

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. New students (upperclassmen) are also required to provide a copy of their ninth grade or current physical and immunizations. A sports physical may not be submitted in lieu of the State of Illinois Department of Human Services form.

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 4th 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 they have been immunized against varicella (chicken pox) or have doctor's verification they have had the disease.**
- E. All students entering ninth grade must present evidence that they have been immunized against mumps and rubella (German or 3-day measles) at one year of age or later or have a doctor's verification 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. STUDENTS WHO DO NOT HAVE A PHYSICAL (NOT A SPORTS PHYSICAL) ON FILE BY THE START OF SCHOOL WILL BE SUBJECT TO EXCLUSION FROM SCHOOL ON OCTOBER 15, 2011 PER STATE CODE.

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

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]

---OVER---

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 _____

**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 _____



**STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

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

Address				Parent/Guardian				Telephone #				Work			
Street	City			ZIP code							Home				

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		Comments
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23		<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. **Clinical diagnosis is acceptable if verified by physician.** *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease	Signature	Title	Date
-----------------	-----------	-------	------

3. **Laboratory confirmation (check one)** Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels															
Date														Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
Age/Grade															
	R	L	R	L	R	L	R	L	R	L	R	L	R		L
Vision															
Hearing															

Printed by Authority of the State of Illinois
(Complete Both Sides)

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

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? 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		Parent/Guardian Signature	Date

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

PHYSICAL EXAMINATION REQUIREMENTS	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date Blood Test Result (Blood test required in Chicago and other high risk zip codes.)				
TB SKIN TEST 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. Date Read / / Result mm				
LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results	Date	Results
Hemoglobin * or Hematocrit *				Sickle Cell * (as indicated)
Urinalysis				Other
SYSTEM REVIEW	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	
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>				
Physician/Advanced Practice Nurse/Physician Assistant performing examination				
Print Name	Signature			Date
Address	Phone			

(Complete both sides)

