

## REGULATIONS REGARDING PHYSICALS AND IMMUNIZATIONS

Dear Parents:

The School Code of Illinois states that prior to entrance into ninth grade, all students must be given physical examinations and show evidence of immunity to diphtheria, tetanus, pertussis, poliomyelitis, measles, rubella (German measles), mumps and Hepatitis B. It is recommended that they receive a dental examination.

The regulations concerning immunizations are as follows:

- A. All students entering ninth grade must have received three or more doses of either diphtheria-tetanus (TD), with the last dose being a booster. If 10 years have passed since the last booster, an additional booster is required.
- B. All students entering ninth grade must have received at least three doses of oral polio vaccine (at least 8 weeks between doses), with the last dose being a booster and having been received on or after the 4<sup>th</sup> birthday.
- C. All students entering ninth grade must present evidence that they: (1) have received two doses of live measles virus vaccine, the first dose by at least 12 months of age and the second dose no less than one month after the first; or (2) have a doctor's verification that they have had the disease; or (3) have a laboratory test indicating they are immune to measles.
- D. All students entering ninth grade must present evidence that they have been immunized against rubella (German or 3-day measles) at one year of age or later.
- E. All students entering ninth grade must present evidence that they have been immunized against mumps at one year of age or later or have a doctor's verification that they have had the disease.
- F. All students entering the ninth grade must have been immunized against Hepatitis B, with the second immunization following 30 days after the first inoculation, and the third immunization following 6 months after the second inoculation.
- G. It is highly recommended, but not mandatory, that all students entering ninth grade have the tuberculin skin test using the intradermal Mantoux method.

Local physicians are aware of these regulations and can bring the immunizations up-to-date at the time of your child's physical examination. The Lake County Health Department provides an immunization clinic at the VFW in Antioch on the third Wednesday of each month from 4 p.m. until 6 p.m. They also have a clinic in Round Lake Beach. Phone the Lake County Health Department at 847-377-8470 or 847-377-8480 for more information. There is a minimal charge for immunizations and physical exams.

### EXCEPTIONS FOR IMMUNIZATIONS AND PHYSICAL:

- A. If your physician feels that the physical condition of the child is such that the administration of one or more of the required immunizing agents would be detrimental to the health of the child, then that agent would not be required. A statement from the physician to this effect is necessary.
- B. If the parent or guardian of a child objects to their immunization or a physical examination due to religious beliefs, they will not be required. In such instances a signed statement of this objection, detailing the grounds for such objections, must be presented.

The physical examination **MUST** be written on the forms provided. These are now the only acceptable forms to be used for school health examinations in the State of Illinois. The immunization dates must be filled in with dates you know are accurate and should include **day, month and year**. This should be done before your child receives his/her examination so your doctor can determine if any additional immunizations are needed. If any are given at that time, they should also be indicated on the form.

**PHYSICAL EXAMINATIONS MAY BE GIVEN WITHIN ONE YEAR PRIOR TO NINTH GRADE ENTRANCE. THE COMPLETED FORM SHOULD BE RETURNED WITH THE STUDENT'S REGISTRATION MATERIALS OR BROUGHT TO THE NURSE AS SOON AS POSSIBLE.**

Please call your doctor early for an appointment as many cannot assure you of an appointment before school begins if called after August 1<sup>st</sup>.

Please fill out and sign the **HEALTH HISTORY/EMERGENCY INFORMATION** form included in this packet.

Needless to say, your child's health is an important factor and his/her school life can be more meaningful and interesting if he or she attends regularly. Some illnesses and conditions which cause frequent absences from school can be prevented. Any known condition concerning ears, eyes, teeth, tonsils, feet or skin should be taken care of before school commences. Any special problems your child may have, including physical education restrictions and vision or hearing difficulties, should be discussed with the school health aide.

Assistant Principal

*P. Fay*

Dr. Phyllis Fay

Health Office

*W. Sobczak*

Wanda Sobczak, R.N.

