WHITESIDE SCHOOL DISTRICT 115
111 Warrior Way
Belleville, Illinois 62221

Telephone 618 239-0000
Middle School Fax 618 239-9240
Elementary School Fax 618 233-7931
http://www.wssd115.org

Mark Heuring
Superintendent
Monica Laurent
Middle School Principal
Jamie Cotto
Middle School Associate Principal
Nathan Rakers
Elementary Principal
Kim Bossler
Elementary Assistant Principal

SCHOOL FEES

2022-2023 School Year

The School Board may establish fees and charges to fund certain school activities. It is recognized that some students will be unable to pay these fees. Consequently, students shall not be denied educational services or academic credit due to the inability of parents or guardians to pay fees.

Whiteside School District's textbook & materials fees are currently as stated below

2022-2023 Registration Fees	
Registration: Early Childhood, Kindergarten, 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, & 8th	$75.00
**Reduced Lunch Registration (upon approval of Household Eligibility Application)*	*$25.00*
Tech Fee: Early Childhood, Kindergarten, 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, & 8th	$15.00
Late Fee (as of 10-1-22)	$10.00
Classroom Fees	
Band Course Fee (not considered an activity fee)	$25.00
Music/Recorder Fee (All 3rd Grade & New to Whiteside 4th Graders)	$5.00

Registration, Tech, and Band Participation Fees should be paid at Registration in July/August. Fees MUST be paid in full by October 1, 2022. Fees not paid by the deadline will be charged a $10.00 Late Fee. Fees for students enrolling *after* the first day of school are due at the time of registration. ALL FEES ARE SUBJECT TO CHANGE.

Note: All fees must be paid in full prior to Middle School Sports Try-outs.

Students whose parents are unable to afford student fees may receive a waiver of some of the fees based upon approval of a completed Household Eligibility Application. However, these students are not exempt from charges for lost and damaged books, locks, materials, supplies and equipment.

Whiteside School District #115
2022-2023 School Calendar

August	15	Teacher Institute - No Student Attendance
		Elementary Open House - TBD
	16	Teacher Institute - No Student Attendance
		Middle School Open House - TBD
	17	First Day of Class - Full day (Kindergarten - Only Last names A-K attend)
		(8:15 am - 2:45 pm - Middle School / 8:30 am - 3:00 pm Elementary School)
	18	Kindergarten - Only Last names L-Z attend
September	5	Labor Day - No School
	7	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
October	5	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
	7	End of 1st Quarter
	10	Columbus Day - No School
	18	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
		Parent-Teacher Conferences 4:00 pm - 7:30 pm
	20	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
		Parent-Teacher Conferences 4:00 pm - 7:30 pm
	21	Teacher Conference Day - No School
November	2	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
	8	Election Day - No School
	11	Veterans' Day - No School
	23 - 25	Thanksgiving Break - No School
December	7	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
	16	End of 2nd Quarter
	19	First Day of Winter Break - No School
January	2	Teacher Institute - No School
	3	School Resumes
	4	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
	16	Dr. Martin Luther King, Jr. Day - No School
February	1	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
	20	Presidents' Day - No School
	24	End of 3rd Quarter
	28	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
		Parent-Teacher Conferences 4:00 pm - 7:30 pm
March	2	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
		Parent-Teacher Conferences 4:00 pm - 7:30 pm
	3	Teacher Conference Day - No School
	8	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
	24	Teacher Institute Day - No School
April	3 - 7	Spring Break - No School
	12	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
May	3	Early Dismissal (1:45 pm - Middle School / 2:00 pm Elementary School)
	25	End of 4th Quarter
		Last Day of attendance IF no emergency days used
		11:15 Dismissal - Middle School / 11:30 Dismissal Elementary School (no lunch)
June	2	Last Day of attendance IF 5 emergency days used
		11:15 Dismissal - Middle School / 11:30 Dismissal Elementary School (no lunch)

Pre-Kindergarten and Early Childhood afternoon classes will not meet on Early Dismissal days.

