

FORRESTVILLE VALLEY SCHOOL DISTRICT #22I

2024 - 2025 School Year

Dear Parents/Guardians,

The **Illinois School Code** requires students to meet various requirements at certain grade levels. Please use this letter as a guide to the requirements your child needs to fulfill for school enrollment in the fall.

<u>Preschool</u>: Completed Illinois Physical Exam form (when first entering preschool), including physician verification of having received all required immunizations including: varicella and pneumococcal vaccines.

<u>Kindergarten:</u> Completed Illinois Physical Exam form including physician verification of having received all required immunizations including two doses of varicella vaccine. A completed professional eye examination and a completed dental form.

2nd grade: A completed dental form.

<u>6th</u> <u>grade</u>: Completed Illinois Physical Exam form including physician verification of having received all required immunizations including: a Td booster and Meningococcal vaccine. A completed dental form.

<u>9th</u> grade: Completed Illinois Physical Exam form including physician verification of having received all required immunizations including: a Td booster and one dose of Meningitis vaccine. A completed dental form.

12th grade: Proof of 2 meningococcal vaccinations.

Students first entering a school in Illinois from out of state are required to complete: a physical exam, professional eye examination and dental exam, all documented on Illinois forms.

Completed Dental forms are to be on file by May 15, 2025. Students must have been seen by a dentist in the previous 18 months of the deadline to complete the requirement, anytime on or after November 15, 2023.

If you object to this process for health reasons, a physician's statement is needed stating the required immunizations are detrimental to the health of the child. Objections to vaccinations due to religious beliefs must be submitted in writing stating supporting biblical scripture with references and parent signatures. Also, an Illinois Certificate of Religious Exemption must be completed and signed by parents and a MD, DO, APN or PA. The district is required to comply with state requirements when enrolling students into school. If the requirements stated above are incomplete as of October 15th, students will be dismissed from school until they can be completed.

If you have any questions, please leave me a message with a building secretary and I will return your call.

Sincerely,

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Jennifer Nelson RN



State of Illinois Certificate of Child Health Examination

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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										
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RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose										
Hepatitis A	And the state of t									
HPV	San Constant and C									
Influenza										
Other: Specify										
Immunization Administered/Dates										
	r (MD, DO, APN, PA	School health prof	essio	nal, health offic	ial) ve	rifving s	hove	immunization	histor	rv must sign below.
If adding dates to the	above immunization	history section, put yo	our in	itials by date(s)	and sig	gn here.				, made digit describ
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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	,,,									
Discase Signature Title										
3. Laboratory Evidence of Immunity (check one)										
*All measles cases d	diagnosed on or after J liagnosed on or after J	July 1, 2002, must be	confi	rmed by laborate	ory evid	dence. lence	Armadin			4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4
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Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: Physician Statements of Immunity MUST be submitted to IDPH for review.										

					THE RESERVE OF THE PROPERTY OF	Birth		Sex	Schoo	1		Grade	Level/ ID
Last	_	fint	~ B & ~		Middle	TICK! -	Numb/Ony/ Year	D 7/ 1:		1	Aure	<u> </u>	
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER ALLERGIES Yes List: MEDICATION (Prescribed or Yes List:													
(Faod, drug, insect, other) Diagnosis of asthma?	No L	O	Yes Yes	No No	a kungarangan kentan karapaparangan ang mengan kentan kentan kan kan kan kan kan kan kan kan kan k	Los	s of function of one of pai ans? (eye/ear/kidney/testic		Y	žš No	egy aariisiicheil la	1266 H 1 P 4264 A 1114 A 1244 A	иналителический и почисация усуче
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Diabetes?			Yes	No		Ser	ious injury or illness?		Y	os No			
Head injury/Concussi	on/Passed	out?	Yes	No		TB	skin test positive (past/pro	esent)?	Y	es* No		s, refer to loc	al health
Scizures? What are the	ey like?	MINISTER BOMESON	Yes	No	and the second s	ТВ	TB disease (past or present)?				depar	tment.	
Heart problem/Shortn	ess of brea	th?	Yes	No		Tol	Tobacco use (type, frequency)?			es No)		
Heart murmur/High b	lood pressi	ire?	Yes	No		Ald	Alcohol/Drug use? Yes No						INIONAL IN CONTRACT OF THE PARTY.
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Eye/Vision problems					Last exam by eye doctor	De	nțal 🗆 Braces 🗇	Bridge	C) Pla	te Othe	Γ	and the second s	
Other concerns? (cros Ear/Hearing problems	emprovide a conference and	oping lids,	squinting Yes	, diffic	culty reading)	Info	ormation may be shared with a	norowist	e nersoon	el for healt	h and educ	cational numos	ės.
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Questionnaire Admi					d Test Indicated? Yes [Blood Test Date			Resu	lt		
TB SKIN OR BLOO	D TEST	Recommer	ided only	for ch	uldren in high-risk groups inclu	uding chile	dren immunosuppressed due	to HIV	infection	or other co	onditions,	, frequent trav	el to or born
					risk categories. See CDC guide	elines. <u>h</u>							
No test needed □	r est bei	formed l			Test: Date Read d Test: Date Reported		Result: Positi Result: Positi		Negati Negati			mm Value	
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Respiratory		<u></u>			Diagnosis of Asth	ma	Mental Health	n atransacionista			***************************************		
Currently Prescribed Asthma Medication: Quick-relief medication (e.g. Short Acting Beta Agonist) Controller medication (e.g. inheled continuous mid)													
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:													
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)?													
On the basis of the exam	ination on t	his day, I a				ERSCH	(If No or Mod	-			on.) odified		THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAM
Print Name	ere Danie I Mart I American				(MD,DO, APN, PA)	Signatu			**************************************			Date	· · · · · · · · · · · · · · · · · · ·
Address													