**MEDICATION ADMINISTRATION/SELF-ADMINISTRATION**  
**CONSENT FORM FOR PRESCRIPTION AND**  
**OVER-THE-COUNTER MEDICATIONS**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_ Emergency Phone \_\_\_\_\_  
School \_\_\_\_\_ Grade \_\_\_\_\_

**Part I – Physician’s Statement** *(This statement may be signed by a physician’s assistant or advance practice registered nurse having such authority delegated by a supervising/collaborating physician.)*

***Narcotics may not be taken prior to or during school hours.***

1. Name/type of medication: \_\_\_\_\_
2. Is the prescribed medication for an asthmatic condition? \_\_\_\_\_
3. If the prescribed medication is an epinephrine auto-injector, is the device for immediate self-administration by a person at risk of anaphylaxis? \_\_\_\_\_
4. Dosage/amount to be given: \_\_\_\_\_
5. Route of administration: \_\_\_\_\_
6. Frequency and time of administration, or special circumstances under which the medication or epinephrine auto-injector is to be administered: \_\_\_\_\_
7. Duration (e.g., week, month, indefinite): \_\_\_\_\_
8. Diagnosis, intended effect and anticipated reaction to medication (symptoms, side effects, etc.):  
\_\_\_\_\_
9. Other medication student is receiving: \_\_\_\_\_
10. Other requirements or special circumstances: \_\_\_\_\_
11. Must this medication be administered during the school day in order to allow the student to attend school? \_\_\_\_\_
12. Is supervised student self-administration authorized? \_\_\_\_\_
13. **For asthma medication or epinephrine auto-injector only\*** -- Is unsupervised self-administration authorized? \_\_\_\_\_

***\*Pursuant to Illinois law, upon parental consent, a student who is prescribed asthma medication or an epinephrine auto-injector may possess and use his/her asthma medication or epinephrine auto-injector during school or at school-sponsored activities without the supervision of district personnel.***

\_\_\_\_\_  
(Physician’s Signature)

\_\_\_\_\_  
(Date Signed)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Telephone Number)

**Part II– Liability Notice**

Community High School District 117 and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of an epinephrine auto-injector by the student.

[Please complete form and fax to Nurse at ACHS Health Office: 847-838-3672]

**PARENTAL CONSENT FORM**  
**EMERGENCY TREATMENT**

I, \_\_\_\_\_, parent/legal guardian of \_\_\_\_\_, have enrolled my child in and hereby authorize Dr. \_\_\_\_\_, my child's physician, or any physician in his or her group practice, on my behalf to administer emergency medical assistance to my child during school or a school-sponsored activity. In the event my child's physician, or any physician in his or her group practice, is not available, or contact with my child's physician is not practical under the circumstances, I hereby authorize Community High School District 117, its employees and agents to provide emergency medical assistance or to arrange for and consent to on my behalf immediate medical treatment by a licensed or certified physician or other medical personnel for my child whenever the authorized school personnel believe such emergency medical assistance is necessary to protect the health, safety and welfare of my child. I further waive any claims against Community High School District 117, the members of the Board of Education, its employees and agents arising out of the provision of or arrangement for emergency medical assistance to my child and agree to hold harmless and indemnify Community High School District 117, the members of its Board of Education, its employees and agents, either jointly or severally, 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 provision of or arrangement for emergency medical treatment.

Signed \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_

**Part III- Parent's Request/Approval**

I hereby request and grant permission for Community High School District 117 school personnel to [***check one***] \_\_\_\_\_ administer or \_\_\_\_\_ permit the self-administration of medication to/by my daughter/son according to the above instructions. I understand that administration by school personnel may be performed by an individual other than a certificated and registered school nurse, and I specifically consent to this. I acknowledge that Community High School District 117 is to incur no liability, except for willful and wanton conduct, arising from the self-administration of medication or use of an epinephrine auto-injector by my daughter/son. I further waive any claims against the School District, members of the Board of Education, its employees and agents arising out of the administration or self-administration of said medication or use of an epinephrine auto-injector, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents, either jointly or severally, 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 or use of such epinephrine auto-injector. With respect to student self-administration of asthma medication or use of an epinephrine auto-injector, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

**For asthma medication or epinephrine auto-injector only** – I consent to my child's possession and unsupervised self-administration of asthma medication: \_\_\_\_\_ yes \_\_\_\_\_ no. I consent to my child's possession and unsupervised use of his/her epinephrine auto-injector: \_\_\_\_\_ yes \_\_\_\_\_ no.

