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

<table>
<thead>
<tr>
<th>2022-2023 Registration Fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration: Early Childhood, Kindergarten, 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, &amp; 8th</td>
</tr>
<tr>
<td>*Reduced Lunch Registration (upon approval of Household Eligibility Application)</td>
</tr>
<tr>
<td>Tech Fee: Early Childhood, Kindergarten, 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, &amp; 8th</td>
</tr>
<tr>
<td>Late Fee (as of 10-1-22)</td>
</tr>
</tbody>
</table>

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’s mission is to help all learners reach their maximum potential so that they may become tomorrow’s leaders.
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.
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 - Sharpended
2 pkg 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)

**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 ruled)
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)
20 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 erasers
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 unascended 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

**Optional Kindergarten Items**
Paper plates, large or small
Play dough
Watercolor paints
Paper / plastic cups
Dingd duffers - any color
Dot stickers - any color

**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 - SHARPENDED 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)
1 #2 pencil sharpener
3 double-pocket plastic folders
2 containers 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 WALT MART RECORDERS.

**GRADE 4**
3 dry erase markers (Expo)
48 #2 pencils (Tiicoderca 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 zippen 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 WALT MART 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 SHOESTRING 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 ruled)
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
9 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/o cover (manual)
3 Tubes Disinfecting wipes
1 bottle of hand sanitizer
2 pr. Earbuds with traditional jack (no Bluetooth) – 1 for classroom & 1 for computers
1 box Galon Baggies (Boys)
1 Box Sandwich Baggies (Girls)

**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)
10 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.

<table>
<thead>
<tr>
<th>Name of person</th>
<th>Relationship to child</th>
<th>Cell #</th>
<th>Home / Work #</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

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 ________________
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
2026 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.castilier@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: ________________
2022-2023
Whiteside P.E. Uniform
($15.00 per set)

Grade:_________  Hour:_________

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________________

2022-2023
Whiteside P.E. Uniform
($15.00 per set)

Grade:_________  Hour:_________

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

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

<table>
<thead>
<tr>
<th>Physician:</th>
<th>Phone #:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentist:</td>
<td>Phone #:</td>
</tr>
<tr>
<td>Orthodontist:</td>
<td>Phone #:</td>
</tr>
<tr>
<td>Preferred Hospital:</td>
<td>Phone #:</td>
</tr>
</tbody>
</table>

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: ________________
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.

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

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

<table>
<thead>
<tr>
<th></th>
<th>First</th>
<th>Middle</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>School/Grade Level/ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student's Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>Zip Code</th>
<th>Parent/Guardian</th>
<th>Telephone #</th>
<th>Home</th>
<th>Work</th>
</tr>
</thead>
</table>

**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.

<table>
<thead>
<tr>
<th>REQUIRED Vaccine / Dose</th>
<th>DOSE 1</th>
<th>DOSE 2</th>
<th>DOSE 3</th>
<th>DOSE 4</th>
<th>DOSE 5</th>
<th>DOSE 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>TdP or Td or Pediatric DT (Check specific type)</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Polio (Check specific type)</td>
<td>□ IPV</td>
<td>□ OPV</td>
<td>□ IPV</td>
<td>□ OPV</td>
<td>□ IPV</td>
<td>□ OPV</td>
</tr>
<tr>
<td>Hib Haemophilus influenza type b</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps, Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Chickenpox)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningooccal conjugate (MCV4)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose**

<table>
<thead>
<tr>
<th>Vaccine / Dose</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
<td></td>
</tr>
<tr>
<td>HPV</td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
</tbody>
</table>

Comments: * indicates invalid dose

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.

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.

