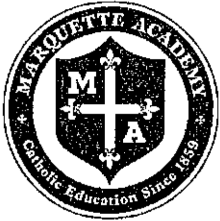


Marquette Academy

Academic Excellence in a Catholic Community

May 20, 2024

Dear Parents,

We are preparing for next school year at Marquette Academy. Enclosed in this packet you will find your registration information and all pertinent documents you will need.

We are offering an early registration discount of $100.00 to families from now until 7:00 pm on Thursday, June 20. We have several opportunities to drop off your completed packets and benefit from the early registration discount. The schedule of dates and times is listed below. **If you complete your packet before this school year is over, you can send it in your student's backpack or return it to the grade school office any time. Please be sure to include the minimum $400 registration fee. You will receive additional financial information via email from Mary Roberson.**

The FACTS website is now open through August 1st to apply for Grant & Aid. Please note if your family situation is divorced or separated, each parent must sign up for FACTS using ½ of the tuition rate.

Any financial appeals will be forwarded to the review committee on July 19. If we receive requests after this date the funds may be already allocated, resulting in no aid.

Thank you very much for your patience and cooperation.

Respectfully yours,

Brooke Rick
Principal

Drop off dates/times for registration:

*ALL COMPLETED PACKET DROP OFFS ARE AT THE **GRADE SCHOOL CAMPUS**

- Starting June 4, every Tuesday & Thursday between the hours of 8:00 am – 4:00 pm at the **Grade School office**
- Thursday, June 20 from 4:00-7:00 pm; drive through at the grade school parking lot (enter off Washington St. headed north) —**last day for the $100 early discount.** In order to receive the **$100 early bird registration discount**, you must have all paperwork and registration fees (minimum $400) turned in by **7:00 pm on Thursday, June 20**.
- Friday, July 19 from 4:00 – 7:00 pm; drive through at the grade school parking lot (enter off Washington St. headed north). **This will be our final registration drop off.**

***Any registration received after July 19 will include a $250 late fee. All accounts must be current to register for the upcoming school year.**

Parents,

All attached financial sheets need to be signed and returned with your packet.

Any changes to your financial sheet (early discount, scholarships, etc.) will be added later and sent to you via email by Mrs. Mary Roberson.

Thank you.

MARQUETTE ACADEMY

Academic Excellence in a Catholic Community

Brooke Rick
Principal

Fr. Austin Bosse
Chaplain

Todd Glade
Dean of Students

Lisa Tenut
Business Manager

RE: 24 25 School Year

Marquette Academy Blue/Gold Hours

Dear MA families,

This letter is the agreement for our Blue/Gold hour's program. Each MA family is required to work a minimum 5 hours of service to the school. These hours will be mandatory for each MA family. Please note—Financial Aid hours are over and above the required 5 Blue/Gold hours. The first 5 hours completed by each family will be logged as your Blue/Gold hours.

Some examples would be (but not limited to) help at May Merriment for set up, clean up or working the event; working the annual pork chop dinner, working the annual fish dinner, helping with cleaning at the school, etc.

We will send out emails from the offices when there is a need for help and then we can log hours as they are worked. You can work 1 hour for an event or do 5 hours for one event, whatever is easiest for you and your family.

Please let us know if you have any questions.

Thank you in advance for your cooperation in this matter.

Sincerely,
Mrs. Brooke Rick

Parent Signature: ________________________________
(By signing above you are confirming that you are aware of the mandatory program)

Please print family name: ___________________________

Preschool & Elementary Campus
1110 LaSalle St., Ottawa, IL 61350
815.433.1199

High School Campus
1000 Paul St., Ottawa, IL 61350
815.433.0125

www.marquetteacademy.net

Traditions are embraced. Dedication is the norm. Excellence is the expectation.

Parents,

<u>This is for your records.</u>

Please use the attached sheet to set up your FACTS payment plan for tuition. If you already have an account, your information will follow from year to year.

Thank you.

MARQUETTE ACADEMY

Academic Excellence in a Catholic Community

Welcome to Marquette Academy. ALL PAYMENTS ARE REQUIRED TO BE ACH PAYMENTS THROUGH FACTS MANAGEMENT ONLY.