3/21/21

WHITESIDE SCHOOL 2022-2023 SUPPLY LIST

KINDERGARTEN

1 book bag - No wheels **(Mark with Name)**
1 bath towel - No plastic mats, no blankets **(Mark with Name)**
1 plastic school supply box (8" x 5") **(Mark with Name)**
1 pair FISKARS brand student scissors **(Mark with Name)**
4 boxes Crayola Crayons (24 count)
24 Elmer's glue sticks
1 Bottle Elmer's Glue
1 spiral bound wide subject notebook
1 large pink eraser
4 dry erase markers - black
24 plain yellow #2 pencils - Sharpened
2 pkgs baby wipes (1 for computers)
2 boxes Kleenex 200 ct. (1 is for Library)
1 roll paper towels
1 package of Napkins
1 box of sandwich size Zip-Loc bags
1 box of gallon size Zip-Loc bags (Girls)
1 box of quart size Zip-Loc bags (Boys)

Optional Kindergarten Items

Paper plates, large or small
Play dough
Watercolor paints
Paper / plastic cups
Bingo daubers - any color
Dot stickers - any color

GRADE 1

Fiskars scissors (metal blade) (Mark with Name)
20 Elmer's glue sticks
2 boxes Crayola Markers: thick tip, classic colors
2 boxes Crayola Crayons (24 count.)
40 plain yellow #2 pencils - sharpened
2 pink erasers
2 boxes Kleenex 200 ct.
3 spiral single subject notebooks (wide rule)
2 2-pocket folders –Five Star Brand (plastic coated cardboard)
1 Spacemaker School box (plastic cigar box size) - mark with name
1 large roll paper towels
1 package of baby wipes
1 box Ziploc storage bags (Quart size) - Girls Only
1 box Ziploc storage bags (Gallon size) - Boys Only
4 Dry Erase Markers
1 bottle Germ-X
2 red plastic 3-prong folders
1 bottle Elmer's liquid school glue
Earbuds (cheap)

GRADE 2

60 plain yellow #2 pencils – **sharpened**
3 boxes Crayola Crayons (24 ct.) leave in original box (1 for Library)
2 10 ct. box Crayola Markers (classic colors, thick tip) leave in original box
1 pair Fiskars pointed school scissors (student size)
3 boxes of Kleenex tissue 200 ct.
1 large roll paper towels or napkins
4 pink eraser
1 12" ruler (inches & centimeters)
10 Large Elmer's glue sticks
4 2-pocket paper folders
1 spiral (wide rule) notebook
1 roll Scotch tape (girls)
1 Zipper Pencil Bag
1 box unscented wipes (boys)
1 contained Clorox Wipes (girls)
2 boxes Ziploc bags (quart size-boys, gallon size-girls)
1 Crayola Watercolor paints (Art)
2 Sharpie highlighters
2 dry erase markers
Earbuds or Headphones

GRADE 3

1 box Crayola crayons (24 ct. only)
1 pair Friskars pointed school scissors (student size)
4 boxes Kleenex 200 ct.
8 Elmer's glue sticks
2 pink erasers
4 dozen #2 pencils – **SHARPENED please!!**
1 Spacemaker pencil box (no larger than 9" x 5")
8 Dry Erase Markers
1 box Crayola markers
1 box Crayola colored pencils
1 12" wooden ruler (inches & centimeters)
2 spiral notebooks (Wide Ruled)
3 double-pocket plastic folders
1 container of Clorox wipes
Pencil and folder for Music
1 box 12 count pencils (Library)
1 large roll of paper towels-Boys to bring
1 box Quart size Ziploc Freezer Bags-Girls to bring
Earbuds (cheap)
Reusable Water Bottle
$5.00 for Recorder **(Purchased at school) NO DOLLAR TREE OR WALMART RECORDERS.**

GRADE 4

3 dry-erase markers (Expo)
48 #2 pencils (Ticonderoga recommended) - please sharpen
1 pink eraser
1 hand held pencil sharpener
1 box Crayola crayons (24 ct.)
1 box Crayola markers - classic colors (water colors - not permanent)
2 boxes Crayola colored pencils (12 ct.)
1 pair Fiskars pointed school scissors
8 Elmer's glue sticks
4 plastic folders with prongs **(one must be red)**
1 non flexible ruler (inches and centimeters)
1 roll scotch tape
1 small **zipper** pencil case
2 highlighters (two different colors)
1 package wide ruled notebook paper - unopened
1 composition notebook
4 1-subject SPIRAL notebooks
1 black sharpie marker
Earbuds (cheap)
1 bottle Elmer's white glue
1 pack index cards
1 box quart sized freezer bags (**girls** to bring)
1 box gallon sized freezer bags (**boys** to bring)
1 package antibacterial wipes
3 boxes Kleenex 200 ct.
2 rolls paper towels
$5.00 for music recorder (purchased at school) **NO DOLLAR TREE OR WALMART RECORDERS**

ART ROOM NEEDS:

Glue Sticks, Paper Towels, Watercolor Paints, Black Sharpies, Kleenex, Crayola Markers (10 ct Classic colors),

Please put names on all supplies including book bag, lunch box, jackets, hats, or anything that could get lost.
ALL GRADE LEVELS MUST HAVE CLEAN TENNIS SHOES WITH SHOESTRINGS FOR P.E.
Additional items may be required by grade level.