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 III. 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.

Student's Name	e: Last	First	Middle		Birth Date: (Month/Day/Year)			
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Parent or Guard	dian: Last Name		First Nam	ne	and the second s			
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o be completed	l by dentist:		A					
·		Chr	eck all services provided	l at this evamir	nation date)			
Date of Most Rec	cent Examination: llant		storation of teeth due to		audit dato,			
Oral Health Stat	us (check all that apply)							
☐ Yes ☐ No	Dental Sealants Present	on Permanent Molar	S					
☐Yes ☐No	Carles Experience / Reste	oration History — A f OR missing permanent t	illing (temporary/permanen st molars.	it) OR a tooth the	at is missing because it was			
∐Yes ∐No	Untreated Carles — At feat walls of the lesion. These crite root, assume that the whole to considered sound unless a car	ria apply to pit and fissure oth was destroyed by ca	e cavitated lesions as well ries. Broken or chipped tee	as those on smi	ooth tooth surfaces. If retained			
☐ Yes ☐ No	Urgent Treatment — absco	ess, nerve exposure, adv	anced disease state, signs	s or symptoms th	at include pain, infection, or			
Freatment Needs	s (check all that apply). Fo	r Head Start Agencies,	please also list appointm	nent date or dat	e of most recent treatment			
•	e Care — amalgams, composite	es, crowns, etc.	Appointment Date:		Activity and a second a second and a second			
Preventive	Care — sealants, fluoride treat	ment, prophylaxis	Appointment Date;					
Pediatric D	entist Referral Recommend	led	Treatment Completion	Date:	Halder Co. Laborator Co.			
Additional comr	ments:	individual statement was specific and drawn to the contemporary of the statement of the contemporary of the statement of the contemporary of the statement of the contemporary of the cont	innutriliteti muutustaajayseesti kaasaa k	त्रे मान्यव्यक्तान्त्रम् इत्त्रम् स्थापन्त्रम् । सावतान्त्रम् स्थापन्त्रम् । सावतान्त्रम् स्थापन्त्रम् स्थापन्				
	ntist		License #:	m .				



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	123	AND	ATTENDED TO THE PROPERTY OF TH	TOTAL STATE OF THE	
	(Las	•		(First)	(Middle Initial)
Birth Date (Month/Day/Y	(OOR)	Gender	Grade	n.	
Parent or Guardian	car)				
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		To Be Combl	cted By Examini	ig Doctor	
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Medical history:					
Drug allergies: DNK					
Other information					A STATE OF THE WASHINGTON TO STATE OF THE ST
outer information	W. Commission of the Commissio	The state of the s	**************************************	enter de la constant	ACCORDANCE OF THE STATE OF THE
Examination					
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			Both		
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Best corrected visual acuity	20/ 20)/ 20/	20/		
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was retraction performed wit	ik ditauoii:	Court I CO			
		Normal	Abnormal	Not Able to Assess	Comments
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Internal exam (vitreous, lens,	-			Q	Make the district the property may use and gift (1974) the high (1974). And the state of the st
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Accommodation and vergence	ė				And the second s
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Glaucoma evaluation					
Oculomotor assessment					STATISTICS AND ADMINISTRATION OF THE PROPERTY
Other	Canada (confessionis)				Deferitive vide and Managarian International Conference of the Con
NOTE: "Not Able to Assess" ref	ers to the inabi	lity of the child to co	omplete the test, not	the inability of the doctor t	o provide the test.
Diagnosis					
	Hyperopia	☐ Astigmatism	☐ Strabismus	☐ Amblyopia	
y 1				<i>J</i>	
Other	The state of the s	AND		20 THE RESERVE OF THE PROPERTY	The second secon



State of Illinois Eye Examination Report

Recommendations 1. Corrective lenses: \(\sigma\) No \(\sigma\) 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: \square 3 months \square 6 months \square 12 months Other Print name License Number Optometrist or physician (such as an ophthalmologist) who provided the eye examination □ MD □ OD □ DO Consent of Parent or Guardian I agree to release the above information on my child Address ____ or ward to appropriate school or health authorities. (Parent or Guardian's Signature) Phone (Date)

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