We've listed below how to sign up on Facts but if you have any questions please let us know. Both Mary Roberson mroberson@marquetteacademy.net and Lisa Tenut ltenut@marquetteacademy.net can help you. They both work at the High School campus and work with all Marquette families. Once we see that you have signed up on the Facts web site your name will be in a pending file and we will finalize it. You can then start paying on the dates you choose. Your monthly payments will not start until August or later if coming to Marquette at a later date. **But please sign up on this site and choose a payment plan as soon as possible.**

*****Starting 2024-25 School Year--If you are an existing MA family you should just roll over to the new year with the same payment plan. Therefore if you want to change the account they are taking out of, you will need to update your account numbers.**

TO SIGN ON TO THE FACTS MANAGEMENT WEBSITE:

Go to our Marquette Academy website www.marquetteacademy.net at the top of the page is ADMISSIONS click on that and a drop down box will appear. The 7th item under **Admissions** is **FACTS**, click that and the Facts app pops up. On the right side of the page it says **CREATE USERNAME AND PASSWORD** for a **new account**, enter your email address and press enter **Create a new FACTS account** pops up hit that and then you can begin entering your information.

Here is the FACTS phone number for Customer Service in case you need help: 1/866-441-4637 you can talk to any Customer Service person. FACTS Management Website at: https://online.factsmgt.com.

After you have finished setting up your account, we will see your name in **pending we will finalize it** and then we will enter your balance. After that you should see your account by the next day. **Keep track of your Customer number or ID number for future reference.**

Let Mary Roberson – mroberson@marquetteacademy.net or Lisa Tenut – ltenut@marquetteacademy.net know if you have any questions or need help with signing on.

Everyone has to be on Facts Management for our accounting purposes but if you need help with adjusting payment dates or creating a new schedule or maybe just adjusting the date that month we can help you with that. Also, if you want to give us the payment we can enter it for you.

If you don't have access to a computer or having trouble with entering on your phone we can also help you.

Tuition Management

FACTS provides flexible payment plan options to families at private and faith-based schools. Families can budget their tuition, making private school more accessible and affordable. Our process is simple, convenient, and secure.

To set up your FACTS agreement go to https://online.factsmgt.com/signin/3FXBJ

FACTS CONFIRMATION NOTICE

Once your information is received and processed by FACTS, you will receive a confirmation notice. This notice will confirm your payment plan information. Please check this information for accuracy, and contact your school or FACTS with any discrepancies.

Frequently Asked Questions

- **Is my information secure?**
  Yes. Your personal information, including payment information, is protected with the highest security standards in the industry. For more information on security, visit FACTSmgt.com/Security-Compliance.
- **When will my payments be due?**
  Your payment schedule is set by your school, and your financial institution will decide the time of day your payments are processed.
- **What happens when my payment falls on a weekend or a holiday?**
  Your payment will be processed on the next business day.
- **What happens if a payment is returned?**
  Returned payments may be subject to a FACTS returned payment fee. Watch for a returned payment notice for additional information.
- **How do I make changes once my agreement is on the FACTS system?**
  Changes to your address, phone number, email address, or banking information can be made at Online.FACTSmgt.com or by contacting your school or FACTS. Any changes to payment dates or amounts need to be approved by the school and the school will then need to notify FACTS. **All changes must be received by FACTS at least two business days prior to the automatic payment date in order to affect the upcoming payment.**
- **What is the cost to set up a payment plan?**
  If an enrollment fee is due, the amount of the fee is indicated when setting up your agreement. If applicable, the nonrefundable FACTS enrollment fee will be automatically processed within 14 days of the agreement being posted to the FACTS system.

FACTS CUSTOMER SERVICE

We are committed to doing all we can to provide you with the highest quality customer service in the industry. Whether you want to view your account online or speak with one of our highly trained customer service representatives, FACTS is dedicated to serving you. **To view your payment plan details, log in to your FACTS account at Online.FACTSmgt.com. Customer Care Representatives are also available to assist you 24/7.**

Parents,

All attached registration forms need to be completed and returned.

Thank you.

MARQUETTE ACADEMY

Early Education & Elementary Campus
1110 LaSalle St., Ottawa, IL
815/433-1199

High School Campus
1000 Paul St., Ottawa, IL
815/433-0125

***Student Information*:**

1. Child's Name: ______________________
   Last First Middle
   Social Security No: (HSOnly): __________ Birth Date: __________
   Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐) (Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
   Other ________ Male: ☐ / Female: ☐ Grade entering: ________

2. Child's Name: ______________________
   Last First Middle
   Social Security No: (HSOnly): __________ Birth Date: __________
   Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐) (Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
   Other ________ Male: ☐ / Female: ☐ Grade entering: ________

