

# FORRESTVILLE VALLEY SCHOOL DISTRICT #221



**SUPERINTENDENT**  
**Mrs. Sheri Smith**

Dear Parent(s)/Guardian(s),

Welcome to Forrestville Valley School District #221 and the 2020-2021 School Year! We are excited you have selected our district and look forward to wonderful things for your student and our school community.

I believe you will find a small community that embraces all aspects of education to include academics, arts, and athletic opportunities. I would encourage you to take a few minutes to review our district and various school and student highlights on our website:


[www.fvdistrict221.org](http://www.fvdistrict221.org).

I am proud to report our school communities are strong and function as one district unit. This is demonstrated in a variety of ways but specifically with our average daily attendance. Each year we exceed the state average as we continue to educate 96% of our student body every day. It is important that your child attends school and does not miss out on great educational opportunities.

Please take the time this year to get involved or stay involved in your child's education. Your son or daughter is never too old to need your participation in school activities. Not only will your child know when you are present, he or she will also remember when you are not. You may contact your school office to learn more regarding parent involvement in the PTO, Sports Boosters, Music Patrons, or classroom volunteers.

I wish you the very best year ahead and please contact my office if I can be of assistance to you.

Sincerely,



Mrs. Sheri Smith

District Superintendent



# Forrestville Valley School District #221

## ELA Registration Forms Checklist 2020-2021

Please provide the following forms for completion of student registration:

Student Information

Certificate of Residence

Residency Verification Checklist

Parent/Student Signature

Release of Student Information

Busing Information

Confidential Student Health Information

Ethnicity and Race Report

Home Language Survey

Physical and Exams (Preschool, Kindergarten, 2<sup>nd</sup>, 6<sup>th</sup>, 9<sup>th</sup>, 12<sup>th</sup>)

Skyward Family Access Sign-Up

ELA Parent Involvement Contract

ROE Information Checklist (2)

ROE Photo Release

ROE Questionnaire

# STUDENT INFORMATION FORM 2020-2021

## FORRESTVILLE VALLEY SCHOOL DISTRICT #221

Student's Name \_\_\_\_\_  
First Middle Last

Address \_\_\_\_\_  
Street P.O. Box Number City, State, Zip

Phone \_\_\_\_\_ Student Cell Phone (if applicable) \_\_\_\_\_

Grade/School \_\_\_\_\_ Previously Attended FV?  Yes  No

Date of Birth \_\_\_\_\_ County/State of Birth \_\_\_\_\_ Gender \_\_\_\_\_

### ALL OTHER CHILDREN IN YOUR FAMILY—INCLUDE THOSE NOT IN SCHOOL THRU 12TH GRADE

1) Name \_\_\_\_\_  
First Middle Last

Date of Birth \_\_\_\_\_ Grade/School \_\_\_\_\_ Gender \_\_\_\_\_

County/State Of Birth \_\_\_\_\_ Previously Attended FV?  Yes  No

2) Name \_\_\_\_\_  
First Middle Last

Date of Birth \_\_\_\_\_ Grade/School \_\_\_\_\_ Gender \_\_\_\_\_

County/State Of Birth \_\_\_\_\_ Previously Attended FV?  Yes  No

3) Name \_\_\_\_\_  
First Middle Last

Date of Birth \_\_\_\_\_ Grade/School \_\_\_\_\_ Gender \_\_\_\_\_

County/State Of Birth \_\_\_\_\_ Previously Attended FV?  Yes  No

### MEDICAL INFORMATION:

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Allergies \_\_\_\_\_

Medical Problems \_\_\_\_\_

**(PLEASE CONTINUE ON BACK)**

Father's Name \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Hours At Work A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Work # \_\_\_\_\_ Email address \_\_\_\_\_

Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Hours At Work A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Work # \_\_\_\_\_ Email address \_\_\_\_\_

Step-Father's Name \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Hours At Work A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Work # \_\_\_\_\_ Email address \_\_\_\_\_

Step-Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

Employer \_\_\_\_\_ Hours At Work A.M. \_\_\_\_\_ P.M. \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Work # \_\_\_\_\_ Email address \_\_\_\_\_

**EMERGENCY CONTACT: Must be someone other than parent - List 2**

\_\_\_\_\_  
Name Relationship Phone #

\_\_\_\_\_  
Name Relationship Phone #

Parent/Guardian is a member of the armed forces?  
-Currently is deployed to active duty?  YES  NO  
-Expects to be deployed to active duty during the school year?  YES  NO

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



**Forrestville Valley School District #221**  
**CERTIFICATE OF RESIDENCE**  
**2020-2021**



Student's Name: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Father's Name: \_\_\_\_\_  Living  Deceased

Father's Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_  Living  Deceased

Mother's Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Please answer the following questions:

1. Are the student's parents divorced or separated?  Yes  No

a. Who has custody of the  student?  Mother  Father  Joint

b. If custody is jointly held who claims the student as a dependent on their federal income tax return?  Mother  Father

c. With which parent does the student reside?  Mother  Father

d. Please attach a copy of the custody order.

