Glenbard East Medical Requirements for 9th grade and new transfer students

ALL DOCUMENTS SHOULD BE SUBMITTED TO THE SCHOOL NURSE
EMAIL: laura_grabowski@glenbard.org FAX: 630-424-6438
Or mailed to: Glenbard East Health Office
1014 S. Main St. Lombard, IL 60148

School Physicals: A Certificate of Child Health Examination (also known as a school physical) is required to enroll in high school for incoming freshmen and/or transfer students by **July 15, 2025.** *(Reminder: This is different from a sports physical which is needed for athletic participation).* The school physical **must** be signed by a physician, nurse practitioner or a physician's assistant, and be **less than 1 year old** at the start of the school year. For example, if the last physical is dated 8/6/2024, it will not be accepted to start of the 2025-2026 school year (the first day is 8/14/2025).

Freshman / Transfer School Physicals are due: July 15, 2025

Summer School Students: A Certificate of Child Health Examination (school physical) is required for **all** freshman and/or transfer students who plan to participate in summer school by **May 20, 2025.** (*If a student has an 8th grade physical on file, a **new** physical must be submitted by July 15, 2025).* All school physicals **must** be **less than 1 year old** as 8th grade physicals will not be accepted at the start of the 2025-2026 school year.

Freshman / Transfer Summer School Physicals are due: May 20, 2025

Students will **not** be permitted to start school (or summer school) on the first day without completing the following requirements (board policy 7:100):

- ☐ **State of IL Certificate of Child Health Examination**
  - Must be completed by your doctor and dated **within the last year** to be accepted.
  - Health history **must** be completed by parent (second page/top)
  - Sport physicals are **NOT** accepted as the school physical
  - Resources and forms can be found on our website www.glenbardeasths.org
- ☐ **Immunizations**
  - ❑ **Tdap** (1 dose)
  - ❑ **DTap, DT, or Td** (3 or more doses: last dose on/after 4th bday)
  - ❑ **IPV/OPV** (3 or more doses: last dose given on/after 4th bday)
  - ❑ **Hepatitis B** (3 doses)
  - ❑ **MMR** (2 doses)
  - ❑ **Varicella** (2 doses)
  - ❑ **Meningococcal** (1 dose on/after the 11th bday)

In addition, the Health Office is requesting:

- ☐ **Medical action plans & medication forms**
- ☐ **Dental Exam** (form from current year)

Requisitos médicos de Glenbard East para noveno grado y nuevos estudiantes transferidos

TODOS LOS DOCUMENTOS DEBEN ENTREGARSE A LA ENFERMERA DE LA ESCUELA
CORREO ELECTRÓNICO: laura_grabowski@glenbard.org FAX: 630-424-6438
O enviado por correo a: Glenbard East Health Office
1014 S. Main St. Lombard, IL 60148

Exámenes físicos escolares: Un Certificado de examen de salud infantil (también conocido como examen físico escolar).) Se requiere que los estudiantes entrantes de primer año y/o los estudiantes transferidos se inscriban en la escuela secundaria antes de **15 de julio, 2025.** *(Recordatorio: esto es diferente de un físico deportivo que es necesario para la participación atlética).* El físico escolar **debe** estar firmado por un médico, enfermero practicante o asistente médico, y estar **menos de 1 año** al inicio del año escolar. Por ejemplo, si el último examen físico tiene fecha del 6/8/2024, va a no ser aceptado a inicios del 2025-2026 año escolar (el primer día es 8/14/2025).

Estudiante de primer año / Transferencia exámenes físicos escolares se deben: 15 de julio de 2025

Estudiantes de la escuela de verano: Se requiere un Certificado de examen de salud infantil (examen físico escolar) para **todo** estudiantes de primer año y/o transferidos que planean participar en la escuela de verano al **20 de mayo de 2025.** (*si un estudiante tiene un examen físico de octavo grado en su expediente, un **nuevo** pago El examen físico debe enviarse antes del 15 de julio de 202.5)***.** En toda la escuela los exámenes físicos **deben** ser de menos **de 1 año** como lo harán los exámenes físicos de octavo grado no serán aceptados al inicio del 2025-2026 año escolar.

Escuela de verano para estudiantes de primer año / transferencia exámenes físicos se deben: 20 de mayo de 2025

A los estudiantes **no** se les permitirá comenzar la escuela (o la escuela de verano) el primer día sin completar los siguientes requisitos. (política de la junta 7:100):

☐ **Certificado de examen de salud infantil del estado de IL**

- Debe ser completado por su médico y fechado. **dentro del último año** para ser aceptado.
- Historial de salud **debe** ser completado por los padres (segunda página/arriba)
- Los exámenes físicos deportivos son **NO** aceptado como examen físico de la escuela
- Los recursos y formularios se pueden encontrar en nuestro sitio web. www.glenbardeasts.org

☐ **Vacunas**

❑ **Tdap** (1 dosis)

❑ **DTap, DT o Td** (3 o más dosis: última dosis en/después del cuarto cumpleaños)

❑ **IPV/OPV** (3 o más dosis: última dosis administrada el cuarto cumpleaños o después)

❑ **Hepatitis B** (3 dosis)

❑ **MMR** (2 dosis)

❑ **Varicela** (2 dosis)

❑ **meningococo** (1 dosis a partir del día 11)

☐ **Además, la Secretaría de Salud solicita:**

__Planes de acción médica y formularios de medicación. __Examen dental

State of Illinois

Certificate of Child Health Examination

Student's Name (Last / First / Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address | City | ZIP Code | Parent/Guardian | Telephone (home/work)

HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.