WHITESIDE SCHOOL 2022-2023 SUPPLY LIST

****NO Birthday Treats are to be sent to school to be handed out in the classrooms or the lunchroom****

GRADE 5
3 large boxes of Kleenex (2-Homeroom/1-Specials)
3 rolls of paper towels
1 package loose leaf paper (wide rule)
9 spiral notebooks-wide rule (orange, yellow, green, red, blue, Purple, + 3 more any color – DO NOT LABEL
1 package note cards
1 pair of scissors (blunt-tip)
10 2-pocket 3-prong folders (orange, yellow, green, red, blue, purple, + 4 more any color) DO NOT LABEL
2 black sharpies (fine point)
6 dozen #2 pencils
1 pink eraser & 1 pkg. eraser heads
1 package red pens
1 box of crayons
1 box of markers
1 package colored pencils
2 highlighters
4 dry erase markers
2 glue sticks
2 Scotch tape
1 dictionary (Webster's paperback)
1 book bag
1 zippered pencil bag
1 package post-it notes
1 see-through 12" ruler (inches & cm.)
2 Hand held pencil sharpeners w/cover (manual)
3 Tubs Disinfecting wipes
1 bottle of hand sanitizer
2 pr. Earbuds with traditional jack (no Bluetooth) – 1 for classroom & 1 for computers
1 box Gallon Baggies (Boys)
1 Box Sandwich Baggies (Girls)

GRADE 6
5 boxes of Kleenex (3-Homeroom/2-P.E.-Specials)
1 rolls of paper towels (for Art)
Clorox Wipes
Hand sanitizer
1 trapper keeper with dividers
2 single subject spiral notebooks
3 Composition notebooks (Composition, Literature & Math)
4 packages loose leaf paper (1 for Library)
7 2-pocket folders (1 for Library & 1 for Literature))
3 pkg. 3" x 5" index cards (Science, Composition, & SS)
5 dry erase markers (3 Math & 2 SS)
1 pencil bag
20+ Pencils with erasers
1 pkg. ballpoint pens (at least 1 red)
1 pkg. multi-colored highlighters
1 pkg. colored pencils
1 pkg. markers/crayons
4 glue sticks (2 for Math)
1 bottle liquid glue (Literature)
2 pr. Earbuds with traditional jack (no Bluetooth) – 1 for classroom & 1 for computers

GRADE 7
4 boxes of Kleenex
3 rolls of paper towels (Science)
1 tub Clorox/Lysol wipes or hand sanitizer
1 zippered trapper keeper (Highly Recommended)
4 100-page wide ruled composition notebooks (2 Science & 2 Comp)
1 pkg. loose leaf paper (Composition)
1 spiral notebook (Math)
1-300ct. pkg. 3" x 5" index cards (S, C, Library)
6 pocket folders with holes (S, C, SS) (will be collected)
1 pencil bag
20+ Wooden Pencils with erasers (will be collected)
Mechanical Pencils or Pens (if desired, not collected)
1 pkg. colored pencils
Simple 4 function calculator (non-scientific)
8 glue sticks (will be collected)
2 Sharpie markers (Science)
1 pr. Earbuds with traditional jack (no Bluetooth) (for classroom)

GRADE 8
4 boxes of tissues for homeroom
1 tub Clorox wipes
2 rolls of paper towels (Science)
3 packages loose leaf paper- college rule
1 composition notebook
1 binder, 1-1/2" size (Composition)
5 2-pocket folders
1 pencil bag
1 Binder / Trapper Keeper for organization
1 pkg. graph paper (Science, Math)
5 packs 3x5" index cards
1 solar scientific calculator with fraction capability (TI-30XA or equivalent)
2 pkgs. Colored pencils (Science)
2 pkgs. Fine tip markers (Literature)
Black and Blue pens
Mechanical pencils with extra lead
Highlighters
2 dry erase markers (Math)
Erasers
12 glue sticks (Science)
2 pr. Earbuds with traditional jack (no Bluetooth) – 1 for classroom & 1 for computers

Students in 6th, 7th, and 8th Grade MUST purchase a P.E. uniform from Whiteside School. They must also have a pair of white socks and tennis shoes for P.E. class. Students will put their names on their uniform with permanent marker the first week of school. Black sweatpants and a gray sweatshirt may be worn as weather conditions warrant.

Please put names on all supplies including book bag, lunch box, jackets, hats, or anything that could get lost.
ALL GRADE LEVELS MUST HAVE CLEAN TENNIS SHOES WITH SHOESTRINGS FOR P.E.
Additional items may be required by grade level.