Signed \_\_\_\_\_ Phone # \_\_\_\_\_ Date \_\_\_\_\_



<b>Student's Name</b>	<b>Birth Date</b>	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
Last First Middle	Month/Day/ Year			

**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during the night coughing	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes No
Developmental delay?	Yes	No		Surgery? (List all.) When? What for?	Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes No
Diabetes?	Yes	No		TB skin test positive (past/present)?	Yes* No
Head injury/Concussion/Passed out?	Yes	No		TB disease (past or present)?	Yes* No
Seizures? What are they like?	Yes	No		Tobacco use (type, frequency)?	Yes No
Heart problem/Shortness of breath?	Yes	No		Alcohol/Drug use?	Yes No
Heart murmur/High blood pressure?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes No
Dizziness or chest pain with exercise?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other	
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Other concerns?	
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.	
Bone/Joint problem/injury/scoliosis?	Yes	No		<b>Parent/Guardian Signature</b>	<b>Date</b>

**Entire section below to be completed by MD/DO/APN/PA (\*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)**

<b>PHYSICAL EXAMINATION REQUIREMENTS</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>				
<b>LEAD RISK QUESTIONNAIRE*</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Blood Test Result</b> _____ (Blood test required in Chicago and other high risk zip codes.)				
<b>TB SKIN TEST</b> Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. <b>Date Read</b> / / <b>Result</b> _____ <b>mm</b>				
<b>LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES</b>	<b>Date</b>	<b>Results</b>	<b>Date</b>	<b>Results</b>
Hemoglobin * or Hematocrit *				Sickle Cell * (as indicated)
Urinalysis				Other
<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>		Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____ Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	
<b>NEEDS/MODIFICATIONS</b> required in the school setting			<b>DIETARY</b> Needs/Restrictions	
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup				
<b>MENTAL HEALTH/OTHER</b> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal				
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.				
<b>On the basis of the examination on this day, I approve this child's participation in</b> (If No or Modified, please attach explanation.) <b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>				
Physician/Advanced Practice Nurse/Physician Assistant performing examination				
<b>Print Name</b>	<b>Signature</b>			<b>Date</b>
<b>Address</b>	<b>Phone</b>			

(Complete both sides)



**ANTIOCH COMMUNITY HIGH SCHOOL  
HEALTH HISTORY AND EMERGENCY INFORMATION**

PARENTS: In order to insure emergency care for a child taken ill or injured at school, the following information is essential. Completing this form each year may seem unnecessary to many parents, but addresses, employment, phone numbers, as well as your child's health, may change from year to year. It must be signed by a parent or guardian.

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

**HEALTH HISTORY:**

Asthma? \_\_\_\_\_ Any restrictions? \_\_\_\_\_

Allergies to food, medicine, insect bites or other? \_\_\_\_\_

Does your child have a hearing loss? \_\_\_\_\_ Wear a hearing aid? \_\_\_\_\_ Wear glasses/contacts? \_\_\_\_\_

Does your child take medicine regularly and for what purpose? \_\_\_\_\_

Does your child have any other significant illness, special problem or disability (include emotional), or use any special equipment such as a brace? Explain: \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY INFORMATION**

Home Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Father's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

List below other responsible persons to be notified if unable to reach parents:

1. \_\_\_\_\_ Relationship \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

2. \_\_\_\_\_ Relationship \_\_\_\_\_ Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

In the event of an emergency rising out of serious illness or injury, permission is hereby granted to transport my son/daughter to a medical facility, if necessary, and to provide necessary treatment. I understand that an attempt will be made by the school administration and/or the attending physician to contact me or my spouse in the most expeditious way possible. If said physician is not able to communicate with me or my spouse, permission is hereby granted to the attending physician to proceed with necessary medical or surgical treatment in the best interest of my son/daughter, and if necessary, to admit him/her to a medical facility. Permission is also granted to the athletic trainer, in the absence of a physician, to provide necessary first aid until such time as a physician is present.

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