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.)	❑	❑	❑	________
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	________
Pupillary reflex (pupils)	❑	❑	❑	________
Binocular function (stereopsis)	❑	❑	❑	________
Accommodation and vergence	❑	❑	❑	________
Color vision	❑	❑	❑	________
Glaucoma evaluation	❑	❑	❑	________
Oculomotor assessment	❑	❑	❑	________
Other ____________	❑	❑	❑	________

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 ____

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State of Illinois
Illinois Department of Public Health

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: ☐ Male ☐ Female
Parent or Guardian: Last Name		First Name	

Student's Race/Ethnicity:
☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other______________________

To be completed by dentist:

Date of Most Recent Examination:__________________ (Check all services provided at this examination date)
☐ Dental Cleaning ☐ 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.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:__________________
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:__________________
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:______________

Additional comments: ____

Signature of Dentist ______________________ License #:______________ Date:______________

State of Illinois
Certificate of Child Health Examination

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

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)	☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT		
Polio (Check specific type)	☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										Comments:								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
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.

Signature **Title** **Date**

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) ☐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.

Proof of Custody and Residency Form

Illinois law provides that the residence of a student is deemed to be the same as the residence of the person who has legal custody of the student and permits only student who are residents of the School District to enroll and attend on a tuition-free basis. The person claiming custody must also resident in the District. To assist the District in determining residency and legal custody, this form must be completed. The District may investigate the residency of any student before or after enrollment and require the involved persons to provide additional information to be considered by the District in determining residency. Enrollment is not completed, and attendance will usually not be permitted, until all residency issues are resolved.

I. Student Identification (Please Print):

Name: ______________________________

Birth Date ______________________________

Student School ID # ______________________________

Person Claiming Custody/Enrolling Student:

Name ______________________________

Address ______________________________

Address ______________________________

Phone ______________________________

Relationship to Student ______________________________

Residency of Person with Whom Student Lives and Who Claims Custody of the Student:
As initial proof of residency, **the person with whom the student lives in the District and who claims custody of the student** must attach one item from Category A and one item from Category B, all of which must be acceptable to the District. If the person enrolling the student claims the student is (1) homeless, or (2) attending school upon a determination of the Department of Children and Family Services, only the appropriate line in Category C must be checked.

***It is not required to show personal information (account #'s, payment amounts $, etc.) on these forms. Please feel free to block out any of the personal information that does not relate to proof of your residency. All documents must be current and include the address of the student's residence.**

***Category A. Check and attach a copy of at least one of the following documents:**
_____1. The most recent real estate tax bill for my residence showing me as the tax payer
_____2. Mortgage Papers/Statement
_____3. Signed lease for my residence
_____4. A closing statement for the purchase of my residence
_____5. Notarized Affidavit of Resident Regarding Residency of Others Form (must provide 2 proofs from Cat. B)
_____6. Notarized statement claiming month to month lease (must provide 2 proofs from Cat. B)

***Category B. Check and attach a copy of at least one of the following documents:**
_____1. Current Gas, Electric, or Water Bill (dated within one month of the student registration date)
_____2. Valid government issued picture ID with current address in which the student resides.
_____3. Public Aid Card/Food Stamp Card/Medical Card
_____4. Current homeowner's/renter's insurance certificate
_____5. Current Telephone or Cable Bill
_____6. Vehicle Registration

***Category C. None of the documents in categories A or B above are applicable because:**
_____1. The student is homeless and eligible for enrollment under the Illinois Education for Homeless Children Act.
_____2. The student is enrolling based on the determination of the Department of Children and Family Services, attach evidence from DCFS.
_____3. Proof of Residency will be established within 3- calendar days; however, a real estate contract, closing statement of lease MUST be presented as initial proof of residence. If the student does not become a resident of the district within 30 days, the parents/legal guardians may be charged tuition and the student may be removed from school.