Whiteside School District #115
Enrollment Form

Student's Name: _____ ☐ **Male** ☐ **Female**
(Last Name) (First Name) (Middle Name)

Address: _____ Phone: _____
(Street) (City) (Zip Code) (main contact number)

Student's Birthdate: _____ **City / State of Birth:** _____

Name of Mother or Legal Guardian: _____ Maiden Name: _____

Mother's Cell # ( ) _____ **Work #** ( ) _____ **Home #** ( ) _____

E-mail address: _____ **Employer:** _____

Mother's home address (if different than Student): _____

Name of Father or Legal Guardian: _____

Father's Cell # ( ) _____ **Work #** ( ) _____ **Home #** ( ) _____

E-mail address: _____ **Employer:** _____

Father's home address (if different than Student): _____

Student's ethnic or racial background:

☐ American Indian / Alaskan Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ White

Must also check one box below:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Is either Parent / Guardian Military (Active Duty / Reserves)?
Must check one box below:

☐ Yes ☐ No

Military deployed or about to deploy?
Optional:

☐ Yes ☐ No

Status of Parents (please check all that apply):

☐ Married ☐ Separated ☐ Divorced ☐ Single ☐ Mother Deceased ☐ Father Deceased

Does a court order or decree prevent either parent from receiving student records or having limited or no access to the student?

☐ Yes ☐ No *If yes, please provide a copy of the court document to the school.*

Child lives with (please check all that apply):

☐ Parents ☐ Mother ☐ Father ☐ Legal Guardian ☐ Foster ☐ Homeless

☐ Other (Give name: _____) Relationship to Student (_____)

Please complete back side

SCHOOL USE ONLY

Student ID _____ Teacher _____ Grade _____ Bus # _____ Bus Stop _____ Car / Walk _____

Start date: _____ IL Transfer _____ Out of State Transfer _____ Special Ed _____ Birth Cert _____

Waiver: _____ Registration approved by: _____

List the persons (other than Parent / Guardian to contact if you are unable to be reached. These people also have permission to pick up your child. List in preferred order of contact.

Name of person	Relationship to child	Cell #	Home / Work #

List NAMES and BIRTHDATES of student's brothers and sisters

_____ _____ _____

_____ _____ _____

School attended last year (Name of School / address) _____

Does your child receive special education services? Yes No

If yes, please indicate program: Speech L.D. Services Self-contained Other (specify) _____

Was your child in an intervention (RTI) program for reading? Yes No

Was your child in an intervention (RTI) program for math? Yes No

Was your child in a gifted / honors program? Yes No

What language(s) other than English, does your child speak? _____

Has your child ever attended Whiteside School District #115 before? Yes No

Health Information

Please Circle: None Asthma ADD/ADHD Seizures Diabetes Allergies

Other Explain _____

Preferred Hospital _____

The District has permission to allow the media to use my child's picture and/or place my child's picture on the website / social media or newspaper for special recognition purposes.

Yes No

Students will be given textbooks to use at the beginning of the school year. It is the students' responsibility to turn their book into the classroom teacher. If textbooks are not returned, or are returned damaged beyond normal wear and tear, the students account will be charged for the cost of replacement or repair. If not paid for the account will be turned over to a collection agency. Fee waivers do NOT cover lost, damaged or stolen textbooks. Parent Initials _____

My signature indicates that I will read a copy of the school's Student Handbook online at wssd115.org (under Information, click Student Handbook).

I voluntarily furnish the above information and hereby certify that the student listed above and I are legal residents of Whiteside School District #115 residing within the boundary lines of said district as mandated by the State of Illinois. I understand that I may be charged with a Class C misdemeanor and may be required to pay back tuition for providing false information.

_____ _____

Signature of parent / legal guardian Date

WHITESIDE SCHOOL DISTRICT 115

111 Warrior Way
Belleville, Illinois 62221

Telephone 618 239-0000
Middle School Fax 618 239-9240
Elementary School Fax 618 233-7931

http://www.wssd115.org

AUTHORIZATION TO RELEASE RECORDS

RE: _____
Name of Student

_____
Grade this school year

_____
Date of Birth

Sent to or receive records from:

_____
School name

_____
Street Address

_____
City, State, Zip Code

I hereby consent to the release of the following information on the above child to the Whiteside School District #115, Belleville, IL.

1. Permanent Record Information (Identifying information, grades, attendance and health records).
2. Temporary Record Information (Ability and Achievement Test results and other pertinent information).
3. Special Education Records (including MDC and IEP), Individual Psychological Test and special testing information.
4. All School Record Information on file.