2. Does the student reside with a person other than his/her natural or adoptive parents?  Yes  No

If the answer to the above question is "Yes", please answer the following questions:

a. What is the name of the adult with whom the student now resides? \_\_\_\_\_

b. Address: \_\_\_\_\_

c. Is this person a relative of the student?  Yes  No

d. If "Yes", what relation is she/he to the student? \_\_\_\_\_

e. Is the person with whom the student resides the legal guardian or custodian of the student?  Yes  No

f. If "Yes", please attach a copy of the guardianship or custody order.

**(PLEASE CONTINUE ON BACK)**

3. Is the student eligible for Special Education services?  Yes  No

If "Yes", please provide a copy of the student's most recent Individualized Education Program (I.E.P), or provide us with a name and address of the school district from which we may obtain a copy.

4. Does any Illinois public agency have legal guardianship of the student?  Yes  No

If "Yes", please attach proof of legal guardianship.

5. Has a court ordered a residential placement for the student?  Yes  No

6. Is the student   homeless? Yes No

If "Yes": a. Is the student currently living in the School District?  Yes  No

b. In what school district was the student last enrolled?

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c. In what school district was the student enrolled when permanently housed?

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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 #221 schools. I further certify that the above information is correct to the best of my knowledge.

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Parent(s) or Guardian(s) Signature

Date:

**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 #221 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 result in your child being excluded from school, and may expose you to monetary liability under Illinois law for payment of tuition for such time as your child was 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.



# Forrestville Valley School District #221

## Residency Verification Checklist 2020-2021

Student Name \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

### ALL NEW & RETURNING STUDENTS:

Please provide **TWO** of the following items of identification reflecting an address within the Forrestville Valley School District #221:

- \_\_\_ Driver's license
- \_\_\_ Home ownership (title or deed)
- \_\_\_ Apartment lease
- \_\_\_ Voter registration
- \_\_\_ Copy of utility bill
- \_\_\_ Copy of auto insurance bill
- \_\_\_ Library card
- \_\_\_ Documentation approved by Superintendent
- \_\_\_ Other (describe)

### NEW STUDENTS ONLY:

Please complete the following steps:

- \_\_\_ Complete Certificate of Residence form
- \_\_\_ Provide a certified copy of birth certificate  
*(If entering kindergarten, the student must be five years of age before September 1st)*
- \_\_\_ Provide records of transfer
- \_\_\_ Provide record of physical examination with immunizations
- \_\_\_ Provide I.S.B.E. Student Transfer form from transferring district

Does the student reside with his natural or adoptive parents?

YES

NO

If no, please check one of the following:

- \_\_\_ On student's own (is student 18 years of age or emancipated?)
- \_\_\_ Guardian/custodian (obtain copy of court order)
- \_\_\_ Relative (obtain copy of court order or refer to Superintendent)
- \_\_\_ Placed by DCFS (obtain copy of court order)
- \_\_\_ Homeless (refer to Superintendent)
- \_\_\_ Other (refer to Superintendent)



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# Forrestville Valley School District #221

## Parent/Student Signature Form

### 2020-2021

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The district is required to present the following agreements for your review. Please review the handbooks and policies by visiting the district website at [fvdistrict221.org](http://fvdistrict221.org) and sign below.

#### PARENT/STUDENT HANDBOOK:

- I have reviewed the guidelines, discipline plan, and athletic standards, which will improve the learning environment in the Forrestville Valley Schools.

These guidelines are not intended to create a contractual relationship with the student; rather, it is intended to describe the school and its current general practices, procedures, rules and regulations at the time of publication for appropriate code of conduct.

#### ACCEPTABLE USE OF ELECTRONIC NETWORK:

- I agree to and accept the Acceptable Use of Electronic Network terms and conditions.

