WESTERN SPRINGS SCHOOL DISTRICT 101
A Place Where Children Thrive

4225 Wolf Road, Western Springs, IL 60558 Ph.708.246.3700 Fax.708.246.4280

Welcome to D101!

Below is a checklist of paperwork and forms necessary for enrollment.

- Completed Kindergarten Class Information Form
- Completed Incoming Kindergarten Screening Parent Survey
- Completed Bus Sign Up if eligible
- Completed Census / Registration Form
- Completed Textbook Loan Form
- Completed Health / Emergency Information Form
- Completed Student/Parent Contact Information
- Completed Home Language Survey
- Signed Children's Online Privacy Policy (COPPA)

Provide the following documents for kindergarten students **who start at the beginning of a school year**:

- Copy of student's birth certificate
- Certificate of Child Health Examination
- Proof of School Dental Examination Form
- Childhood Lead Risk Questionnaire
- State of Illinois Eye Examination Report

Provide the following documents for kindergarten students **transferring mid year**:

- Copy of student's birth certificate
- Copy of the most recent physical with immunizations
- Obtain an *ISBE Student Transfer Form* from the school last attended. Required when transferring from an Illinois public school to another Illinois public school.
- Signed Request for Access/Release of Student Records (Form enclosed) Please send to your current school so that we may receive student's records at the earliest convenience.

Provide three proofs of residency from the following:

- Category I (one document)
  - Real estate tax bill (preferred)
  - Signed lease
  - Mortgage papers
  - An Agreement of Sale
- Category II (two documents)
  - Driver's license (preferred)
  - Current gas or electric bill (preferred)
  - Voter Registration
  - Auto Registration
  - Public aid card
  - Home/apartment insurance papers

Permission for Medication Order Form, if applicable, can be found on school website: d101.org

Any questions or concerns can be directed to your respective school's administrative assistant.

Field Park School
Attn: Denise Stetler
4335 Howard Avenue
Phone: 708-246-7675
dstetler@d101.org

Forest Hills School
Attn: Erin McLaughlin
5020 Central Avenue
Phone: 708-246-7678
emclaughlin@d101.org

Laidlaw School
Attn: Elizabeth Walker
4072 Forest Avenue
Phone: 708-246-7673
ewalker@d101.org

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STUDENT/PARENT CONTACT INFORMATION

Student Name: Last, First, Middle	**Grade:**
Preferred First Name:	**Birthdate:**
Address:	**Home Phone:**
Parent 1:	**Parent 2:**
Cell Phone Number:	**Cell Phone Number:**
Work Phone Number:	**Work Phone Number:**
Employer:	**Employer:**
Email Address:	**Email Address:**

STEP-PARENT INFORMATION (If Applicable)

Name (Parent #3/Parent #4) _____/_____

Work Phone Number _____/_____

Cell Phone Number _____/_____

Email Address _____/_____

SECONDARY ADDRESS: (Parents living at separate addresses.)

Please complete if you wish to have a duplicate mailing of report cards, testing information, etc. mailed to a secondary address:

Name: _____

Addresses: _____

Student Directory Permission:

Directory information published includes: Student Name, Parent(s) Name, Address, Home/Cell Phones, and Parent Email: **CIRCLE ONE: Yes No**

Photo / Video Permission:

Permission given for a student's picture to appear for possible publication: (i.e. district newsletter, local newspaper, district website, classroom videos, social media, etc.) **CIRCLE ONE: Yes No**

Early Dismissal Due to Illness:

In the event my child needs to go home due to illness, I give permission for my Emergency Contact Person to take him/her home if either parent cannot be reached. **CIRCLE ONE: Yes No**

PARENT SIGNATURE: _____

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REGISTRATION / CENSUS CARD

Date of Entrance: _____
(First Day of School)

In the space below, please print the student's name EXACTLY as it appears on the birth certificate:

_____
Last Name **First Name** **Middle Name** **Nickname**

_____ _____
Street Address **Home Phone**

☐**Male** ☐**Female** _____ _____ _____

☐**Other**_____ **Age** **Date of Birth** **Place of Birth** (City, State, Country)