K-4 Records
Whiteside Elementary School
2028 Lebanon Ave
Belleville, IL 62221
Fax: 618-233-7931
E-mail: julie.burns@wssd115.org

5-8 Records
Whiteside Middle School
111 Warrior Way
Belleville, IL 62221
Fax: 618-239-9240
E-mail: sarah.castiller@wssd115.org

I understand that the information thus obtained will be treated in a confidential manner.

_____
Signed / Relationship to Student

_____ _____
Address Date

Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.

WHITESIDE SCHOOL DISTRICT #115
22-23 SCHOOL YEAR

STUDENT AUTHORIZATION FOR ELECTRONIC NETWORK ACCESS

STUDENT NAME: _____
Last, First *(Please print)*

Student Section

I understand and will abide by the Whiteside School District 115 *Student Acceptable Use Policy for Electronic Networks*. I understand that the district and/or its agents may access and monitor my use of the Internet, including e-mail and downloaded material, without prior notice to me. I further understand that should I commit any violation, my access privileges may be revoked, and school disciplinary action and/or appropriate legal action may be taken. In consideration for using the district's electronic network connection and having access to public networks, I hereby release the school district and its board members, employees, and agents from any claims and damages arising from my use, or inability to use the Internet.

USER SIGNATURE: _____ **DATE:** _____

Parent/Guardian Section

I have read the Whiteside School District 115 *Student Acceptable Use Policy for Electronic Networks*. I understand that access is designed for educational purposes and that the district has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the district to restrict access to all controversial and inappropriate materials. I will hold harmless the district, its employees, agents, or board members for any harm caused by materials or software obtained via the network. I accept full responsibility for supervision if and when my child's use is not in a school setting. I have discussed this authorization with my child. I hereby request that my child be allowed access to the Whiteside School District 115 Electronic Network.

PARENT/GUARDIAN NAME *(Please print)*: _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

AUTHORIZATION FOR USING A PHOTOGRAPH OR VIDEO OF A STUDENT

Parent/Guardian Section

☐ I grant consent to Whiteside School District 115 to identify a picture of my child or ward, by full name and/or the school he or she attends, in any school-sponsored material, publication, video, or website. This consent is valid for the entire time my child or ward is enrolled in Whiteside School District 115. I may revoke this consent at any time by notifying the Building Principal in writing.

☐ I deny consent to Whiteside School District 115 to include a photo of my child in any school-sponsored material, publication, video, or website, even if my child is not identified by name

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Pictures of students taken by non-school agencies: While the school limits access to school buildings by outside photographers, it has no control over news media or other entities that may publish a picture of a named or unnamed student. School staff members will not, however, identify a student for an outside photographer.

HANDBOOK RECEIPT

_____ (parent/guardian initials) I have received the Student & Parent Handbook/Agenda and understand that my child and I are responsible for following the rules and policies as stated in the handbook. Note: The handbook may be updated throughout the school year. Notice of handbook amendments will be sent to parents through Skyward and will be published in the monthly Smoke Signals Newsletter.

MOVIE PERMISSION FORM

_____ I give permission for my child to watch "G" and "PG" rated movies as might pertain to the curriculum.

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

Grade:_____ **2022-2023** Hour:_____

Whiteside P.E. Uniform

($15.00 per set)

Students Name_____ Date_____

Shirt Size: Small Medium Large Ex-Large
(Circle One)

Short Size: Small Medium Large Ex-Large
(Circle One)

No. of Uniforms_____ Amount_____ Collected by_____

Uniform(s) issued by_____

Date_____

Grade:_____ **2022-2023** Hour:_____

Whiteside P.E. Uniform

($15.00 per set)

Students Name_____ Date_____

Shirt Size: Small Medium Large Ex-Large
(Circle One)

Short Size: Small Medium Large Ex-Large
(Circle One)