3. Child's Name: ______________________
   Last First Middle
   Social Security No: (HSOnly): __________ Birth Date: __________
   Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐) (Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
   Other ________ Male: ☐ / Female: ☐ Grade entering: ________

4. Child's Name: ______________________
   Last First Middle
   Social Security No: (HSOnly): __________ Birth Date: __________
   Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐) (Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
   Other ________ Male: ☐ / Female: ☐ Grade entering: ________

Parent Information:

Lives with *(Circle One)*: Mother Father Both

***Primary Guardian*:** ______________________

Address: ______________ City/Zip: ______________

Employment: ______________ Occupation: ______________

Home Phone: ______________ Cell Phone: ______________

Work Phone: ______________________

E-Mail: ______________________

***Secondary Guardian*:** ______________________

Address: ______________ City/Zip: ______________

Employment: ______________ Occupation: ______________

Home Phone: ______________ Cell Phone: ______________

Work Phone: ______________________

E-Mail: ______________________

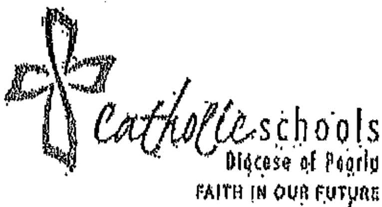
Parish or Church You Attend: ______________________

School District in which you reside:

____

School transferring in from:

____



MEDICAL INFORMATION
ONE PER STUDENT

STUDENT/MINOR NAME (first, middle, last): ____________________

Address: ____________________ Date of Birth: __________

STUDENT/MINOR'S DOCTOR (first, middle, last): ____________________ Phone: __________

MEDICAL CONDITIONS: Please list any medical conditions of the student/minor (asthma, diabetes, epilepsy, etc.):

____

____

List any allergies or allergic reactions to medications of the student minor: ____________________

____

List any medications the student/minor is presently taking: ____________________

____

Other pertinent medical information: ____________________

Date of student/minor's most recent tetanus shot: ____________________

MEDICAL INSURANCE INFORMATION: Insurance Company: ____________________

Plan Number: ____________________ Employee Identification#: ____________________

EMERGENCY CONTACTS: Parent or Guardian (first, middle, last name): ____________________

Cell: __________ Work: __________ Home: __________

Other Contact: Name (first, middle, last): ____________________

Phone (with area code): __________ Relationship to student/minor: __________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school/parish. A copy may be distributed to the person in charge of each trip or athletic activity in which the student/minor participates. Should the need arise this information will be given to the proper medical authorities.

I, ____________________, [parent/guardian], understand that in the case of illness or injury to my child, ____________________ [child's name], the school/parish will try to notify me or the person I have listed as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school/parish to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited tom, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Signature of Parent/Guardian: ____________________ Date: __________

Reviewed 7-1-2021

Marquette Academy
PERMISSION FORM FOR SCHOOL WALKING TRIPS

I am the custodial and responsible parent/guardian of ______________________________
Name of Student(s)

I request that Marquette Academy allow my school aged child(ren) to participate in walks to various locations around the Marquette Academy Preschool/Elementary/High School campuses neighborhoods. The Marquette Academy teachers and students will take walks to learn about what is currently being studied in class, such as the signs of changes in the seasons and traffic signs.

I request that Marquette Academy allow my preschool, elementary and/or high school aged child(ren) to participate in walks between the Marquette Academy campuses for Masses, plays, retreats, etc. I also request that M.A. allow my student to participate in walks to WCMY Radio Station, 216 Lafayette Street and to area parks.

The activity will be supervised by at least one school employee.

If my child is injured in any way during this trip and if I cannot be immediately contacted at the following phone number ______________________, I grant full power to the supervising school employee to do as follows:

1. Arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and

2. Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

I understand the risks such trips present to my child, including, but not limited to, serious personal injury or death. Any questions I have concerning these trips have been answered.

In consideration for my child being allowed to make any walking trip, I hereby RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS the Diocese, the parish, the school and their employees and agents, and the volunteers assisting the school, from any and all liability for injuries, damages, medical expenses, or any other loss to my child or family or me (including attorney's fees) arising from or related to my child's participation in an activity.

______________________________ ______________________________
Signature of Parent/Guardian Signature of Parent/Guardian

______________________________ ______________________________
Printed name of Parent/Guardian Printed name of Parent/Guardian

______________________________ ______________________________
Date Date

Edition 2022

Student(s) Name(s): ______________________________

HANDBOOK AGREEMENT

We have read and understand the contents of the parent/student handbook and agree to abide by the rules and expectations stated therein.

