

FORRESTVILLE VALLEY SCHOOL DISTRICT #221

2023 - 2024 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> <u>grade</u>: 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, 2024. 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, 2022.

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,

year Helson
Jennifer Nelson RN



State of Illinois Certificate of Child Health Examination

Student's Name				Birth Date		Sex	Race	e/Ethnicity	Scho	ol /Grade Level/ID#
Last	First	Middle	den en e	Month/Day/Year	naumanarathashna kuliyayi	ndratement transcence.	lps months are seen	di di upanis regginos (sens ten tribit) am esic (difect e rad	топутьюникостр	gynny sigys af saaliss aa aka sigu ka
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REQUIRED	DOSE 1	DOSE 2		DOSE 3		DOSE 4		DOSE 5		DOSE 6
Vaccine / Dose	MO DA YR	MO DA YR	М	O DA YR	мо	DA	YR	MO DA	YR	MO DA YR
DTP or DTaP										
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Pneumococcal Conjugate		A CONTRACTOR OF THE CONTRACTOR			***************************************	-		COMMUNICATION CONTRACTOR AND		
Hepatitis B					in the second second				***************************************	
MMR Measles Mumps, Rubella	And the second s				Com	ments:		* indicates inv	alid d	ose
Varicella (Chickenpox)										
Meningococcal conjugate (MCV4)	AND	namamanista kari (interpreta proporti periode de un mistri del Prometico de un alem e malam pinh hasa (int	-CHRONIAN (REPORTED	Marcha (Lacendon II) es la composition de processo de la composition della composit						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose										
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Influenza										
Other: Specify				8						The state of the s
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	MIN DO APN PA	school health profe	aceion	al health offici	al) va	ifving o	bove i	ina marina irratian B	inton	w must sign balow
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.										
Signature Title Date							#480TTENENROMNIN - PARKKHANIOO WALKELLO LEEU LEEU LEEU LEEU LEEU LEEU LEEU			
Signature Title Date										
ALTERNATIVE PROOF OF IMMUNITY										
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach										
copy of lab result. *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR										
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as										
documentation of disease. Date of										
Disease Signature Title										
3. Laboratory Evidence of Immunity (check one)										
*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.										
Physician Statements of Immunity MUS1 be submitted to IDPH for review.										