Grade: ____ **School:** ☐Field Park ☐Forest Hills ☐Laidlaw ☐McClure

Name and Address of School Last Attended: _____

If your child was born outside of the U.S., on what date did he/she enter U.S. Schools? ____/____/____

Ethnicity: Is the student Hispanic or Latino? ☐No ☐Yes Primary language spoken at home: _____

Race: Check all that apply. ☐American Indian or Alaska Native ☐Asian ☐Black or African American
☐Native Hawaiian / Other Pacific Islander ☐White

Parent 1 Last Name _____
First Name _____
Cell Phone _____
Business / Day Phone _____
Email Address _____

Parent 2 Last Name _____
First Name _____
Cell Phone _____
Business / Day Phone _____
Email Address _____

Student resides with: ☐Parents ☐**Parent #1** ☐**Parent #2** ☐Other (specify): _____
☐ **Parent #1/Step-parent** ☐ **Parent #2/Step-parent**

State of Illinois Required Information:
Is either parent an active member of the United States Armed Forces? Parent 1: ☐No ☐Yes Parent 2: ☐No ☐Yes

Do you/your child(ren) reside at this Western Springs address? ☐No ☐Yes _____

If "No" please explain_____

Will you be living at this Western Springs address on the first day of school? ☐No ☐Yes _____

If "No" please explain_____

Children in Household:

Name	Gender (M/F/Other)	Birth Date (month/day/year)

Signature Parent/Guardian: _____ 1/2024

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STUDENT REQUEST FOR LOAN OF TEXTBOOK

Student's Full Name: _____

I hereby request the loan of secular textbooks in accordance with Public Act 79-961 of 1975 in Western Springs Public School District 101, Western Springs, Cook County, Illinois.

I understand that this request will remain valid so long as my child is enrolled in Western Springs Public School District 101 and that I may withdraw this request at any time.

_____
Signature of Parent/Legal Guardian

_____
Date

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Home Language Survey

The Illinois State Board of Education requires the school district to collect a Home Language Survey for every new student. This information is used to count students whose families speak a language other than English at home. It also helps to identify the need for TPI (Transitional Program of Instruction) services for English Language Learners in the schools.

Please answer the questions below.

Student First Name:	Student Last Name:

School:	Grade:	Today's Date:
Male _____ Female _____ Other____	Date of Birth: (mm/dd/yyyy):	
Place of Birth City:	Place of Birth State:	Place of Birth Country:

1. Does your child speak English? Yes _____ No _____

2. Does your child speak a language other than English? Yes _____ No _____

   If yes, what other language?_____

3. What is the dominant language spoken in your home?_____

If the answer to question 1 is no or 2 is yes, the school will assess your child's English language proficiency. The school will measure your child's listening and speaking skills and, for students in grades 1 through 8, reading and writing skills.

Signed _____ Date _____
(Parent/Guardian)

Home phone _____

Work phone _____

Cell phone _____

Email _____

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Encuesta Del Idioma Del Hogar

La Junta de Educación del Estado de Illinois requiere que el distrito escolar recopile una encuesta del idioma del hogar para cada nuevo estudiante. Esta información se usa para contar a los estudiantes cuyas familias hablan un idioma que no es inglés en casa. También ayuda a identificar la necesidad de servicios TPI (Programa de Instrucción de Transición) para los Estudiantes del Idioma Inglés en las escuelas.

Por favor responda las preguntas a continuación.

Apellido del estudiante:	**Nombre del estudiante:**

Escuela:	**Grado:**	**Fecha de hoy:**
Hombre _____ Mujer _____ Otro:___	**Fecha de nacimiento: (mm / dd / aaaa):**	
Lugar de nacimiento Ciudad:	**Lugar de nacimiento Estado:**	**Lugar de nacimiento País:**

1. ¿Su niño habla inglés? **Sí _____ No _____**

2. ¿Habla su hijo un idioma diferente al inglés? **Sí _____ No _____**

En caso afirmativo, ¿qué otro idioma? _____

3. ¿Cuál es el idioma dominante que se habla en su hogar? _____

Si la respuesta a las preguntas 1 es no o 2 es sí, la escuela evaluará el dominio del idioma inglés de su hijo. La escuela medirá las habilidades de escucha y habla de su hijo y, para los estudiantes en los grados 1 a 8, las habilidades de lectura y escritura.

