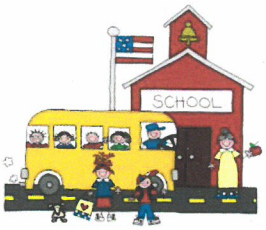

Welcome to the Minooka Schools! We are glad you are joining our school family! Minooka Community Consolidated School District 201 has an outstanding reputation for providing academic programs that provide students with a sound education foundation.

New students may register at any of our Minooka schools. See "Building Assignment 2020/2021" to determine what school(s) your student(s) will attend. Appointments are requested to register your child (ren), and may be made by contacting any of the Building Secretaries at the numbers listed below. District 201 does not accept tuition students. Students must reside in the District in order to attend our schools. **You may not register without the required registration documents.** Registration forms are available on our website (www.min201.org) for your convenience.

Required Physical Examination and Immunizations:
Health forms are also located on our website for your convenience. All new students enrolling in our District must have a current Illinois Department of Human Services Health Examination Form on file prior to beginning school. New physicals, dentals, and eye examinations are required for kindergarten. Two doses of Varicella and two doses of MMR are required for kindergarten. Dental examinations are required for second grade. New physicals and dental exams are required for 6th grade. Tdap booster and two doses of Varicella and one dose of Meningococcal Conjugate Vaccine (MCV4) are required for 6th grade.

Aux Sable Elementary School
Ms. Ciara Manno, Principal
1004 Misty Creek Dr, Minooka 60447
815-467-5301
Hours: 8:35 a.m. – 3:25 p.m.
Grades K through 4

Jones Elementary School
Dr. Rodney Hiser, Principal
800 Barberry Way Dr, Joliet 60431
815-290-7100
Hours: 8:35 a.m. – 3:25 p.m.
Grades K through 4

Minooka Elementary School
Mrs. Natalie Baxter, Principal
400 Coady Dr, Minooka 60447
815-467-2261
Hours: 8:35 a.m. – 3:25 p.m.
Grades K through 4

Minooka Intermediate School
Mrs. Jeana Pekol, Principal
321 W McEvilly Rd, Minooka 60447
815-467-4692
Hours: 7:40 a.m. – 2:30 p.m.
Grades 5 and 6

Minooka Junior High School
Ms. Sarah Massey, Principal
333 W McEvilly Rd, Minooka 60447
815-467-2136
Hours: 7:45 a.m. – 2:35 p.m.
Grades 7 and 8

Walnut Trails Elementary School
Dr. Kathleen Cheshareck, Principal
301 Wynstone Dr, Shorewood 60404
815-290-7400
Hours: 8:35 a.m. – 3:25 p.m.
Grades K through 4

Minooka Primary Center
Ms. Teresa Miller, Principal
305 W Church St, Minooka IL 60447
815-467-3167
Grades Early Childhood & Pre School
Hours: (AM) 8:45 – 11:25 (PM) 12:55 – 3:35

MINOOKA COMMUNITY CONSOLIDATED SCHOOL DISTRICT #201
STUDENT REGISTRATION FORM 2020/2021

STUDENT INFORMATION:

_____ _____ _____
First Name Middle Name Last Name

Gender: M F Birthdate: _____ School: _____ Grade: _____ Age: _____
P.O. Box# _____ Street Address: _____ Subdivision: _____
City: _____ County: _____ Zip: _____ Home Phone: _____
1st Custodial (resides with Y or N) Parent/Guardian Contact Name: _____
Address: _____ City _____ Zip _____
Relationship to student: _____ E-Mail: _____ Employer: _____
Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____
2nd Custodial (resides with Y or N) parent/Guardian Contact Name: _____
Address: _____ City _____ Zip _____
Relationship to student: _____ E-Mail: _____ Employer: _____
Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____
Non-Custodial Parent Name (if applicable): _____ Employer: _____
Address: _____ City _____ Zip _____
Relationship to student: _____ E-Mail: _____
Home Phone: ( ) _____ Cell: ( ) _____ Work: ( ) _____
Does the Non-Custodial Parent have permission to pick up student from school? Yes or No
Does the Non-Custodial parent received school mailings? Yes or No

Will you be purchasing a pe uniform? Yes or No (grade 6, 7, 8 only)

In an emergency, when parent cannot be reached, please indicate someone we can call to come for your child during school hours:
Name:
_____ Relationship: _____ Phone: _____
Name:
_____ Relationship: _____ Phone: _____

Name(s) of Sibling(s) in District 201 and Grade(s):

_____

_____

I give permission for the school district to use the mass calling system to notify the guardians of my child, through calling and emailing? Yes or No If you also would like to receive text alerts, please list your primary cell number _____

STUDENT TRANSPORTATION RECORD

Note: STUDENTS MUST RESIDE AT THE LOCATION PROVIDED IN STUDENT INFORMATION AS LISTED ABOVE TO BE ELIGIBLE FOR TRANSPORTATION. DUE TO SPACE LIMITATIONS, STUDENTS WILL NOT BE ALLOWED TO RIDE ANY OTHER BUS THAN THE BUS THEY ARE ASSIGNED TO RIDE.

PICK-UP PROCEDURE

PLEASE MARK THE APPLICABLE OPTION.