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ALLERGIES (Faod, drug, insect, other)	*************	ist:				ME	DICATION (Prescribed or on a regular basis.)	NAME OF TAXABLE PARTY OF TAXABLE PARTY.	lst:			
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Birth defects?	- Annual Annua		Yes	No	-Fire filtricking a sector and discoverage printers and described and admitted by the sector and a sector and	Hos	pitalizations?	DUTHICH DETINISATION AND ADDRESS AND ADDRE	Yes	No		
Developmental delay?		Annual Annual States	Yes	No	yekhir den der sen yang maggan ngga mengan senera sen	Wh	en? What for?					
Blood disorders? Hemophilia, Yes No Sickle Cell, Other? Explain.						Surgery? (List all.) When? What for?			No	State Marcal Charles (parties)	idelesel din henry somen engagenga din energende en energen en energen en e	
Diabetes?	3 F	_	Yes	No		Ser	Serious injury or illness?			No		
Head injury/Concussion	on/Passed	out?	Yes	No	<u> </u>	ТВ	TB skin test positive (past/present)?			⊧ No		efer to local health
Seizures? What are th	ey like?	//////////////////////////////////////	Yes	No	porture con agricultura de la constantina della	ТВ	disease (past or present)?	Yes	* No	departm	ent.	
Heart problem/Shortn	ess of brea	th?	Yes	No	NUMBER OF THE PERSON NAMED	Tol	Tobacco use (type, frequency)?			No		
Heart murmur/High b	lood pressi	ıre?	Yes	No	NAME OF THE PROPERTY OF THE PR	Alc	ohol/Drug use?		Yes	No		
Dizziness or chest pai exercise?	n with	A PARTICIPATION OF THE PROPERTY OF THE PARTICIPATION OF THE PARTICIPATIO	Yes	No	SPANNANSESSESSESSESSESSESSESSESSESSESSESSESSES		nily history of sudden deat ore age 50? (Cause?)	h	Yes	No	Nittenskus tyrounder attender	A A A A A A A A A A A A A A A A A A A
Eye/Vision problems					Last exam by eye doctor	De	nțal 🗆 Braces 🗀 1	Bridge	☐ Plate	Other	аЗ _{фициничник п} осторой	i yaki engini daga ayga gali (iga di bilaga m 1930 bakun bama da katan
Other concerns? (cros		oping lids,		hy nnaminating are	ulty reading)	Info	rmation may be shared with a	nyranciata	nacconal :	for bealth	and education	and phenoses
Ear/Hearing problems	www.wikishkakikakisha	inania and management	Yes	No	erron a constitut e sus allen esta porte sus allens sus		ent/Guardian	hhrohuwe	personner	ioi neann	and concarr	mat putposes.
Done/Joint problem/in			Yes	No			nature	204 C 4 4 4	managa an	Marie Ma	Da	C
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	The same of the sa	_			ren age 6 months through 6				and the second second			
and/or kindergarten.	(Blood test	t required	if resid	es in C	Chicago or high risk zip coo	de.)	•		•	•		·
Questionnaire Admir	and the second second second second	and the second second second second	NAME OF TAXABLE PARTY.		d Test Indicated? Yes []		Blood Test Date	**************************************	Stranicularium manadolistism	Result		
TB SKIN OR BLOO	D TEST	Recommer	ided only	for ch	ildren in high-risk groups inch isk categories. See CDC guide	uding child	ren immunosuppressed due	to HIV in	ifection or ic/footelie	other con	nditions, fre	quent travel to or born
No test needed []		rformed I			Test: Date Read	· ·	Result: Positi		Negative		mn	
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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	; Last	First	Middle		Birth Date: (Month/Day/Year)		
Address:	Street	City	HET HELITATION DOGGO AND HEALTH THAT EVEN AND A MEMORIT COMPARE DESIREMENT COMPARE COMPARE DESIREMENT COMPARE	1881/14888	ZIP Code		
Name of School		ZIP Code	Grade Level:	gy/Areastusgiji dogradvestudumasonimidilmis	Gender:		
Parent or Guard	lian: Last Name		First Nam	e	Male D Female		
Student's Race/ White Native Ameri	☐ Black/African Ame	Pacific Islander 🔲 🛭	Hispanic/Latino Multi-racial	☐ Asian			
	ristation materials and the state of the sta						
o be completed	by dentist:						
Oate of Most Red ☐ Sea	ent Examination:_ lant		call services provided tration of teeth due to		nation date)		
Oral Health Stat	us (check all that apply)						
☐ Yes ☐ No	Dental Sealants Present	on Permanent Molars					
☐Yes ☐No	Carles Experience / Rest	oration History — A fillir OR missing permanent 1st	g (temporary/permanen molars,	t) OR a tooth the	at is missing because it was		
☐ Yes ☐ No	Untreated Caries — At lea walls of the lesion. These crit root, assume that the whole to considered sound unless a care.	eria apply to pit and fissure on the control of the	cavitated lesions as well s. Broken or chipped tee	as those on sm	ooth tooth surfaces. If retained		
Yes No	Urgent Treatment — absc swelling.	ess, nerve exposure, advan	ced disease state, signs	or symptoms th	nat include pain, infection, or		
reatment Needs	s (check all that apply). Fo	r Head Start Agencies, pl	ease also list appointm	ent date or dat	e of most recent treatment		
	Care — amalgams, composit		Appointment Date:	and the second section of the section o	**************************************		
I-may-	Care — sealants, fluoride treal entist Referral Recommen		Appointment Date: Treatment Completion Date:				
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Additional comr	ments:	disease and statement are repaired and description of the statement of the	ने वर्षा स्थापना स्थापन	SATURNING CONTRACTOR OF THE SATURATION OF THE SA	HIRAMITE BAUGUSI II IRAMA PYŠKI ATVERNACIJA II KARALINI II KARALINI II KARALINI II KARALINI II KARALINI II KARA		



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		La / HELLICALITAD DE STERVES STOCKHES TRES EXTREM .	ALLEGA AND THE		NOTE OF THE				
Rirth Date	(Last	•	Grade	(First)	(Middle Initial)				
Birth Date (Month/Day/Yo	ear)	Gender	Orauc	No.					
Parent or Guardian		Nadalana (j. 1882 – 1888) ar sait ar shindra dha na ann ann ann ann ann ann ann ann an		en e	NOTICE AND ALEXANDER OF THE PROPERTY OF THE PR				
		(Last)		(First)					
Phone (Area Code)	The minimum of the signification of the significant	samangiit.							
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(Numb		(Street)		(City)	(ZIP Code)				
County		Missiphotolisciscisciscisciscisciscisciscisciscisci	ENALUMA.						
	18	To Be Comple	ted By Examini	ig Doctor					
Case History Date of exam									
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Other information									
Other information	and the second s	A STATE OF THE STA		under the state of	The state of the s				
Examination									
Jan Beller and State Control of the State Control o	Distance		Vear						
	Right Le		Both						
Uncorrected visual acuity	20/ 20/		0/						
Best corrected visual acuity 20/ 20/ 20/ 20/									
Was refraction performed wit	h dilation?	□Yes □No							
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Binocular function (stereopsis	e)				MS-000007092-MILA ADALON-MANUAL MANUAL AND ASSAULT STATE OF THE CONTRACT OF TH				
Accommodation and vergence	•				**************************************				
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Glaucoma evaluation		ō		Account a lateral transport of the second second by 77th					
Oculomotor assessment	ā	ā		The commence of the control of the c					
Other	ā	Ō		BLOUR TEST SOUR DESCRIPTION AND AND AND AND AND AND AND AND AND AN					
NOTE: "Not Able to Assess" ref			mplete the test, not		o provide the test.				
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Diagnosis ☐ Normal ☐ Myopia ☐	Hyperopia	☐ Astigmatism	☐ Strabismus	☐ Amblyopia					
Other	## # ^{****}	<u> </u>		y - p					
Manuscript and The Control of the Co	A CONTRACTOR OF THE PROPERTY O		Charles and the control of the contr	WATER TO THE PARTY OF THE PARTY	The state of the s				



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 _____)