My signature below indicates that I have read and reviewed the District's Residency policy and understand that only residents of the District, i.e. those who physically occupy and live within the residence in the District's boundaries, are eligible to attend District schools on a tuition free basis. I understand that it is my responsibility to verify whether my residence is within the District's boundaries. I further understand that it is my obligation to notify the District of any change in residence. I acknowledge that any person who enrolls or attempts to enroll in the schools of a school district, on a tuition free basis, a pupil known to hat person to be a nonresident of the district, or any person who presents to any school district any false information regarding the residency of a pupil for the purpose of enabling that pupil to attend any school in that district without the payment of a nonresident tuition charge, shall be guilty of a Class C misdemeanor. I understand that, if the District determines I have provided false information about a student's residency within the District, I may be referred for criminal prosecution.

I affirm that I am a resident of this District and that the information presented in this affidavit and in connection with any investigation of my residency or the residency of the student is true, complete, and accurate.

______________________________ ______________________________
Signature of the person claiming custody/enrolling student **Date**

Student Housing Questionnaire
Pope County CUSD
Confidential Form

The McKinney-Vento Act provides rights and services to children and youth experiencing homelessness, which includes those who are: sharing the housing of others due to loss of housing, economic hardship, or a similar reason; staying in motels, trailer parks, or camp grounds due to the lack of an adequate alternative housing option. (See reverse side for more information)

If you own/rent your home, please place an x on one of the following

_____Student lives with a parent and they are the legal guardian.
_____Student lives with grandparents/aunt etc. and they are not the legal guardians

If you do not own/rent your home, please check all that apply.

____Living in someone else's house or apartment with another family.
____ Living in a motel
____ Living in a shelter
____ Living in a car, park or campsite
____ In a residence with no water, heat, or electricity.
____In a residence with an infestation issue
____In a residence that is not safe, warm or dry.

Name of student: ________________________________Grade: ________

Current address: ____

____

Contact number: ____

Signature: ____________________________________ Date: ____________

List any siblings:

________________________ ________________________ ___________________

HEALTH AND MEDICAL HISTORY
Pope County Elementary/Jr. High School

GENERAL INFORMATION		
Child's Name	Male • Female •	Grade entered this school year
Birthdate	Address	Home Telephone
Siblings at current school? Please list.	Family Physician	School Last Attended (City & State)

Father's/Guardian's Name	Phone Number	Mother's/Guardian's name	Phone Number

Emergency Contact (other than parent)	Emergency Contact Phone Number	Relationship to child

Does child have any allergies? YES NO If yes, please list below.	
Medication Allergies	
Food Allergies	
Environmental Allergies	

(Note: Any modifications to the child's diet that are to be provided by the school must be detailed on the Food Modification Form and signed by a physician. Obtain this form from the School Nurse or Secretary)

Is child taking any medication at home? (Prescription or OTC on a routine basis and/or medication taken as needed)
YES NO If yes, please list below. If more space is needed please use back side of this paper.

Medication	Dosage	How often	Med to be taken @ school?

(Note: For meds to be given at school, the Medication Authorization Form must be completed and signed by a physician and by a parent prior to that med being given at school. Obtain this form from the School Nurse or Secretary)

DISEASE HISTORY(Indicate if your child has had any of the following:

Disease	Yes	Year		Disease	Yes	Year
Chicken Pox				Diabetes		
Asthma				Heart		

Pope County Elementary/Jr. High

Registration Form

Teacher: ______ **Grade:** ______ **Bus:** ______

Student Name: ____
First Middle Last

Mailing Address: ____

Residence Address: ____

Living Situation: (Please Check One) ___ Rent ___ Own ___ Foster Care

___ Live w/ Someone Else ___ Live w/others due to Economy

Sex: Female Male **Ethnicity:** White Hispanic Black Asian Multi-Racial Indian/Alaskan

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**

Birthdate: ____________________ Age: _______ Social Security: ____________________

Attended Pope County Elementary/Jr High before: Yes____ No___

If no, previous school attended: ______________________________

Student Resides with: ______________________________ Relationship: ______________

Guardian Email: ____

(Used for TeacherEase Communication)

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