1. My child will ride a bus. _____
2. My child will be a car rider. _____
3. My child will be a walker. _____

***NOTE: PARENTS MUST NOTIFY STUDENT'S SCHOOL IF STUDENT WILL BE PICKED UP RATHER THAN RIDE THE ASSIGNED BUS HOME AFTER SCHOOL. STUDENT WILL BE PLACED ON ASSIGNED BUS IF SCHOOL IS NOT NOTIFIED.**

DAY CARE PROVIDER PROCEDURE

1. **My child will ride the bus to and from a day care provider.** _____
   Name of Day Care: _____
   Address of Day Care: _____
   Phone Number of Day Care: _____
2. **My child will be picked up by a day care provider.** _____
   Name of Day Care: _____
   Address of Day Care: _____
   Phone Number of Day Care: _____

SPECIAL DAYCARE ARRANGEMENTS:

MINOOKA COMMUNITY CONSOLIDATED SCHOOL DISTRICT #201
STUDENT REGISTRATION FORM 2020/2021

CERTIFICATION OF RESIDENCE:

CHILD RESIDES WITH: (please circle) Both parents Mother Only Father Only Mother/Stepfather Father/Stepmother Legal Guardian Other (Please specify): _____

Father: Living _____ Deceased _____ Mother: Living _____ Deceased _____

Please answer the following questions:

1. Are the student's parents divorced, separated or never married: Yes or No
2. If yes, who has custody of the student: Mother___Father____Joint_____
3. If custody is jointly held, which parent provides the student's primary regular nighttime abode: Mother_____Father_____
4. Does the student reside with a person other than his/her natural/adoptive parents? Yes____No_____
   If yes, please answer the following questions:
   A. Name of the adult with whom the student now resides:_____
   B. Address:_____City:_____State:_____Zip:_____
   C. Is this person a relative of the student? Yes_____No_____
   D. If yes, what relation is (s)he to the student:_____
   E. Is this person the student's legal guardian or custodian: Yes_____No_____
   F. If yes, please attach a copy of the guardianship or custody order.
5. Is the student eligible for special education or other special services? Yes_____No_____
   If yes, please provide a copy of the student's most recent Individualized Education Program (I.E.P.) or Section 504 Plan and provide the name and address of the student's most recent prior school district of attendance.
6. Does an Illinois public agency have legal guardianship of the student? Yes_____No_____
   If yes, please attach a proof of legal guardianship.
7. Has a court ordered a residential placement for the student? Yes_____No_____
   If yes, please attach a copy of the court order.
8. Is the student homeless: Yes_____No_____
   If yes, is the student currently living in the School District? Yes_____No_____
   A. In what school district was the student last enrolled? _____
   B. In what school district was the student enrolled when last permanently housed?
   _____
9. The child is currently in or at any point during the past year has lived in a foster care setting? Yes_____ No_____
10. One or more of the legal guardian(s) of the student is a member of the armed forces or full-time national guard on active duty? Yes_____ No_____

I certify that I am the parent(s) or legal guardian(s) of the above named student and that this child's residence has not been established solely for the purpose of attending District Schools. I further certify that the above information is correct to the best of my knowledge.

_____Date:_____
Parent(s) or Guardian(s) Signature(s)

Note: It is contrary to the policy of the Board of Education to admit students who do not legally reside with their parents or legal guardians within the District boundaries. The information you provide will be used by school officials to help establish the eligibility of each applicant for admission. Falsification of information on this form or otherwise submitted to the District may expose you to monetary liability under Illinois law for payment of tuition for such time as your child illegally enrolled in the District. Further, any person who knowingly enrolls or attempts to enroll a non-resident student in the District or presents to the District any false information regarding the residency of a student commits a Class C misdemeanor and shall be referred for criminal prosecution.

***Emergency Consent*:**
If the parents/legal guardian cannot be reached at the time of an emergency, and if immediate observation or treatment is urgent in the judgment of the school authorities, do you authorize and direct the school to send the child, properly accompanied, to the hospital? Yes _____No_____ Signed by: _____ (Custodial parent/guardian)

***Photo Permission/Website Permission*:**
Permission is granted for the photograph of my child to be taken and possibly published in local newspapers and/or other media sources. This photograph may be taken due to any special events or activities that take place during the child's continued attendance at our school. Directory information will only be released with parent permission. Yes _____ No_____ Permission is granted for my child's work to be published on the school district website. I understand my child will be identified on the website by first name only. Yes _____ No _____
Signed by: _____ (Custodial parent/guardian)

MINOOKA DISTRICT #201

REGISTRATION REQUIREMENTS

The following items are required for registration:

(Registrations will not be accepted without the required documents.)

_____ 1. Current completed **Illinois** Physical Form,Immunization Record, and Eye Exam.

_____ 2. Completed Dental Exam Form for grades Kindergarten, 2nd, 6th.

_____ 3. Certified Birth Certificate. (Must be county or state issued. Hospital certificate not accepted.)

_____ 4. Illinois Student Transfer Form
(Applies to students transferring within Illinois schools only.
This form must be obtained from your previous school.)

_____ 5. Two Proofs of Residency: (The laws of the State of Illinois declare that students who wish to enroll in District 201 must have a permanent residency in District 201. The only exceptions are those declared homeless.)

***MUST INCLUDE ONE OF THE FOLLOWING:**

Valid home ownership title, deed, or current property tax bill; Apartment or home lease or rental agreement.

****AND ONE ITEM FROM THE FOLLOWING:**

Current Utility Bills (water, electric, gas, cable, dish, phone); Insurance bills (homeowners, renters, auto). All items must have occupant's name and current address on them.

Note: Please contact school if student will be living at address that is not in the parent/guardian's name for additional requirements.

_____ 6. Special Accommodations Information: If the student has an Individual Education Plan (IEP) and/or other accommodations at the previous school, we will need a copy of the most recent evaluation.