____

Student(s) Signature   Date

____

Parent(s)/Guardian(s) Signature   Date

PARENT PERMISSION FORM FOR INTERNET ACCESS

Marquette Academy believes that the benefit to students from access to the Internet in the form of information resources and opportunities for collaboration far exceed the disadvantages of access. Should a parent prefer that a student not have Internet access, use of the computers is still possible for more traditional purposes such as word processing.

Terms and Conditions of Internet Agreement

I have read the Marquette Academy Internet policy that is found in the handbook and will review this policy with my child(ren).

I understand that the school does not have control of the Internet content, and I realize that students may be accidentally exposed to material that is controversial or offensive while partaking in an educational lesson.

I release Marquette Academy from any liability or damages that may result from my child's inappropriate or unauthorized use of the Internet.

I release Marquette Academy from any liability related to consequences resulting from my child's unauthorized use of the Internet.

Having carefully read the school's Internet policy, I give permission for my child(ren) to have Internet access at the school. I will support the school's Acceptable Use Policy and reinforce it with my child(ren).

____

Parent(s)/Guardian(s) Signature   Date

PUBLICITY FORM

On occasion, Marquette Academy takes photographs or makes an audio or video tape recording of children and/or adults involved in school/parish activities. Such photographs or video records may be used by staff and participants to remember the activities or participants. In addition, such photographs and audio/visual recordings may be used in publications or advertising materials to let others know about our school/parish. In addition, local news organizations may hear of our activities or events, and our school/parish may invite or allow them to photograph or record our events to be used, distributed, or displayed as agents of the school/parish see fit. This consent includes but is not limited to: photographs, videotape, and audio recordings.

____

Parent(s)/Guardian(s) Signature   Date

SERVICE PROJECT (GRADE 8)

I hereby agree that my child ______________________________ may help in the school cafeteria during lunch hour when needed.

____

Parent(s)/Guardian(s) Signature   Date

Parents,

All attached medical exams need to be completed and returned at the start of school.

Thank you.

Dear Parents,

Below are the State medical requirements for the upcoming school year. Please let us know if you have any questions. The appropriate forms for your students are included in the packets and online. All of these forms are **DUE AT THE START OF SCHOOL** with the exception of the dental exam. That can be completed at their first scheduled dental appointment during the school year but has to be turned in by April.

Preschool:
Complete doctor physical with updated immunizations for the first time in preschool.

Kindergarten:
Complete doctor physical with updated immunizations
Complete eye exam
Complete dental examination

Grade 2:
Complete dental examination

Grade 6:
Complete doctor physical with updated immunizations
**IESA sports preparticipation physical evaluation (if playing sports)
Complete dental exam

Grade 5-12:
**Complete IESA/IHSA preparticipation physical evaluation (if playing sports).
Concussion Information Acknowledgement and Consent Form (only parent signature required-if playing sports) IESA form is required for grades 5-8. IHSA form is required for grades 9-12.

Grade 9:
Complete doctor physical with updated immunizations
Complete dental examination
**IHSA sports preparticipation physical evaluation (if playing sports)
Concussion Information Acknowledgement and Consent Form (only parent signature required-if playing sports). IHSA form is required for grades 9-12.

****The IESA/IHSA preparticipation form is new from the State of Illinois. This form needs to be completed and signed by both parents and the physician completing the physical.**

New Student entering from outside Illinois:
Complete doctor physical with updated immunizations
Complete dental examination
Complete eye exam
IESA/IHSA sports preparticipation physical evaluation (if playing sports in grades 5-12)
Concussion Information Acknowledgement and Consent Form (only parent signature required). IESA form is required for grades 5-8 and IHSA form is required for grades 9-12.

State of Illinois

Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Street Address City ZIP Code	Parent/Guardian			Telephone (home/work)

HEALTH HISTORY: MUST 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		Hospitalization? 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 disorder? 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				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				
Eye/Vision problems? ______ ☐ Glasses ☐ Contacts Last exam by eye doctor ______			☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other		
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) ______			Additional Information:		
Ear/Hearing problems?	☐ Yes ☐ No		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No		Parent/Guardian Signatures: ______ Date: ______		

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				Comments: * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal Conjugate						
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 ______________

Student's Name	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#
Last First Middle				

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: ________

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 ________

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 aged 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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

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 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:__________________

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

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State of Illinois
Illinois Department of Public Health

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

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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