#### ELECTRONIC DEVICE HANDBOOK:

- I agree to and accept the Electronic Device Agreement as presented and understand that Forrestville Valley School District #221 owns the device, software, and issued peripherals. If the student is no longer enrolled in Forrestville Valley School District #221 schools, the device will be returned in good working order. In no event shall the student or parent/guardian hold Forrestville Valley School District #221 liable for any claim of damage, negligence, or any breach of duty resulting from any act or omission related to the unauthorized use of the device.

#### STUDENT ACCIDENT INSURANCE WAIVER:

All students in grades K-12 are offered the opportunity to enroll in an accident insurance plan. Please refer to our website for information on the *Student Accident Insurance Program* if applicable to you. If not, please check below:

- I have adequate insurance to protect my son/daughter in case of an accident.
- I certify that I have reviewed all information provided above and understand that the Forrestville Valley School District #221 agreements are made available on the district website: [www.fvdistrict221.org](http://www.fvdistrict221.org).

By signing below, parent/guardian and student acknowledge, review and accept the following:

•Parent/Student Handbook  
•Electronic Device Handbook

•Acceptable Use of Electronic Network  
•Student Accident Insurance Waiver

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date





# Forrestville Valley School District #221

## Release of Student Information 2020-2021

### DIRECTORY INFORMATION:

The law and school district policy designate certain information as "Directory Information". Throughout the school year, the district may release directory information regarding students, limited to: student name, gender, grade level, birthdate and place, parent/guardian name, academic awards, degrees and honors, information regarding school-sponsored activities, organizations and athletics, major field of study, and period of attendance in school. A parent/guardian or eligible student may prohibit the release of any or all of the above information by delivering a written objection to the Building Principal.

### USING A PHOTOGRAPH OR VIDEO OF A STUDENT:

Students may occasionally appear in photographs and videos taken by school staff members or other individuals authorized by the Building Principal. The district may use these pictures, without identifying the student, in various publications, including the school yearbook, school newspaper, and district website. No consent or notice is needed or will be given before the district uses these pictures of unnamed students taken while they are at school or a school-related activity.

In order for the district to publish a picture with a student identified by name, a parent or guardian must give prior written permission.

### MILITARY & INSTITUTIONS OF HIGHER EDUCATION (GRADES 9-12 ONLY):

From time to time, military recruiters and post-secondary educational institutions request the names, telephone numbers, and addresses of our secondary students. The school must provide this information unless the parent/guardian requests that this is not to be disclosed without their prior written consent.

*Please respond to the following statements by placing a check in the "Yes" or "No" column and then sign in the space below.*

STATEMENT	YES	NO
I grant permission for the district to publish a picture with my student identified by name in various publications as listed above		
I grant permission to have my child's information released to military recruiters and institutions of higher education. (GRADES 9-12 ONLY)		

**I certify that I have reviewed all information provided above and understand that the Forrestville Valley School District #221 Parent/Student Handbook is made available on the district website: [www.fvdistrict221.org](http://www.fvdistrict221.org).**

\_\_\_\_\_  
Student Name / Grade / School

\_\_\_\_\_  
Date

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



**Forrestville Valley School District #221**  
**Busing Information**  
**2020-2021**

Student's Name: \_\_\_\_\_ Grade/School: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Home address: \_\_\_\_\_

**NO**, my student **DOES NOT** need busing.

**Please Note: There will be ONE address for pick-up and ONE address for drop-off.**

**AM Pick-Up:**       Yes       No      (Write Address below if **DIFFERENT** than Home Address)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**PM Drop-Off:**       Yes       No      (Write Address below if **DIFFERENT** than Home Address)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Other Considerations/Comments:**

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**\*\*Busing requests will be reviewed before assignment to routes. Please note any legal constraints by all parties involved will override district authorization and/or district ability to accommodate a variety of issues. The following are a few examples of such issues; child custody rights, out of district transportation, sex offender information, etc. Please keep us informed of any changes.**

**TRANSPORTATION OFFICE USE ONLY:**

AM Bus # / Driver:		PM Bus # / Driver:	
Parent Notified:	Driver Notified:	School Notified:	



# Forrestville Valley School District #221 Confidential Student Health Information 2020-2021



STUDENT'S NAME: \_\_\_\_\_ Grade/School: \_\_\_\_\_

**NO**, my student **DOES NOT** have health concerns.

**YES**, my student **DOES** have health concerns. **PLEASE CHECK ANY CONDITIONS LISTED BELOW THAT APPLY TO YOUR STUDENT.** If you have any questions or concerns about your child's health, please contact the school nurse.