Please Note:

APPOINTMENTS ARE REQUESTED TO REGISTER YOUR CHILD. PLEASE CALL THE SCHOOL YOUR CHILD WILL ATTEND TO SCHEDULE AN APPOINTMENT.

Note: Please allow a 2 day processing time prior to new students starting classes during the school year.

MINOOKA COMMUNITY CONSOLIDATED SCHOOL DISTRICT 201
YEARLY HEALTH INFORMATION

_____ SCHOOL YEAR GRADE: _____

Student Name: _____ Phone: _____ M / F Birthdate: _____

HOSPITAL PREFERENCE: Provena St. Joseph Medical Center _____ Morris Hospital _____

Doctor's Name: _____ Phone: _____ Last Exam: _____

Dentist's Name: _____ Phone: _____ Last Exam: _____

HEALTH HISTORY	YES	NO	COMMENTS (Be Specific)	HEALTH HISTORY	YES	NO	COMMENTS (Be specific)
Asthma? ***				Heart Problems?			
INHALER at school?				Eye/Vision Problems?			
ALLERGIES***: **FOOD**				Glasses/Contacts?			
SEASONAL				Concussion/Migraines			
OTHER				Seizures/Fainting			
EPI PEN at school? ***				Speech Problems?			
Birth Defects?				Stomach Problems?			
Developmental Disability?				Dietary Restrictions? ***			
Bone/Joint Problems?				Kidney/Urinary Problems?			
Dental Problem? Braces?				Hospitalizations/Surgery?			
Diabetes? ***				Skin condition?			
Hearing Problems?				Blood Disorders?			
Chronic Ear Infections?				Other Concerns?			

***Additional form required**

Please list all medications your child is taking at home or school:

MEDICATION	DOSE	TIME
_____	_____	_____
_____	_____	_____
_____	_____	_____

NOTE: If your child will be taking medication at school, whether prescription or over-the-counter, **A PHYSICIAN MUST** complete the school **Medication Administration** form.

Does your child have any restrictions at school? **Yes** _____ **No** _____ If so a doctor's note is required.

(Circle one.)

Parent/Guardian Signature: _____ Date: _____

MINOOKA SCHOOL DISTRICT 201
BUILDING ASSIGNMENTS FOR 2020-2021

Aux Sable Elementary School

Kindergarten - 4th Grade

- Amberleigh Estates
- Arbor Lakes
- Chestnut Ridge
- Deer Ridge
- Dresden Acres
- Eagles Approachway
- Hunters Crossing
- Hunters West
- Keating Pointe
- Lakewood Trails West
- Mallard Point
- Misty Creek
- Reflections
- SE Country
- SW Country
- The Highlands
- Wedgewood Highlands
- Westwind Estates
- Whispering Oaks
- Woods of Aux Sable

Jones Elementary School

Kindergarten - 4th Grade

- Hunters Ridge
- Kearney Glen
- Lakewood Prairie
- Neustoneshire
- NW Country
- Sable Ridge
- Summerfield

Minooka Intermediate School

All 5th & 6th Grade Students

Minooka Elementary School

Kindergarten - 4th Grade

- Cumberland Estates
- Eden Hills
- Grand Ridge
- Heather Ridge
- Indian Ridge
- Lakewood Trails East
- Ninovan Lake Estates
- Prairie Ridge
- Shady Oaks
- The Meadows
- Town South
- Town North
- Westview

Walnut Trails Elementary School

Kindergarten - 4th Grade

- Camelot
- Estates of Hidden Creek
- Hunt Club
- Kipling Estates
- Lake Forrest
- Minwood Glen
- NE Country
- Red Oak Estates
- River Oaks
- Shorewood Towne Center
- Vintage
- Walnut Trails
- Westminster Gardens

Minooka Junior High School

All 7th & 8th Grade Students

Minooka CCSD #201

Home Language Survey

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 who need to be assessed for English language proficiency

Please answer the questions below and return this survey to your child's school.

Student's Name: _____

1. Is a language other than English spoken in your home?

   Yes_____ No _____

   If so, what language? _____

2. Does your child speak a language other than English?

   Yes _____ No _____

   If so, what language? _____

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

_____ _____

Parent/Legal Guardian Signature Date

Minooka CCSD #201

Spanish
Español

Encuesta del Idioma en el Hogar

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 y devuelva esta encuesta a la escuela de su niño.

Nombre del estudiante: _____

1 . ¿Se habia en su casa otro idioma que no es el inglés?

Si _____ No _____

¿Cuál?_____

I . ¿Habla su niño(a) un idioma que no es el inglés?

Sí _____ No _____

¿Cuál?_____

Si ia 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

HEALTH REQUIREMENTS

FOR 2020-2021 SCHOOL YEAR

PRESCHOOL

Illinois Physical
All Preschool children will be required to have 1 dose of Pneumococcal vaccine after 24 months of age if the student did not receive any Pneumococcal vaccine or had an incomplete series.

KINDERGARTEN

Illinois Physical
Illinois Dental Examination
Illinois Vision Examination

All Kindergarten students will be required to have 2 doses of MMR and 2 doses of Varicella

*All Kindergarten students will be required to show proof of 4 or more doses of the same type of Polio vaccine with the last dose received on or after the 4th birthday

SECOND

Illinois Dental Examination

FIFTH

No Physical Required

SIXTH

Illinois Physical
Illinois Dental Examination
Tdap Booster Requirement
2 doses of Varicella
1 dose of Meningococcal Conjugate Vaccine (MCV4) received on or after the 11th birthday

SEVENTH-EIGHTH

1 dose of Meningococcal Conjugate Vaccine (MCV4) (if coming in from an out of state school vaccine is required if did not have in sixth grade)

Illinois State Board of Education

New U.S. Department of Education Race and Ethnicity Data Standards

Dear Parent or Guardian:

The U.S. Department of Education has issued new guidance on the collection and reporting of race and ethnicity data for public school students and staff. The guidance implements new federal race and ethnicity categories that were developed to obtain a more accurate picture of the nation's diversity. The new data collection process requires respondents to answer a two-part question, indicating ethnicity first and then one or more of five races. (In the past, individuals were allowed to choose only one race or ethnicity category.)