ALERGIAS (Alimentos, drogas, insectos, otro)	☐ Sí ☐ No	**Anote todas las alergias:**	**MEDICAMENTOS** (Recetados o tomados con regularidad)	☐ Sí ☐ No	**Anote todos los medicamentos:**

¿Tiene diagnóstico de asthma?	☐ Sí ☐ No		¿Tiene pérdida de funciones en uno de los órganos?(Ojos/Oídos/Riñones/Testículos)	☐ Sí ☐ No	
¿Despierta el niño tosiendo en la noche?	☐ Sí ☐ No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Tiene defectos de nacimiento?	☐ Sí ☐ No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Tiene retrasos del desarrollo?	☐ Sí ☐ No		¿Ha tenido heridas graves o enfermedades?	☐ Sí ☐ No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique.	☐ Sí ☐ No		¿Prueba positiva de TB (Pasado o Presente)?	☐ Si* ☐ No	*Si contestó sí, refiera al departamento de salud local
¿Tiene diabetes?	☐ Sí ☐ No		¿Enfermedad de TB (Pasado o Presente)?	☐ Si* ☐ No	
¿Tiene heridas en la cabeza/golpe/desmayo?	☐ Sí ☐ No		¿Usa tabaco (tipo, frecuencia)?	☐ Sí ☐ No	
¿Tiene convulsiones? Cómo se manifiestan?	☐ Sí ☐ No		¿Toma alcohol/drogas?	☐ Sí ☐ No	
¿Tiene problemas cardiacos/Dificultad para respirar?	☐ Sí ☐ No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	☐ Sí ☐ No	
¿Tiene soplo en el corazón/presión arterial alta?	☐ Sí ☐ No		☐ Dental ☐ Frenos ☐ Puente ☐ Placas ☐ Otro		
¿Tiene mareos o dolor de pecho al hacer ejercicios?	☐ Sí ☐ No		**Información Adicional:**		
¿Problemas con los ojos/visión? _____ ☐ Lentes ☐ Lentes de Contacto Último examen _____			La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee) _____			**Firma del Padre/ Tutor:** _____ **Fecha:** _____		
¿Tiene problemas de los oídos/no oye bien?	☐ Sí ☐ No				
¿Tiene problemas de los huesos/articulaciones/heridas/ escoliosis?	☐ Sí ☐ No				

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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 _____

State of Illinois

Certificate of Child Health Examination

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

Street Address, City, ZIP Code	Parent/Guardian	Telephone (home/work)

HEALTH HISTORY: MUST 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		Hospitalization? 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 disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
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				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Additional Information:

Ear/Hearing problems?	☐ Yes ☐ No	
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No	

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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 _____

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

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

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

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ 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 aged 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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

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
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 of Exam _____

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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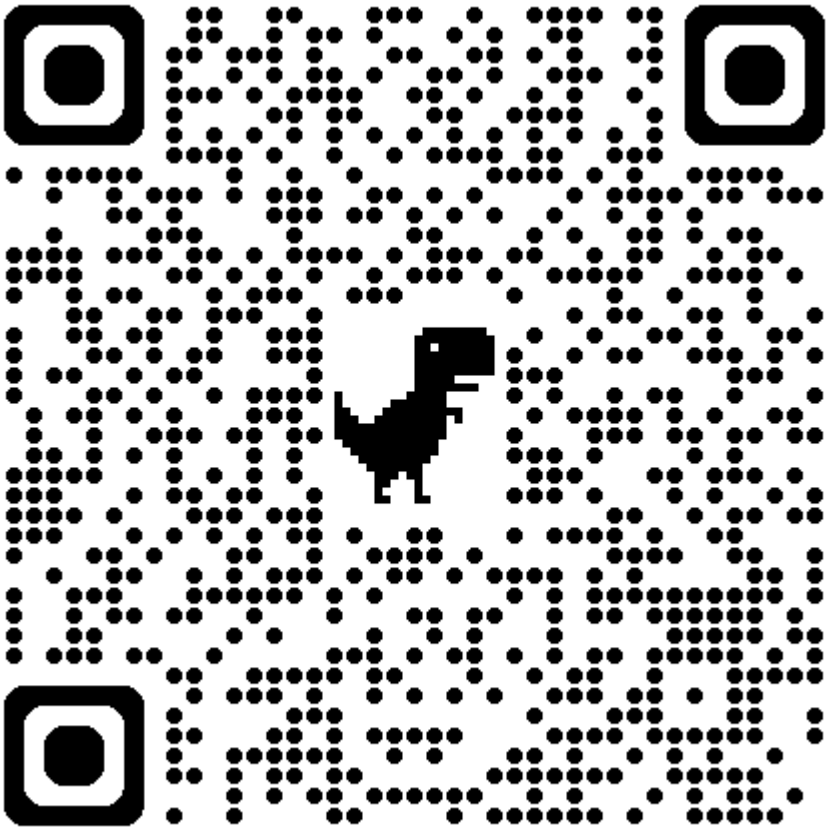

QR code for Health Requirements 2025-2026 School Year - English