No. of Uniforms_____ Amount_____ Collected by_____

Uniform(s) issued by_____

Date_____

Whiteside School District #115
Medical History

Student Name: **Birth Date:**

ALLERGIES: (food, Drug, insect, other) Reaction:	**MEDICATION:** (List all prescribed or over the counter taken on a regular basis) Home: School:
Diagnosis of Asthma? Y N Triggers	Inhaler use? Y N _____Home _____School
Birth Defects Y N	**Loss of function of one of the paired organs** (eye, ear, kidney, testicle) Y N
Developmental Delay Y N	**Hospitalizations** Y N Please explain
Blood Disorders? Hemophilia, Sickle Cell, Other. Y N Explain	
Diabetes Type: _____ Y N _____ Blood sugar testing _____ Insulin injection _____ insulin pump	**Surgeries** Y N Please explain
Head Injuries Y N _____ concussion (age & treatment) _____ _____ skull fracture (age & treatment) _____	**Serious Injury or illness** Y N Please explain
Seizures Y N Please describe	**Eye / Vision Problems** Y N _____ Glasses _____ Contacts _____ Amblyopia (lazy eye) _____ Loss of Vision _____right eye _____ left eye
Heart Problems **Shortness of Breath** Y N **Heart Murmur** Y N **High Blood Pressure** Y N **Dizziness or chest pain with exercise** Y N Restrictions Y N	**Ear / Hearing Problems** Y N _____ Hearing loss _____ right ear _____ left ear _____ Hearing aids _____ right ear _____ left ear
Bone / Joint problems / Injury; scoliosis Y N Explain	**Dental** _____ Braces _____ Bridge _____ Plate _____ other
	Childhood Illnesses: _____ Chickenpox (yr) _____ _____ Pertussis or Whooping Cough (yr) _____
Other Concerns:	

Physician:	**Phone #:**
Dentist:	**Phone #:**
Orthodontist:	**Phone #:**
Preferred Hospital:	**Phone #:**

Information may be shared with appropriate personnel for health and educational purposes. I further give permission for school medical personnel to contact my medical providers during the school year to clarify appropriate care for my child.

Parent / Guardian Signature _____

Date _____ Phone: _____

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SCHOOL PHYSICAL & IMMUNIZATION REQUIREMENTS – 2022-2023

All students must be up to date with physical and immunizations by the start of school.

Students will NOT be able to attend school until ALL required health information is on file.
It is not too early to begin scheduling physical and immunization appointments.

- Physical - The Health History portion is a requirement and must be completed by parent or guardian.
- Immunizations
- Dental
- Vision

Requirements by Grade:

Preschool Students

- Physical Exam on Illinois Form
- Complete Immunization Record
- (4) DTaP, (3) Polio, (4) Hib, (3) Hep B, (1) MMR, (1) C.pox, (4) Pneumococcal

Kindergarten Students

- **New** Physical Exam on Illinois Form (Preschool Exam cannot be used for Kindergarten)
- Complete Immunization Record
- (5) DTaP, (4) Polio, (4) Hib, (3) Hep B, (2) MMR, (2) C.pox, (4) Pneumococcal
- Dental Exam on Illinois Form
- Eye Exam on Illinois Form

Second Grade Students

- Dental Exam on Illinois Form

Sixth Grade Students

- **New** Physical Exam (dated 8/15/21 or later) on Illinois Form.
- Complete Immunization Record
- (1) Tdap, (3) Hep B, (2) MMR, (2) C.pox, **(1) Meningitis-(on or after 11 birthday)**
- Dental Exam on Illinois Form

Ninth Grade Students

- **NEW** Physical Exam on Illinois Form
- Complete Immunization Record Including
- (1) Tdap, (3) Hep B,, (2) C.pox, (1) Meningitis
- Dental Exam on Illinois Form

Religious Exemption

- **A New Religious Exemption Certificate** is required for children entering Kindergarten, sixth, or ninth grade.

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Nurse's office phone- x2313 (E), x3366 (M)

WHITESIDE SCHOOL MEDICATION PERMIT FORM

TO BE COMPLETED BY HEALTHCARE PROVIDER: GRADE:_____

STUDENT'S NAME: _____ DATE OF BIRTH _____

MEDICATION/ HEALTH CARE TREATMENT: _____

ROUTE: _____ DOSAGE: _____ FREQUENCY OR TIME TO BE ADMINISTERED:_____

EXPECTED OR POSSIBLE SIDE EFFECTS: _____

ADDITIONAL INSTRUCTIONS: _____

DISCONTINUE * RE-EVALUATE * FOLLOW- UP:(CIRCLE ONE) DATE: _____

PRESCRIBER'S NAME (PRINT) _____

PRESCRIBER'S SIGNATURE: _____DATE:_____

CONTACT PHONE # _____

PARENT/GUARDIAN AUTHORIZATION:

I hereby authorize Whiteside School District 115 and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer, while under the supervision of the employees and agents of Whiteside School District 115) lawfully prescribed medication in the manner described above. I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse, and specifically consent to such practices. I further acknowledge and agree that when the lawfully prescribed medication is administered or attempted to be administered, I waive any claims I might have against the School District, its employees and agents arising out of the administration of said medication. In addition, I agree to hold harmless and indemnify the School District, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration or attempts at administration of said medication.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

CONTACT PHONE#_____

Whiteside School Medication Policy:
All medicines to be given at school require a medication permit signed by a healthcare provider. The ONLY exception is for the use of an asthma inhaler.
All medicine must be in a pharmacy labeled container or original package, properly labeled.
Controlled medicine can only be brought in or picked up by an adult.
All medication permits must be filled out- one for each medicine and a new permit completed every school year.
ANY changes in the medication administration must be in writing and will require a new permit from the healthcare provider.