The Illinois State Board of Education (ISBE) is using the new categories which started with data reported for the 2011-2012 school year. This requires school districts to identify race and ethnicity for all students—and the identification is to **be done by parents or guardians**. If a student's parents or guardians decline to indicate race and/or ethnicity, observer identification by school district staff is required.

The new race and ethnicity data will be used in the same manner as previously collected data, e.g., in reporting and analyzing test results by race and ethnicity. The information will not be used to check immigration status, and the confidentiality of individual student information will be protected.

Enclosed is the form that parents or guardians need to complete to identify race and ethnicity for their children. Please **complete one form per child**, and be sure to answer both parts of the two-part question. (Remember that school district staff is required to provide any missing information by observer identification).

Thank you for your cooperation in providing the needed data.

Sincerely,

Dr. Kris Monn
Superintendent

Illinois State Board of Education

New U.S. Department of Education Race and Ethnicity Data Standards

Student's Name:_____ **Date:** _____

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 Signature: _____

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.

MINOOKA COMMUNITY CONSOLIDATED SCHOOL DISTRICT #201

Tiffany Staab, Director of Special Education
305 W Church St, Minooka, IL 60447
Phone: (815) 467-5042, Fax: (815) 467-2616

PARENTAL CONSENT TO OBTAIN OR RELEASE RECORDS

RE: _____
STUDENT NAME

_____
DATE OF BIRTH TODAY'S DATE

Minooka Community Consolidated School District #201 is committed to a policy of maintaining the confidentiality of medical or educational records of all students. Requesting or releasing any information is only done with the written authorization of the child's parent or guardian. You have the right to inspect and copy your child's records, to challenge the content of such records, and to limit any such consent to designated records or designated portion of information within the records. Information obtained by Minooka Community Consolidated School District #201 shall be accessible only to Minooka Community Consolidated School District #201 personnel who have cause to provide direct service to your child. If it should become necessary, additional copies of this consent form will be made. This release is effective for six months after the date above.

RECORDS ARE TO BE OBTAINED FROM:	RECORDS ARE TO BE RELEASED TO:
	MINOOKA CCSD #201 SPECIAL EDUCATION
SCHOOL NAME	SCHOOL NAME
	305 W CHURCH ST, MINOOKA IL 60447
SCHOOL ADDRESS	SCHOOL ADDRESS
	815-467-5042
TELEPHONE	TELEPHONE

CONSENT IS GIVEN FOR MINOOKA COMMUNITY CONSOLIDATED SCHOOL DISTRICT #201 TO:

OBTAIN	RELEASE	
x		Achievement Test Scores
x		Psychological Report
x		Social Development Reports
x		Speech & Language Reports
x		Audiological Reports
x		Annual Progress & Staffing Reports
x		Consultation
x		Other: ISP

_____ _____ _____
PARENT OR LEGAL GUARDIAN RELATIONSHIP DATE

Inspire learners to be responsible, confident and successful!

MINOOKA CONSOLIDATED COMMUNITY SCHOOL DISTRICT 201

305 W. Church St
Minooka, IL 60447
Phone: (815) 467-6121 Fax: (815) 467-9544

Student Name: _____

Date of Birth: _____ Grade: _____

Date Requested: _____

TRANSFERRING SCHOOL INFORMATION

School Name: _____

Address: _____

City, State; Zip: _____

School Phone: (___) _____ Fax: (___) _____
Area code Area code

This student, who formerly attended your school, has registered at our school. Please send all school records pertaining to this student, including:

- Transcript of Grades
- Achievement Test Scores
- Physical, Dental, Medical Reports
- Health and Immunization Reports
- Cumulative Folder

Any other information that would assist us.

Please mail records to the school indicated at left. Thank you.

All special education records need to be sent to the special education office. (please see attached release of records.)

Under the provisions of Public Law 93-380, I hereby give my permission to release information requested above. I also certify that my student is not currently serving a suspension or expulsion imposed by the school from which the student is transferring

Parent/Guardian Signature:_____

Date:_____

In accordance with the revised federal statutes, permission of the parent is no longer required when records are requested by authorized school personnel. (Fed. Register Vol. 41 #118-24673, June 17, 1976)

☐ ***Aux Sable Elementary***
1004 Misty Creek Drive
Minooka, IL 60447
Ms. Ciara Manno, Principal
Phone: (815) 467-5301
Fax: (815) 467-2166

☐ ***Jones Elementary***
800 Barberry Way
Joliet, IL 60431
Dr. Rodney Hiser, Principal
Phone: (815) 290-7100
Fax: (815) 290-7120

☐ ***Minooka Elementary***
400 Coady Drive
Minooka, IL 60447
Mrs. Natalie Baxter, Principal
Phone: (815) 467-2261
Fax: (815) 467-4423

☐ ***Minooka Intermediate***
321 W. McEvilly Road
Minooka, IL 60447
Mrs. Jeana Pekol, Principal
Phone: (815) 467-4692
Fax: (815) 467-3121

