



St. Ferdinand School

June 01, 2025

Dear Parent(s) or Guardians,

The Illinois State Board of Education, in accordance with the rules of the Illinois Department of Public Health, requires that the students entering the following grades update their health records.

Kindergarten: Physical Exam / Immunizations

Dental Exam

Vision Exam

2nd Grade: Dental Exam

6th Grade: Physical Exam / Tdap Vaccine, Meningococcal Vaccine

Dental Exam

Please also note that all the children entering the 6th grade should have a dose of the Meningococcal vaccine. Children in the 6th through 8th grade are to have the booster Tdap vaccine. Please check with your child's pediatrician if the vaccine is needed and provide proof that the vaccine was given or that it is not indicated at this time. The note or letter must include: month, day, and year the vaccine was given. We need to have written documentation on file to show compliance for all the students in 6th to 8th grade, regardless of the interval of the last dose.

Please make any appointment during the summer months and bring the required forms to school by the first day of class to ensure compliance. For your convenience, our school fax number is 773-622-2807.

We appreciate your cooperation and prompt attention.

Sincerely,

Mrs. Erin Boyle Folino, Principal



STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

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

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given after the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										Comments								
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23			<input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23		
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature	Title	Date
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)		
Signature	Title	Date
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)		

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying 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 Date

3. Laboratory confirmation (check one) ☐ Measles ☐ Mumps ☐ Rubella ☐ Hepatitis B ☐ Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels																		
Date																		Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/ Contacts
Age/Grade																		
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L		
Vision																		
Hearing																		

Printed by Authority of the State of Illinois

(Complete Both Sides)

Student's Name				Birth Date		Sex	School		Grade Level/ ID #		
Last		First		Middle		Month/Day/ Year					
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER											
ALLERGIES (Food, drug, insect, other)						MEDICATION (List all prescribed or taken on a regular basis.)					
Diagnosis of asthma?		Yes	No	Indicate Severity		Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes	No		
Child wakes during the night coughing		Yes	No			Hospitalizations? When? What for?		Yes	No		
Birth defects?		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 <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____						Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other					
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)						Other concerns?					
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 Signature		Date			

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)											
PHYSICAL EXAMINATION REQUIREMENTS				HEIGHT		WEIGHT		BMI		B/P	
DIABETES SCREENING BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>											
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 Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date Blood Test Result (Blood test required in Chicago and other high risk zip codes.)											
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read / / Result mm											
LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES			Date		Results				Date		Results
Hemoglobin * or Hematocrit *							Sickle Cell * (as indicated)				
Urinalysis							Other				
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs					Normal	Comments/Follow-up/Needs			
Skin						Endocrine					
Ears						Gastrointestinal					
Eyes	Normal	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Objective screening	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Result
	Amblyopia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	Referred to Ophthalmologist/Optometrist	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	
Nose						Musculoskeletal					
Throat						Spinal examination					
Mouth/Dental						Nutritional status					
Cardiovascular/HTN						Mental Health					
Respiratory											
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>		INTERSCHOLASTIC SPORTS (for one year)				Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>	
Physician/Advanced Practice Nurse/Physician Assistant performing examination											
Print Name				Signature				Date			
Address						Phone					

(Complete both sides)



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City	ZIP Code	
Name of School:	ZIP Code	Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Last Name	First Name		
Student's Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)
☐ 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: _____





DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
				/ /
Address:	Street	City	ZIP Code	Telephone:
Name of School:			Grade Level:	Gender:
				<input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Address (of parent/guardian):			

I am unable to obtain the required dental examination because:

- ☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).
- ☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).
- ☐ My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.
- ☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature _____

Date _____



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)
Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)
Parent or Guardian _____
(Last) (First)
Phone _____
(Area Code)
Address _____
(Number) (Street) (City) (ZIP Code)
County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____
Ocular history: ☐ Normal or Positive for _____
Medical history: ☐ Normal or Positive for _____
Drug allergies: ☐ NKDA or Allergic to _____
Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other _____



State of Illinois 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 _____

Signature _____

Date _____

Consent of Parent or Guardian

I agree to release the above information on my child
or ward to appropriate school or health authorities.

(Parent or Guardian's Signature)

(Date)

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