Whiteside's mission is to help all learners reach their maximum potential so that they may become tomorrow's leaders.

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				Comments: * indicates invalid dose		
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.

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** **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 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
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 _____)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

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

State of Illinois
Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

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_____				

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 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.

Parent or Guardian Signature _____ 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

IOCI 0600-10 Printed by Authority of the State of Illinois

Miles of Smiles, Ltd.

ATTENTION PARENTS!!!!!!

Miles of Smiles, Ltd. is providing preventive dental services at your school to eligible children in **all grades**.

Services may include exam, cleaning, fluoride varnish, and sealants if needed.

This also satisfies the dental requirement mandated by the State of Illinois for school children (Kindergarten, 2nd, 6th, and 9th).

Please sign up your child today to receive this wonderful service.
There is ***no cost*** to the family or school.

After the services are performed, the following entities will be billed where applicable: IL Medicaid program, public/private grants, or private dental insurance. Miles of Smiles, Ltd. will accept any reimbursement as the final payment (even if the claim is denied). The families and the schools are never billed for any co-payments, deductibles, or balances.
There is never any cost to the school or to the families.

If you see a dentist regularly, please continue for routine exams and x-rays!

All Kids online application & forms:
https://www.illinois.gov/hfs/MedicalPrograms/AllKids/Pages/application.aspx
All Kids Hotline: 1-866-ALL-KIDS (1-866-255-5437)

2424 N. 8TH St., Pekin, IL 61554 * Office: 309-382-6404 * Fax: 309-382-6405

ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

Rev 06/17

PLEASE PRINT IN INK

DENTAL EXAM

MUST BE RETURNED TOMORROW **(ONLY IF YOU *WANT* THESE SERVICES)**

Services Rendered By:
Miles of Smiles, Ltd.
2424 N 8th St
Pekin, IL 61554-1547
309-382-6404

NAME OF SCHOOL:_____

TEACHER:_____ GRADE: _____

COUNTY:_____

DO YOU HAVE A DENTIST? YES / NO **DENTIST'S NAME:** **EXAM DATE:**

PROVIDE THE FOLLOWING INFORMATION ONLY IF YOU WANT THESE DENTAL SERVICES
to be rendered by Miles of Smiles, Ltd at school.

Dear Parent or Guardian,
Miles of Smiles, Ltd. and The Illinois Department of Healthcare and Family Services have arranged for dental services for eligible children. These services may include an exam, cleaning, fluoride treatment and sealants (a protective coating on the chewing surfaces of back teeth). Licensed dentists, hygienists, and assistants will come to your child's school with portable equipment. In order for your child ***to receive these services***, you must **PROVIDE ALL THE INFORMATION** REQUESTED BELOW **AND SIGN** IN THE AREA INDICATED.

YOUR CHILD'S LEGAL NAME:_____ BIRTH DATE: ____/____/____

ADDRESS:_____ GENDER: M / F

CITY/ZIP:_____ HOME PHONE: _____-_____-_____

DOES YOUR CHILD QUALIFY FOR FREE OR REDUCED MEALS: YES / NO
IS YOUR CHILD ENROLLED IN THE 'Medicaid/All Kids' PROGRAM: YES / NO
MCO COMPANY NAME (if not listed): _____

MCO COMPANY NAME (circle one): Aetna, BCBS, Cigna, CommunityCare, CountyCare, Family Health Network, Harmony, Humana, IlliniCare, Meridian, Molina

IF YES, INCLUDE YOUR **CHILD'S RECIPIENT ID NUMBER:** ⟶ _____
Medicaid/All Kids will be billed (9 DIGIT ID NUMBER ON BACK OF MEDI-PLAN CARD)

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO (If incomplete, only grades K, 2nd, & 6th may be eligible for an exam)

If YES, please fill out **ALL** the insurance information below: ***(DENTAL INSURANCE COMPANY WILL BE BILLED)***

Name of Dental Insurance Company:_____

Dental Insurance Company Address:_____

Member's (employee) ID *or* SS #:_____ Dental Insurance plan or **group number:**_____