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333 W. McEvilly Road
Minooka, IL 60447
Ms. Sarah Massey, Principal
Phone: (815) 467-2136
Fax: (815) 467-5087

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305 W. Church Street
Minooka, IL 60447
Ms. Teresa Miller, Principal
Phone: (815) 467-3167
Fax: (815) 467-3168

☐ ***Walnut Trails Elementary***
301 Wynstone Drive
Shorewood, IL 60404
Dr. Kathleen Cheshareck, Principal
Phone: (815) 290-7400
Fax: (815) 290-7420

MINOOKA SCHOOL DISTRICT #201

MEDICATION ADMINISTRATION/SELF-ADMINISTRATION CONSENT FORM

(ONLY FILL OUT IF STUDENT REQUIRES MEDICATION AT SCHOOL)

The State of Illinois mandates that the following guidelines be followed for administration of medication in the school setting:

1. Provide the building nurse with this district medication consent form completed, signed and dated by a health care provider (physician, physician's assistant or advanced practice registered nurse having such authority delegated by a supervising/collaborating physician) and the parent/guardian for any medication including nonprescription. NOTE: A health care provider's signature is not required for students who require asthma inhalers during the school day as long as the inhaler's original prescription label/box is provided to the school.
2. Medication must be delivered to the nurse's office by the parent/guardian, unless prior arrangements have been made to independently carry an inhaler, epi-pen, or insulin pump.
3. School policy prohibits students from having in their possession any prescription or non-prescription medication other than the above mentioned, which have been pre-approved by the nurse.
4. Medication must be in its original, unopened container. Prescription medication must have the correct pharmacy labeled directions for administration.
5. Notification by the health care provider must be provided when a medication is discontinued or a change in dosage or interval occurs.
6. Medication administration consent forms must be completed annually.
7. **PLEASE NOTE: The school does not assume responsibility for medication that is not delivered to and kept in the nurse's office or other secure designated area by a parent/guardian.**

STUDENT NAME_____ **GRADE**_____ **DOB**_____

PARENT/GUARDIAN NAME_____ **PHONE**_____

MEDICATION_____ **DIAGNOSIS**_____

DOSAGE_____ **ROUTE** _____ **TIME/FREQUENCY**_____

OTHER REQUIREMENTS OR SPECIAL CIRCUMSTANCES_____

DISCONTINUE DATE_____ **POSSIBLE SIDE EFFECTS**_____

IS SUPERVISED STUDENT SELF-ADMINISTRATION AUTHORIZED? YES NO

IS IT MEDICALLY NECESSARY FOR THE STUDENT TO CARRY HIS/HER INHALER/EPI-PEN AT ALL TIMES? YES NO

FOR ASTHMA MEDICATION/EPINEPHRINE AUTO-INJECTORS ONLY*: IS UNSUPERVISED SELF-ADMINISTRATION AUTHORIZED?
YES NO

PURSUANT TO ILLINOIS LAW, UPON PARENTAL CONSENT (FOR ASTHMA INHALERS) OR PHYSICIAN AUTHORIZATION (FOR EPINEPHRINE AUTO-INJECTOR), A STUDENT WHO IS PRESCRIBED ASTHMA MEDICATION AND/OR EPINEPHRINE AUTO-INJECTOR MAY POSSESS AND USE HIS/HER ASTHMA MEDICATION AND /OR EPINEPHRINE AUTO-INJECTOR WHILE AT SCHOOL OR DURING SCHOOL-SPONSORED ACTIVITIES WITHOUT THE SUPERVISION OF DISTRICT PERSONNEL.

PHYSICIAN SIGNATURE_____ **DATE**_____

PRINT PHYSICIAN NAME_____ **PHONE**_____

PARENT SECTION:

I HEREBY AUTHORIZE MINOOKA CCSD #201 PERSONNEL TO _____ADMINISTER OR_____ PERMIT THE SELF-ADMISTRATION OF MEDICATION TO/BY MY CHILD DURING SCHOOL HOURS ACCORDING TO THE ABOVE INSTRUCTIONS.

I HEREBY CONFIRM MY PRIMARY RESPONSIBILITY TO ADMINISTER MEDICATION TO MY CHILD. HOWEVER, IN THE EVENT THAT I AM UNABLE TO DO SO, I HEREBY AUTHORIZE MINOOKA CCSD #201 AND ITS EMPLOYEES AND AGENTS, IN MY BEHALF AND STEAD, TO ADMINISTER OR TO ATTEMPT TO ADMINISTER TO MY CHILD (OR TO ALLOW MY CHILD TO SELF-ADMINISTER, WHILE UNDER SUPERVISION OF THE EMPLOYEES AND AGENTS OF MINOOKA CCSD #201) LAWFULLY PRESCRIBED MEDICATION IN THE MANNER DESCRIBED ABOVE. **I ACKNOWLEDGE THAT IT MAY BE NECESSARY FOR THE ADMINISTRATION OF MEDICATION TO MY CHILD TO BE PERFORMED BY AN INDIVIDUAL OTHER THAN A SCHOOL NURSE AND SPECIFICALLY CONSENT TO SUCH PRACTICES.** I FURTHER WAIVE ANY CLAIMS AGAINST MINOOKA CCSD #201, ITS INDIVIDUAL BOARD MEMBERS, EMPLOYEES, AND AGENTS ARISING OUT OF THE ADMINISTRATION OR SELF-ADMINISTRATION OF SAID MEDICATION, AND AGREE TO HOLD HARMLESS AND INDEMNIFY MINOOKA CCSD #201, ITS INDIVIDUAL BOARD MEMBERS, EMPLOYEES AND AGENTS, FROM AND AGAINST ANY AND ALL LIABILITY, CLAIMS, DEMANDS, DAMAGES, OR CAUSES OF ACTION OR INJURIES, COSTS, AND EXPENSES, INCLUDING ATTORNEYS' FEES, RESULTING FROM OR ARISING OUT OF THE ADMINISTRATION OR SELF-ADMINISTRATION OF MEDICATION. I ALSO ACKNOWLEDGE THAT MINOOKA CCSD #201 SHALL INCUR NO LIABLITY, EXCEPT FOR WILLFUL AND WANTON CONDUCT, AS A RESULT OF ANY INJURY ARISING FROM A STUDENT'S SELF-ADMINISTRATION OF MEDICATION OR EPINEPHRINE AUTO-INJECTOR OR THE STORAGE OF ANY MEDICATION BY DISTRICT PERSONNEL, REGARDLESS OF WHETHER THE SELF-ADMINISTRATION OF AN ASTHMA INHALER OR EPI-PEN WAS AUTHORIZED BY THE PARENT OR HEALTHCARE PROVIDER.