ADD/ADHD

Allergies – Food

Allergies – Insect

Allergies – Medicine

Asthma

Birth Defects

Bone/Joint Problems

Depression

Diabetes

Ear/Hearing Problems

Migraines

Glasses/Contacts

Heart Problems

Physical Restrictions

Other

If your child has a condition not listed above, please describe in detail below:

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If your child requires medication during school hours, please refer to the section regarding medication found in the *Parent-Student Handbook* and obtain a *Request for Administration of Medicine* form from the school office.

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

\_\_\_\_\_  
Date

# U.S. Department of Education Ethnicity and Race Report

The U.S. Department of Education has issued new guidelines on the collection and reporting of race and ethnicity data for public schools and staff. Please complete this form and return to your child's school.

Student's Name: \_\_\_\_\_ SIS ID# \_\_\_\_\_  
(School to Supply)

**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 to 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 maintain 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, and 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 Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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# Forrestville Valley School District # 221

## Home Language Survey

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The state requires the district to collect a Home Language Survey for every 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 yes, what language? \_\_\_\_\_

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

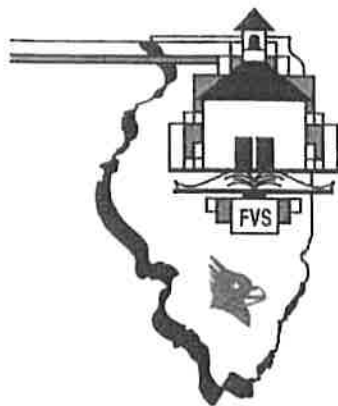
Yes \_\_\_\_\_ No \_\_\_\_\_

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

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

\_\_\_\_\_  
Date

# FORRESTVILLE VALLEY SCHOOL DISTRICT #221



April 2020

Dear Parents or Guardians;

The *Illinois School Code* requires all pupils entering Preschool, Kindergarten, 6<sup>th</sup> and 9<sup>th</sup> Grades *as well as students moving to Illinois from out of state*, to have completed an Illinois physical exam form with a physician's verification of the required immunizations.

All students entering Preschool through 12<sup>th</sup> grades must have proof of having received the varicella (chickenpox) vaccine. All students in **Kindergarten through 4<sup>th</sup> and grades 6<sup>th</sup> through 12<sup>th</sup> must now show proof of having had two doses of the varicella vaccine.**

Students in 6<sup>th</sup> **and** 12<sup>th</sup> grades must show proof of having had the Meningitis vaccine. Sixth graders must show proof of having one dose of the vaccine, seniors must show proof of having 2 doses. (If the first dose was given after age 16, only one dose is required)

Students entering 6<sup>th</sup> through 12<sup>th</sup> grades must show proof of having had a Tdap booster.

Preschool students must show proof of pneumococcal vaccination, according to schedule.

All students in Kindergarten, 2<sup>nd</sup>, 6<sup>th</sup> grade and 9<sup>th</sup> grades are required to have a completed dental form on file by May 15<sup>th</sup>. Students must have been seen by a dentist within 18 months of the May 15<sup>th</sup> deadline.

All students entering Kindergarten *or at first entrance to any school* in the State of Illinois will be required to have a professional eye examination.

If you object to this process for health reasons, you must include a physician's statement that the required immunizing agents would be detrimental to the health of the child. Objections to vaccinations due to religious beliefs must be submitted in writing stating supporting scripture with references and parent signatures. Also, an Illinois Certificate of Religious Exemption must be completed and signed by a parent 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 15<sup>th</sup>, students will be dismissed from school until requirements can be completed.