Firmado _____ **Fecha** _____
(Tutor)

Teléfono de casa _____

Teléfono del trabajo _____

Teléfono móvil _____

Correo electronico _____

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Kindergarten Class Information Form

The school district kindergarten classes are conducted on half-day schedules. All placements are determined by the building principal. Sessions are as follows:

- Morning Session 8:40 - 11:40 a.m.
- Afternoon Session 12:30 - 3:30 p.m.

Please circle your session **preference**. AM PM

Please note ***compelling rationale or information*** you wish for us to consider in session placement (childcare, additional programming activities, etc.)

_____

_____

Principals determine all placements based on the following priorities:

- Equal distribution of children between classrooms
- Special unique characteristics/needs of the child (physical, learning, etc.)
- Alternate educational programming opportunities

Please complete the following and return. PLEASE PRINT!

Child's Name: _____ Male____ Female____ Other_____

Date of Birth: _____

Parent's Name: _____ Phone #: _____

Email address: _____

School of Residence: ____Field Park ____Forest Hills ____ Laidlaw

Bus Transportation: ____No ____Yes (If yes, please complete the bus form for the school your student is attending.)

Administrative Assistants will confirm transportation needs prior to the start of school.

Field Park School Bus Stops – Kindergarten

STUDENT NAME:_____

ADDRESS:_____

Please check:	Bus Stop	Additional Comments
	45th & Franklin	
	45th & Howard	
	45th & Clausen	
	45th & Harvey	
	4433 Harvey	
	Burlington & Harvey	
	Burlington & Clausen	
	46th & Johnson	
	46th & Howard	
	46th & Clausen	
	46th & Harvey	
	Grand Avenue	
	Montessori School WS Rec Center	

Forest Hills School Bus Stops – Kindergarten

STUDENT NAME:_____

ADDRESS:_____

Please check:	Bus Stop	Additional Comments
	45th & Johnson	
	45th & Franklin	
	46th & Franklin	
	46th & Johnson	
	48th & Johnson	
	47th & Howard	
	Grand Avenue	
	Montessori School WS Rec Center	
	Adventure Children's Academy @ Music Makers	

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Laidlaw School Bus Stops – Kindergarten

STUDENT NAME:_____

ADDRESS:_____

Please check:	Bus Stop	Additional Comments
	Elm & Lawn	
	Elm & Grand	
	Elm & Woodland	
	Elm & Central	
	Grand Avenue	
	Montessori School WS Rec Center	
	Kensington WS Rec Center	
	Adventure Children's Academy at Music Makers	

CHILDREN'S ONLINE PRIVACY POLICY

(COPPA POLICY)

In accordance with the Children's Online Privacy Protection Act ("COPPA") and the Rules related thereto, specifically 16 CFR Section 312 et seq., please be advised that the only person who will be maintaining and collecting student information is Eddie Barrios, Director of Technology for Western Springs School District 101 and Google Apps Educational Edition in the Western Springs School District 101 domain. Such information may be reviewed by any of the students' teachers, their building principals or by the Superintendent of the District.

The only personal information being collected from the students shall be their names and email addresses. Please be advised that there shall be no access to the outside world and students are restricted to communication to the d101.org domain addresses.

Parents shall have the ability to view student shared work and the District shall be monitoring for any globally (world visible) content. If there is work that is found global, the District shall restrict it as soon as it is found. If any parent has concerns, restrictions may also be placed on the student account to prevent global documents from being created. Finally, a parent can review and have deleted the child's personal information and refuse to permit its further collection or use, upon written notice to either the technology director, their child's principal, or superintendent.

All parent inquiries should be directed to Eddie Barrios at (ebarrios@d101.org, 4225 Wolf Road, Western Springs, IL 60558. 708-246-3700).

By using Google Apps Education Edition in the Western Springs School District 101 Domain, Western Springs School District 101 assumes responsibility for complying with COPPA and the information that students submit. When offering online services to children under 13, schools must be cognizant of the Child Online Privacy Act which requires parental consent(s) for the online information about users under 13.