FOR ASTHMA MEDICATION/EPINEPHRINE AUTO-INJECTORS ONLY: I AUTHORIZE MINOOKA CCSD #201 AND ITS EMPLOYEES AND AGENTS, TO ALLOW MY CHILD/ WARD TO CARRY AND SELF-ADMINISTER HIS/HER ASTHMA INHALER AND/OR USE HIS/HER EPINEPHRINE AUTO-INJECTOR: (1) WHILE IN SCHOOL, (2) WHILE AT A SCHOOL-SPONSORED ACTIVITY, (3) WHILE UNDER THE SUPERVISION OF SCHOOL PERSONNEL, OR (4) BEFORE OR AFTER NORMAL SCHOOL ACTIVITIES, SUCH AS WHLE IN BEFORE-SCHOOL OR AFTER-SCHOOL CARE ON SCHOOL-OPERATED PROPERTY. ILLINOIS LAW REQUIRES THE SCHOOL DISTRICT TO INFORM PARENT/GUARDIAN THAT IT, AND ITS EMPLOYEES AND AGENTS, INCUR NO LIABILTY, EXCEPT FOR WILLFUL AND WANTON CONDUCT, AS A RESULT OF ANY INJURY ARISING FROM THE ADMINISTRATION OF ASTHMA MEDICATION OR EPINEPHRINE AUTO-INJECTOR(105ILCS 5/22-30).

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

Student: Acceptable Use Policy

At Minooka 201, we acknowledge that there is an inherent risk with using the internet in a classroom environment. However we firmly believe that the benefits of using the Internet in a constructive manner, far exceeds the risk of inappropriate material being displayed. Minooka 201 takes internet filtering (safe search, etc.) with great importance but acknowledge that no filtering technology is perfect and it will not catch everything.

All use of any Minooka 201 network (and/or any other technology resource) shall be consistent with the District's goal of promoting a safe and efficient learning environment for all. This Acceptable Use Policy (AUP) does not attempt to state all required or prescribed behavior by users, but does show some basic examples. The failure of any staff or student to follow the terms of the Acceptable Use Policy will result in the loss of privileges, disciplinary action, and/or appropriate legal action.

The signature(s) at the end of this document is legally binding and indicates the party who signed has read the terms and conditions carefully and understands their significance.

1. Acceptable Use - Access to the District's network (and/or any other technology resource) must be for the purpose of education or research, and be consistent with the educational purposes of the District.

2. Privileges - The use of the district's technology resource is a privilege, not a right, and inappropriate use will result in a revocation of access. The building principal or district office administration will make a decision regarding whether or not a user has violated this Acceptable Use Policy and may deny, revoke, or suspend access at any time.

3. Unacceptable Use - Users are responsible for their actions and activities involving all technology resources. Some examples of unacceptable uses are

   a. Using the network (and/or any other technology resource) for any illegal activity, including violation of copyright or other contracts, or transmitting any material in violation;
   b. Sharing your account or password with others;
   c. Downloading copyrighted material for reasons other than personal use;
   d. Using the network (and/or any other technology resource) for private financial or commercial gain or fraud;
   e. Wastefully using resources, including non-educational streaming or saving personal family photos to district computers;
   f. Gaining or seeking to gain unauthorized access to resources or entities;
   g. Posting private or personal information about another person and/or invading other's' privacy;
   h. Gaining unauthorized access to the files of others, or vandalizing the data or files of another user;

i. Using another user's account or password;
j. Posting material authored or created by another without his/her consent
k. Posting anonymous messages;
l. Installing or downloading unauthorized software;
m. Using the network (and/or any other technology resource) for commercial or private advertising;
n. Accessing, submitting, posting, publishing, or displaying any defamatory, inaccurate, abusive, obscene, profane, sexually oriented, threatening, racially offensive, harassing, or illegal material;
o. Possessing any data which might be considered a violation of these rules in paper, magnetic (disk), or any other form;
p. Using the network (and/or any other technology resource) while access privileges are suspended or revoked; and
q. Circumventing web content filtering or firewall rules to gain access to websites that are normally blocked, including anonymizers, proxy bypass servers and secret search engines.