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

Sincerely;  
Jennifer Nelson, RN  
School Nurse



## 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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Last Name		First Name	
Student's Race/Ethnicity:				
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				

**To be completed by dentist:**

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

- |  |                                  |
|--|----------------------------------|
| <input type="checkbox"/> Restorative Care — amalgams, composites, crowns, etc.       | Appointment Date: _____          |
| <input type="checkbox"/> Preventive Care — sealants, fluoride treatment, prophylaxis | Appointment Date: _____          |
| <input type="checkbox"/> Pediatric Dentist Referral Recommended                      | Treatment Completion Date: _____ |

Additional comments: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ License # \_\_\_\_\_ Date: \_\_\_\_\_



# 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 \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
 (Month/Day/Year)

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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 \_\_\_\_\_





## State of Illinois Certificate of Child Health Examination

<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>
Last	First	Middle	Month/Day/Year			
<b>Address</b>			<b>Parent/Guardian</b>		<b>Telephone # Home Work</b>	
Street City Zip Code						

**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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap, Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps, Rubella										<b>Comments:</b> * indicates invalid dose								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

**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.**

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**ALTERNATIVE PROOF OF IMMUNITY**

- 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
- 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
- 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.**

<b>Last</b> _____ <b>First</b> _____ <b>Middle</b> _____	<b>Birth Date</b> Month/Day/Year _____	<b>Sex</b> _____	<b>School</b> _____	<b>Grade Level/ ID</b> _____
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

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

HEAD CIRCUMFERENCE if < 2-3 years old	HEIGHT	WEIGHT	BMI	BMI PERCENTILE	B/P
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) 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. (Blood test required if resides in Chicago or high risk zip code.) <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Result</b> _____					
<b>TB SKIN OR BLOOD TEST</b> 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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____					

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		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting	DIETARY Needs/Restrictions
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**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 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 \_\_\_\_\_

License Number \_\_\_\_\_

Optometrist or physician (such as an ophthalmologist)  
 who provided the eye examination  MD  OD  DO

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 \_\_\_\_\_)



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# Forrestville Valley School District #221

## Skyward Family Access Sign-Up

### 2020-2021

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By Signing and returning this form, you are authorizing Forrestville Valley School District #221 to provide you with one login and password for all your children in FVSD #221.

Parent/Guardian Name (please print): \_\_\_\_\_

Email Address: \_\_\_\_\_

**You will receive your login and password by email.**

Student Name (print)	Grade	School

**Please return this form to your child's school secretary.  
Login and password information will not be communicated by phone.**

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I agree to keep my user name and password confidential. I will notify my child's school secretary immediately if I become aware that anyone else has accessed my password. Any misuse of this system will result in me being permanently restricted from future use.

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

\_\_\_\_\_  
Date



Sarah Kuhlemeier  
 Early Childhood Coordinator  
 27 S. State Ave.  
 Freeport, IL 61032  
 815-599-1408



Early  
 Learning  
 Academy

## Early Learning Academy Parent Involvement Contract

Child First Name: \_\_\_\_\_ Child Last Name: \_\_\_\_\_

Parent Name (s): \_\_\_\_\_

*You are a very important part of your child's education and this Project. Please indicate below how you would like to be involved in the program.*

- Attend parent/child activity events
- Classroom volunteer
- Prepare classroom materials (*felt-board stories, games, teacher aides*)
- Assist with field trips and other special events
- Share a hobby, trade, or interest with the class
- Attend classroom special events (*end of year celebrations, holiday events, etc.*)
- Access the Parent Lending Library (*resource books, take home packets*)
- Read a book or do storytelling with class
- Other: \_\_\_\_\_

The classroom teachers' time is very limited and they would welcome any help you can give them. If you can't make it into the classroom, please ask the teacher how you can help in other ways.

There are procedures specific to each school district for being in the classroom on a regular basis. If you wish to pursue this avenue, please contact district personnel for more information.

*Please read the following statement carefully and then sign and date this agreement below.*

I (We) \_\_\_\_\_ understand that each parent is an integral part of the **Early Learning Academy** Preschool program. My (Our) child's acceptance into **Early Learning Academy** includes the fact that I (we) will participate in the program **a minimum of six (6) times** throughout the school year. **Two of the six must include attendance at parent/teacher conferences and/or parent/child activity events.**

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

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

\_\_\_\_\_  
 Date



Sarah Kuhlemeier  
 Early Childhood Coordinator  
 27 S. State Ave.  
 Freeport, IL 61032  
 815-599-1408



Early  
 Learning  
 Academy

As a requirement of the Preschool for All program funded by the Illinois State Board of Education, the following information is requested to be verified by the serving school district upon enrollment in preschool.

<b>Child's Name</b>	<b>Birthdate</b>

Please list all persons living in the household, and their relationship with the child listed above.

Person	Relationship

Please check the box the best fits your family structure:

	Both parents in the home
	Single parent family
	Lives with an adult other than parent or guardian
	Youth in care (DCFS)
	Parents have joint custody

I \_\_\_\_\_ verify, that the above information is true and correct.

