_\_\_\_

**Glenbard Student Directory**  
For the convenience of students, our school publishes a list of all students enrolled, including their name, address, and telephone number(s). If you do not wish this information to appear in our directory, please check those items.

**Exclude from Directory:**  Student Name  Address  Phone Number(s)

**Glenbard use of student images**  
Glenbard District 87 reserves the right to use images, photographs or likenesses of students, while engaged in school activities, in digital, video or printed form. Unless parent or guardian requests in writing to the Assistant Principal for Student Services **within the first 30 days of school** that identifiable images of his or her child not be used, Glenbard has the right to publicize student images.

**Military Recruiters & Post Secondary Institutions**  
From time to time, military recruiters and post-secondary institutions request the names, telephone numbers, addresses, and email address (commonly referred to as "directory information,") of our secondary students. The school must provide this information unless the parents(s)/guardian(s) request that we don't release it. **If you DO NOT want military recruiters and/or institutions of high learning to be given your student's name, address and telephone number, please checkmark below.**

Military Recruiters  Post-Secondary Institutions

Physician Name \_\_\_\_\_ Physician Phone: ( ) \_\_\_\_\_

**Emergency Data**

**Choose emergency contacts other than parent or guardians**

Emergency Contact #1 \_\_\_\_\_  
Phone ( ) \_\_\_\_\_ Phone (optional) ( ) \_\_\_\_\_

Emergency Contact #2 (optional) \_\_\_\_\_  
Phone: (optional) ( ) \_\_\_\_\_ Phone (optional) ( ) \_\_\_\_\_

Emergency Contact #3 (optional) \_\_\_\_\_  
Phone: (optional) ( ) \_\_\_\_\_ Phone (optional) ( ) \_\_\_\_\_

My signature indicates the information on this form is accurate and truthful. School authorities have my consent to act in an emergency to secure the necessary aid and transportation for the preservation of my child's health.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Office Use Only**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Glenbard High School District #87  
U.S. Department of Education Race and Ethnicity  
Data Collection

**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.**

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Class of: \_\_\_\_\_

**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.)
- White** (A person having origins in any of the original peoples of Europe, the Middle East, or North 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.)
- Black or African American** (A person having origins in any of the black racial groups of Africa.)

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Observer Identification (parent/guardian did not respond):

Name: \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

**Glenbard District 87  
Home Language Survey  
(to determine ESL eligibility)**

Student Name \_\_\_\_\_  
Last First Middle

The State requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students that need to be tested for English language proficiency. **If you would like to receive this document in any other languages please contact your home school for a copy in any of the 44 languages provided by ISBE.**

**If the answer to either question is YES, the law requires the school to test your child's English language proficiency.**

1. Is a language other than English spoken in your home? Yes \_\_\_\_\_ No \_\_\_\_\_ Language? \_\_\_\_\_

2. Does your child speak a language other than English? Yes \_\_\_\_\_ No \_\_\_\_\_ Language? \_\_\_\_\_

\_\_\_\_\_  
*Parent/Legal Guardian Signature*

\_\_\_\_\_  
*Date*

**Encuesta del Idioma en el Hogar  
(para determinar elegibilidad para servicios de ESL)**

Nombre del estudiante: \_\_\_\_\_

El estado requiere que el distrito recoja información en una Encuesta del Idioma que se Habla en el Hogar (*Home Language Survey* o HLS por sus siglas en inglés) para cada estudiante nuevo. Esta información se usa para contar a los estudiantes cuyas familias hablan en el hogar un idioma que no es el inglés. También ayuda a identificar a los estudiantes que necesitan ser evaluados para la fluidez en el idioma inglés.

Por favor, conteste las preguntas a continuación.

1. ¿Se habla en su casa otro idioma que no es el inglés? Sí \_\_\_\_\_ No \_\_\_\_\_ ¿Cuál? \_\_\_\_\_

2. ¿Habla su niño(a) un idioma que no es el inglés? Sí \_\_\_\_\_ No \_\_\_\_\_ ¿Cuál? \_\_\_\_\_

**Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la fluidez de su niño en el idioma inglés.**

\_\_\_\_\_  
*Firma del Padre/Madre/Encargado/Tutor Legal*

\_\_\_\_\_  
*Fecha*

E

Revised 09/14

Original to ELL File



# Glenbard Community Notification System

The Glenbard District 87 Administration realizes being informed in a prompt way is very important to our parents/guardians and students. We need your help to keep you better informed on important news and events. Our mass notification system, IRIS, has the ability to alert you using several different contact methods/levels. The levels are based on the urgency and severity of the message being sent, "Level 1" being the least urgent to "Level 5" being the most urgent. The levels are generally defined as follows:

**Level 1:** Time insensitive information sent to email (general news)

**Level 2:** Time sensitive information sent to 2 different email addresses (time sensitive news)

**Level 3:** Time insensitive announcements/alerts (school/district events, reminders, general announcements etc)

**Level 4:** Time sensitive announcements/alerts (snow days, major event updates, progress report notice, etc)

**Level 5:** Urgent information used only in the event of a serious situation or event (emergency school closing, evacuation, other extreme events)

The higher the level the more communications will be sent out. Here is the breakdown of what type and what level each communication will be sent.

	Level 1	Level 2	Level 3	Level 4	Level 5
<b>Email 1</b>	Sent	Sent	Sent	Sent	Sent
<b>Email 2</b>		Sent	Sent	Sent	Sent
<b>Phone 1 (required)</b>			Called	Called	Called
<b>Phone 2</b>				Called	Called
<b>Phone 3</b>					Called

Please fill in your information below and return to your student's school. The recommended phone numbers are listed in italics below the description. Please note that all calls will display "Sugarland Texas" on your caller ID.

<b>Student ID Number</b>	
<b>Student Name</b>	
<b>Email 1</b> <i>(Your primary email)</i>	<input type="checkbox"/> <b>Include in Glenbard News Letter</b>
<b>Email 2</b> <i>(Secondary e-mail)</i>	<input type="checkbox"/> <b>Include in Glenbard News Letter</b>
<b>Phone 1 (required)</b> <i>(Home Phone)</i>	<input type="checkbox"/> <b>Check here to receive text messages at this number</b>
<b>Phone 2</b> <i>(Day Phone)</i>	<input type="checkbox"/> <b>Check here to receive text messages at this number</b>
<b>Phone 3</b> <i>(Cell Phone)</i>	<input type="checkbox"/> <b>Check here to receive text messages at this number</b>



**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	
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	<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	<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	<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	<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													
	R	L	R	L	R	L	R	L	R	L	R	L	
Vision													
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
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? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Parent/Guardian Signature	Date	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
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:  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)