4. Network Etiquette - Users are expected to abide by the generally accepted rules of network etiquette. These include, but are not limited to, the following:
   a. Be Polite. Do not become abusive in your messages to others.
   b. Use appropriate language. Do not swear, or use vulgarities or any other inappropriate language.
   c. Do not reveal personal addresses, telephone numbers or other sensitive information of students or colleagues
   d. Understand that a user's actions can be "seen" by administrators of the network. It is likely that someone knows the connections you are making, knows what you are doing and what you viewed while on the network.
   e. Recognize that electronic mail (E-mail) is not private. People who operate the system have access to all mail. Messages relating to or in support of illegal activities will be reported to the authorities.
   f. Do not use network in any way that would disrupt its use by other users.
   g. Consider all communications and information accessible via the network to be private property.
   h. Illegal activities are strictly forbidden.

5. Storage - The storing of files must be saved on Minooka 201 district owned computers and servers. The use of flash drives or thumb drives, while acceptable, should only be used as a temporary storage for transportation or backups. Cloud storage, using Google Drive with a min201.org account is the preferred storage location for all students. Storing classwork on private accounts not associated with Minooka 201 is not permitted.

6. Freedom of Information Act - Student files and records may be searched and produced as part of a Freedom of Information Act (FOIA) response.

7. Printing - Students are allowed to print after being instructed to do so by the teacher. The use of student color printing is heavily discouraged. Students found to be sending unnecessary print jobs to the printer may have their network access revoked.

8. No Warranties - The District makes no warranties of any kind, whether expressed or implied, for the service it is providing. The District will not be responsible for any damages users suffer. This includes loss of data resulting from delays, non-deliveries, missed deliveries, or service interruptions caused by its negligence or a user's errors or omissions. Use of any information obtained via the Internet is at your own risk. The District specifically denies any responsibility for the accuracy or quality of information obtained through its services, or any costs or charges incurred as a result of seeing or accepting such advice.

9. Indemnification - The user agrees to indemnify the School District for any losses, costs, or damages, including reasonable attorney fees, incurred by the District relating to, or arising out of, any breach of this Acceptable Use Policy.

10. Security - Network security is a high priority. If a user discovers any sign of network security issues, they must notify the system or building administrator. Do not demonstrate the problem to other users unless asked to do by the system or building administrator. Keep your account and password confidential. Do not use another individual's account or password. Attempts to log on to the network as a system administrator will result in cancellation of user privileges. Any user identified as a security risk may be denied access to the network.

11. Vandalism - Vandalism will result in cancellation of privileges, other disciplinary action, and restitution for costs associated with hardware, software, and system restoration. Vandalism is defined as any malicious attempt to harm or destroy hardware, software, another user's data, the Internet, or any other network. This includes, but is not limited to, the uploading or creation of computer viruses.

12. Telephone Charges - The District assumes no responsibility for any unauthorized charges or fees, including telephone charges, long-distance charges, per-minute surcharges, and/or equipment or line costs.

13. Google Apps for Education - Google Apps for Education is considered a core requirement for classwork. Minooka 201 is using Google Apps for Education as our primary tool for document creation and collaboration in the classroom. All files and e-mails created in the Google Apps for Education environment are searchable by the Superintendent or his designee. This includes the ability to search for common inappropriate phrases used in cyber bullying. The use of a personal google or "gmail" or any other account not associated with Minooka 201 is not permitted.

3rd & 4th Grade:
Students in 3rd and 4th grade are given access to document creation and collaboration tools and not e-mail. Effectively, these students will have access to a cloud based word processing and presentation slideshow creation tools. Most documents created will be ultimately shared or

submitted with their given teacher, reducing the need to print. The installation of Chromebook or Google "apps" or tools, by students must have the teacher's permission prior to installation..

5th - 8th Grade:
5th through 8th grade, e-mails for students are configured in a very guarded configuration where students can only e-mail teachers and receive service type email notifications. Students will be forced to change their password to something only the student knows. Most documents created will be ultimately shared or submitted with their given teacher, reducing the need to print. The installation of Chromebook or Google "apps" or tools, by students must have the teacher's permission prior to installation.

14. Appeal: After a student's access has been revoked, an appeal by the custodian/guardian to the decision can be made to the Superintendent of Minooka 201.

By signing and dating this document:

1. The parent or guardian understands that access to the network (and/or any other technology resource) is designed for educational purposes and that the District has taken precautions to eliminate controversial material. However, he/she also recognizes it is impossible for the District to restrict access to all controversial and inappropriate materials. He/she will hold harmless the District, its employees, agents or Board members for any harm caused by materials or software obtained via the network. He/she will accept full responsibility for supervision if and when the child's use is not in a school setting. He/she has discussed the terms of this Acceptable Use Policy with their child and hereby requests that the child be allowed access to the district's network.

2. The student understands and will abide by this Acceptable Use Policy. He/she further understands that any violation of the regulations above is unethical and may constitute a criminal offense. Should he/she commit any violation, privileges may be revoked, school disciplinary action and/or appropriate legal action may be taken.

If you wish to make any changes to your student's AUP status, you will need to request a new form.