Signature

Date



Sarah Kuhlemeier  
 Early Childhood Coordinator  
 27 S. State Ave.  
 Freeport, IL 61032  
 815-599-1408



Early  
 Learning  
 Academy

Preschool for All is a need-based program and as such, the serving school district is required to **verify and copy** physical proof of your household income based on the following federal guidelines, using 1 or more of the following sources:

Family/Household Size	50%	100%	200%	400%	Over 400%
1	\$6380 or ↓	6381 - 12760	12761 - 25520	25521 - 51040	\$51041 or ↑
2	\$8620 or ↓	8621 - 17240	17241 - 34480	34481 - 68960	\$68961 or ↑
3	\$10860 or ↓	10861-21720	21721- 43440	43441- 86880	\$86881 or ↑
4	\$13100 or ↓	13101-26200	26201- 52400	52401- 104800	\$104801 or ↑
5	\$15340 or ↓	15341-30680	30681- 61360	61361-122720	\$122721 or ↑
6	\$17580 or ↓	17581-35160	35161- 70320	70321-140640	\$140641 or ↑
7	\$19820 or ↓	19821-39640	39641- 79280	79281-158560	\$158561 or ↑
8	\$22060 or ↓	22061-44120	44121- 88240	88241-176480	\$176481 or ↑

(Staff Please indicate the income level above by circling, and initial and date on the chart below.)

Verified By & Date	Type of Documentation
	2 Most Recent Pay Stubs, Consecutive
	Tax Return (Most Recent)
	Wages and Tax Statement (Most Recent W-2)
	Verification Letter of Wages from Employer
	Signed written statement from the family verifying no income

I \_\_\_\_\_ verify, that the above information is  
*Parent/Guardian*  
 true and correct. I understand that if my Family or Household income exceeds the above listed amounts, my child may not qualify for Preschool for All unless other needs are indicated during the screening process.

\_\_\_\_\_  
 Signature

\_\_\_\_\_  
 Date



Sarah Kuhlemeier  
Early Childhood Coordinator  
27 S. State Ave.  
Freeport, IL 61032  
815-599-1408



Early  
Learning  
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## Photo Release

\_\_\_\_\_  
Child's First Name

\_\_\_\_\_  
Child's Last Name

- I give permission for my child to be photographed or video-taped while participating in **Early Learning Academy**. I understand that these photo/tapes will be used for educational purposes only within the classroom and school.
  
- I give permission for my child's photo to be shared with news outlets (newspapers and TV stations) and preschool and district social media sites (Facebook, Twitter, Instagram) for educational purposes.
  
- I prefer that my child **NOT** be photographed while participating in **Early Learning Academy** events and activities.

\_\_\_\_\_  
Parent/Guardian Name (Print)

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

\_\_\_\_\_  
Date





**Sarah Kuhlemeier**  
Early Learning Academy  
Program Coordinator



Early  
Learning  
Academy

Parent Name: \_\_\_\_\_ Child Name: \_\_\_\_\_

## **A Questionnaire for Families about Celebrations**

1. What special days do you celebrate in your family?
  
  
  
  
  
  
  
  
  
  
2. How would you like our program to be involved in your celebrations?
  
  
  
  
  
  
  
  
  
  
3. How do you think we could celebrate everyone's special days in a preschool as diverse as ours?
  
  
  
  
  
  
  
  
  
  
4. What are some of the myths/stereotypes about your culture that you would like us to understand so as not to perpetuate them?
  
  
  
  
  
  
  
  
  
  
5. How do you feel about celebrations at the preschool that are not part of your family's tradition?
  
  
  
  
  
  
  
  
  
  
6. What kinds of things can we do to celebrate our preschool as an inclusive "human" community?
  
  
  
  
  
  
  
  
  
  
7. Would you have time to:
  - ❖ Read a favorite story in your native language?
  - ❖ Share a favorite family recipe?
  - ❖ Donate articles of clothing that you no longer use for our "dress-up" corner?

*Created by Tamar Meyer, Program Coordinator, and the lead teachers  
At the University at Buffalo Child Care Center, Buffalo, New York*



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Early  
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# Permission to Enroll

\_\_\_\_\_  
Child's First Name

\_\_\_\_\_  
Child's Last Name

I give permission for my child to be enrolled in *Early Learning Academy* Preschool Program at no cost.

\_\_\_\_\_  
Parent Name (Print)

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date