In signing below, you hereby authorize the collection of personal information as set forth above and acknowledge that you have read the above policy in regards to your child(ren).

Student(s) name: _____

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

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Brian T. Barnhart, Ph.D.
Superintendent of Schools

Sarah L. Coffey, Ed.D.
Assistant Superintendent for Instruction

Health / Emergency Information

Student Name:	Student Cell Phone (optional):	Grade:
Home Phone:	Address:	Birthdate:

Parent #1 Name:	**Employer:**
Cell Phone:	**Business Phone:**
Email:	

Parent #2 Name:	**Employer:**
Cell Phone:	**Business Phone:**
Email:	

(Please make sure these people are notified that they will be your emergency contact).
IF PARENTS CANNOT BE REACHED, PLEASE NAME THREE CONTACTS:

Contact 1	**Contact 2**	**Contact 3**
Name:		
Phone Number:		
Relationship:		
Phone Type:		

Does your child have any allergies? _____

Are there any known health conditions other than allergies? _____

Does your child take any medications? If so, what medication and when?

_____

Will your child be required to take any medications while at school? _____
(A medication permission form signed by you and your child's physician is required and can be downloaded from the District website: www.d101.org. Click Parents > Health Services > Medication Authorization and Permission)

I hereby give permission to the officials of School District 101, for my child to be taken to the hospital if an accident or serious illness occurs at school and I cannot be located. I hereby accept financial responsibility for transportation and treatment in the event such action is necessary. I acknowledge that this information will be shared with appropriate school staff when necessary to protect the health and safety of the student or other persons.

_____ _____

Date Signature of Parent or Guardian

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 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 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						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments:

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.

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

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

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

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

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 required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST 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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** / / **Result: Positive** ☐ **Negative** ☐ **mm**_____

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value**

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		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

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: ☐ 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
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, 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 require 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:

Parent or Guardian: Last Name First Name

Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races

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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). Please 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:_____

Dental Office Address: _____ Office phone number: _____

Signature of Dentist _____ 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.)	❑	❑	❑	_____
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 _____

Continued on back

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 _____

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

License Number _____

Address _____

_____

Phone _____

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)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

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6/09

IOCI1271-09

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE EVALUATED FOR LEAD POISONING (410 ILCS 45/6.2)

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area
- all Medicaid-eligible children should have a blood lead test prior to 12 months of age and 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If responses to all the questions are "No":

- re-evaluate at every well child visit or more often if deemed necessary

Child's name _____ Today's date _____

Age_____ Birthdate_____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**RESPONSE**		
1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC?	Yes	No	Don't Know
2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher?	Yes	No	Don't Know
3. Does this child live in or regularly visit a home built before 1978?	Yes	No	Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978?	Yes	No	Don't Know
5. Is this child a refugee or an adoptee from any foreign country?	Yes	No	Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)?	Yes	No	Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)?	Yes	No	Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)?	Yes	No	Don't Know
9. Does this child reside in a high-risk ZIP code area? (see reverse side of page for list)	Yes	No	Don't Know

If there is any **"Yes"** or **"Don't Know"** response; **and**

- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), **and**
- there has been no change in the child's living conditions, a blood lead test is not needed at this time.

Test 1: Blood Lead Result _____mcg/dL Date _____ Test 2: Blood Lead Result _____mcg/dL Date _____

_____ _____

Signature of Doctor/Nurse *Date*

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

IOCI 15-678 IEC

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WESTERN SPRINGS SCHOOL DISTRICT 101
A Place Where Children Thrive

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Brian T. Barnhart, Ph.D.
Superintendent of Schools

Sarah L. Coffey, Ed.D.
Assistant Superintendent for Instruction

District Student Fees Per Year: Prorated Per Date of Entry

Grade Level	Total Fees	Includes
Kindergarten	$100	Registration, Technology, Curriculum Items, Activity Fees
Grades 1-2	$125	Registration, Technology, Curriculum Items, Activity Fees
Grades 3-5	$175	Registration, Technology, Curriculum Items, Activity Fees, Robert Crown Fees (as applicable), Assignment Notebook, Chromebook Ownership/Trade In following end of Fifth Grade