Member's name:_____ **Member's** Birth Date:_____

Member's Address *(if different than child's)*:_____

Member's Phone Number *(if different than child's)*:_____ Employer:_____

Has your child had any history of, or conditions related to, any of the following: (Please circle)							
Anemia:	YES / NO	Chronic Sinusitis:	YES / NO	Growth problems:	YES / NO	Seizures:	YES / NO
Asthma:	YES / NO	Diabetes:	YES / NO	Hearing:	YES / NO	Thyroid:	YES / NO
Bleeding disorders:	YES / NO	Ear aches:	YES / NO	Heart Disease:	YES / NO	Tobacco / drug use:	YES / NO
Cancer:	YES / NO	Epilepsy:	YES / NO	Latex allergy**:	YES / NO	Allergies:	
Cerebral Palsy:	YES / NO	Fainting:	YES / NO	Pregnancy (teens):	YES / NO	Other:	
Is your child taking any prescription and/or over the counter medications at this time? YES / NO If yes, please list:							
Does you child have any known heart condition? YES / NO DESCRIBE:							
Does your child have any artificial joints: YES / NO IF YES, WHEN & WHAT JOINT:							
Has a doctor ever recommended any special precautions or pre-medication for your child's dental treatment? YES / NO IF YES, WHAT:							

IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED *(ONLY IF YOU WANT THESE SERVICES)*

I am a custodial parent or legal guardian of the minor child named above. I **authorize and consent** to this child receiving the dental **treatment** described, and allow the school nurse/ school representative and dental provider access to child's dental record.

This will also give permission for the Illinois Department of Public Health to provide Quality Assurance Audits by evaluation of your child's sealants that were placed at the school. Upon determination, this permission will also allow for the sealants to be replaced by the provider if indicated.

To the extent permitted by law, I consent to the use and disclosure of the minor child's protected health information to carry out payment activities in connection with this claim. I hereby **authorize and direct payment** of the dental benefits directly to Miles of Smiles, Ltd.

SIGNATURE: **PRINT NAME:** **DATE:**

IF YOU HAVE A DENTIST, SEEK DENTAL CARE THERE! DDS INITIALS_____RDH INITIALS_____

Child's Name:_____ Date of Birth:_____Grade:____

DO NOT WRITE BELOW THIS LINE

ALL KIDS SCHOOL-BASED DENTAL PROGRAM DENTAL RECORD

(BELOW TO BE COMPLETED BY MILES OF SMILES, LTD. DENTIST)

PRIOR TREATMENT

Restorations:	Sealants:	

TREATMENT NEEDED

Restorative:	Sealants: ✓	Sealants: ✓
	S___	S___
	S___	S___
	S___	S___
	S___	S___
	S___	S___
	S___	S___

(Check off sealants placed today; occlusal is assumed)

ORAL HYGIENE STATUS:	_____Good	_____Fair	_____Poor
PERIODONTAL STATUS:	_____Good	_____Fair	_____Poor
MALOCCLUSION:	I	II	III

(Circle one) **ORAL HEALTH ASSESSMENT RATING & SCORE:**

3	URGENT Treatment:	5+ carious lesions, gross caries, root tips, caries likely to involve pulpal tx, abscess, soft tissue pathology, pain from disease or foreign object.
2	RESTORATIVE Care:	4 or less cavitated, occlusal, or incipient caries. Caries not close proximity to pulpal tissue.
1	PREVENTIVE Care: (services rendered today)	There is no visual evidence of caries activity or periodontal pathology.

MILES OF SMILES

✓ TREATMENT COMPLETED TODAY: *(Check off)*

_____ EXAM

_____ PROPHYLAXIS

_____ FLUORIDE TREATMENT VARNISH / GEL

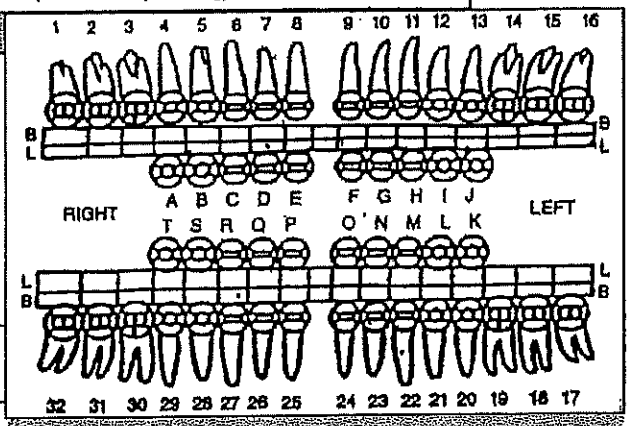
_____ SEALANTS *(tooth #s listed above)*

Total # sealants placed today: _____

Treatment Date: _____

Dentist's Signature: _____

Hygienist's Initials: _____



Charting: BLUE=existing restorations; RED=treatment needed

☐ NO TX ☐ MOS yellow ☐ CCHC green OTHER DR: ☐ Haarman purple ☐ Dietz blue ☐ REFER red

NOTES:

(Revised 06/17)