Sign: _____ **Date:** _____

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? / Child wakes during night coughing?	Yes / Yes	No / No	
Birth defects?	Yes	No	
Developmental delay?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	
Diabetes?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No	
Seizures? What are they like?	Yes	No	
Heart problem/Shortness of breath?	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 _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			
Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List all.) When? What for?	Yes	No	
Serious injury or illness?	Yes	No	
TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
TB disease (past or present)?	Yes*	No	
Tobacco use (type, frequency)?	Yes	No	
Alcohol/Drug use?	Yes	No	
Family history of sudden death before age 50? (Cause?)	Yes	No	
Dental ☐ Braces ☐ Bridge ☐ Plate Other			

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian Signature **Date**

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		
			Other		

Currently Prescribed Asthma Medication:
☐ Quick-relief medication (e.g. Short Acting Beta Agonist)
☐ Controller medication (e.g. inhaled corticosteroid)

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

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City		ZIP Code
Name of School: ZIP Code		Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name		

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other_____

To be completed by dentist:

Date of Most Recent Examination:_____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ 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 **Urgent Treatment —** abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Additional comments: _____

Signature of Dentist _____ License #: _____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

IOCI 0600-10 Printed by Authority of the State of Illinois

State of Illinois
Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name: Last	First	Middle		Birth Date: (Month/Day/Year)
Address: Street	City			ZIP Code
Name of School:	ZIP Code	Grade Level:	Gender: ☐ Male ☐ Female	
Parent or Guardian: Last Name	First Name			
Student's Race/Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown ☐ Other_____				

I am unable to obtain the required dental examination because:

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

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

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

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

Parent or Guardian Signature _____ Date:_____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

IOCI 0600-10 Printed by Authority of the State of Illinois

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides 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 the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____ (Last) _____ (First) _____ (Middle Initial)

Birth Date _____ (Month/Day/Year) Gender _____ Grade _____

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

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts 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 (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number _____

Address _____

_____

Phone _____

Signature _____

Date _____

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)

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

Printed by Authority of the State of Illinois

IOCI 15-391

State of Illinois
Illinois Department of Public Health

Eye Examination Waiver Form

Please print:

Student Name _____ Birth Date _____
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name _____ Grade Level_____ Gender: ❑ Male ❑ Female

Address _____
(Number) (Street) (City) (ZIP Code)

Phone_____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

❑ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ ALL KIDS.

❑ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

❑ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations:

_____

_____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois

IOCI 13-378

ILLINOIS STATE BOARD OF EDUCATION

AFFIDAVIT OF ENROLLMENT AND RESIDENCY

This affidavit form may be used if you are an adult who has assumed responsibility for a pupil and provide the pupil with a fixed, night-time abode, **for reasons other than access to the educational programs of the school district**.

This form should *not* be used, however, if you are the natural or adoptive parent of the pupil, have been granted court-ordered custody or guardianship, or are receiving public aid on behalf of the pupil. For these situations, you are only required to provide documentation (such as a birth certificate or court order), without the need of an affidavit like this one.

This form is also *not* required for pupils who are sharing the housing of others due to lack of housing, economic hardship, or similar reason, or are otherwise homeless as defined in state and federal law. **Homeless pupils must be enrolled immediately.**

If you have ***any*** questions about residency, including homelessness, please contact the Illinois State Board of Education's Educator and School Development Division at (217) 782-2948.

I, _____, reside at _____,
Name of Adult *Address*

which is located within the boundaries of _____.
School District

Provide the appropriate information and check each of the following:

☐ I am at least 18 years of age.

☐ I have provided proof in the form(s) of _____
Proof of Residency
_____

that I am a resident of _____.
School District

☐ I have assumed and exercise responsibility for _____.
Name of Pupil

☐ I provide a fixed, night-time abode for _____.
Name of Pupil

☐ _____ is not living with me for the purpose of having access to the educational programs of the school district.
Name of Pupil

☐ I understand that knowingly or willfully providing false information to a school district regarding the residency of a pupil for the purpose of enabling that pupil to attend any school in that district without the payment of nonresident tuition is a Class C misdemeanor.

☐ I understand that knowingly enrolling or attempting to enroll a pupil in the school of a school district of a tuition free basis when I know that pupil to be nonresident of the school district, unless the nonresident pupil has a lawful right to attend, is a Class C misdemeanor.

_____	_____	_____
Date	*Signature of Adult*	*Adult (Print Name)*
_____	_____	_____
Date	*School District Employee (Signature)*	*School District Employee (Print Name)*

Students

Exhibit - Letter of Residence to Be Used When the Person Seeking to Enroll a Student Is Living with a District Resident

A person seeking to enroll a child should use this form as evidence of residency when he or she cannot produce a lease, purchase property agreement, or other similar document – other documents will also be required to establish residency. The School District reserves the right to evaluate the evidence presented; completing this form does not guarantee admission.

To be completed by the individual enrolling the child and returned to the Principal. Please print.

Child _____ School _____

Individual enrolling the child _____ Home Telephone _____

Relationship to the child _____

Residence street address _____ City _____ Zip code _____

Signature of the individual enrolling the student _____ Date _____

To be completed and signed by the individual who is responsible for the residence. Please print.

Name of the individual who is responsible for the residence _____ Telephone _____

I am responsible for this residence by ☐ ownership, ☐ lease, or ☐ other _____

Total number of: Persons living at this residence _____ Rooms in residence _____ Bedrooms _____

State the reasons for this living arrangement, including your relationship to the individual enrolling the child:

_____

I certify that this information is true and that the individuals named above are living in my residence.

Signature of the individual who is responsible for the residence _____ Date _____

WARNING: If a student is determined to be a nonresident of the District for whom tuition must be charged, the persons enrolling the student are liable for nonresident tuition from the date the student began attending a District school as a nonresident.

A person who knowingly enrolls or attempts to enroll in this School District on a tuition-free basis a student known by that person to be a nonresident of the district is guilty of a Class C misdemeanor, except in very limited situations as defined in State law (105 ILCS 5/10-20.12b(e)).

A person who knowingly or willfully presents to the School District any false information regarding the residency of a student for the purpose of enabling that student to attend any school in that district without the payment of a nonresident tuition charge is guilty of a Class C misdemeanor (105 ILCS 5/10-20.12b(f)).