11/2015

(COMPLETE BOTH SIDES)
### Health History

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

<table>
<thead>
<tr>
<th>ALLERGIES</th>
<th>MEDICATION</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Food, drug, insect, other)</td>
<td>(Prescribed or taken on a regular basis)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis of asthma?</td>
<td>Loss of function of one pair of organs? (eye/ear/kidney/testicle)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Child wakes during night coughing?</td>
<td></td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth defects?</td>
<td>Hospitalizations?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Developmental delay?</td>
<td>When?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood disorders?</td>
<td>Surgery? (List all)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Sickle Cell, Other?</td>
<td>When?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes?</td>
<td>Serious injury or illness?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Head injury/Concussion/Passed out?</td>
<td>TB skin test positive (past/present)?</td>
<td>Yes*</td>
<td>No</td>
<td>Yes*</td>
<td>No</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>Seizures?</td>
<td>*If yes, refer to ocal health department.</td>
<td>Yes*</td>
<td>No</td>
<td>Yes*</td>
<td>No</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>Heart problem/Shortness of breath?</td>
<td>TB disease (past or present)?</td>
<td>Yes*</td>
<td>No</td>
<td>Yes*</td>
<td>No</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>Heart murmur/High blood pressure?</td>
<td>Tobacco use (type, frequency)?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dizziness or chest pain with exercise?</td>
<td>Alcohol/Drug use?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Eye/Vision problems?</td>
<td>Family history of sudden death before age 50?</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Glasses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last exam by eye doctor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other concerns? (crosed e, drooping lid, scruning, difficulty reading)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Braces</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Bridge</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Plate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farr/Heating problems?</td>
<td>Information may be shared with appropriate personnel for health and educational purposes.</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone/Joint problem/injury/coliosis?</td>
<td>Parent/Guardian Signature Date</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Physical Examination Requirements

Entire section below to be completed by MD/DO/APN/PA

<table>
<thead>
<tr>
<th>HEAD CIRCUMFERENCE if &lt; 3 years old</th>
<th>WEIGHT</th>
<th>BMI</th>
<th>BM% PERCENTILE</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB SKIN OR BLOOD TEST</td>
<td>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 scabies in high-risk categories. See CDC guidelines: <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TBTesting.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TBTesting.htm</a></td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
<tr>
<td>Lead Risk Questionnaire:</td>
<td>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 for children age 6 months through 6 years.)</td>
<td>Yes □ No □</td>
<td>Yes □ No □</td>
</tr>
</tbody>
</table>

### Laboratory Tests

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 | Eadocrine
| Ears | Gastrointestinal
| Eyes | Genito-Urinary
| Nose | Neurological
| Throat | Musculoskeletal
| Mouth/Throat | Spinal Exam
| Cardiovascular/Hypertension | Nutritional status
| Respiratory | Diagnosis of Asthma

### DIABETES SCREENING

Not required for day care.

<table>
<thead>
<tr>
<th>BMD-subject to BMI</th>
<th>Subject to BMI</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethical Minority</td>
<td>Yes □ No □</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Signs of Insulin Resistance</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

### LEAD RISK QUESTIONNAIRE

Yes □ No □ | Blood Test Indicated | Yes □ No □ | Blood Test Date | Result
---|---|---|---|---

### Lab Tests

| Test performed | Date | Results | Date | Results
---|---|---|---|---
| Skine Test | Date Read | | | |
| Blood Test | Date Reported | | | |

### Needs/Modifications

Dietary Needs/Restrictions

### Special Instructions/Devices

<table>
<thead>
<tr>
<th>Special instructions/devices</th>
<th>Yes □ No □</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety glasses, glass eye, chest protector for asthma, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/wrap</td>
<td></td>
</tr>
</tbody>
</table>

### Mental Health/Other

Is there anything else the school should know about this student?

If you would like to discuss student’s health with school or school health personnel, check title:

<table>
<thead>
<tr>
<th>Nurse</th>
<th>Teacher</th>
<th>Counselor</th>
<th>Principal</th>
</tr>
</thead>
</table>

### 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)?

<table>
<thead>
<tr>
<th>Yes □ No □</th>
<th>If yes, please describe</th>
</tr>
</thead>
</table>

### Physical Education

Yes □ No □ Modified □ | Interscholastic Sports | Yes □ No □ Modified □ |

### Print Name

(MD, DO, APN, PA) Signature Date

### Address

Phone

---
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 _______ _______ _______ (Month/Day/Year)
Gender _____ Grade _____
Parent or Guardian ___________________________ (Last) ___________________________ (First)
Phone ___________________________
(Address) ___________________________ (Area Code) ___________________________
(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

<table>
<thead>
<tr>
<th>Distance</th>
<th>Near</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncorrected visual acuity</td>
<td></td>
</tr>
<tr>
<td>Right 20/</td>
<td>20/</td>
</tr>
<tr>
<td>Left 20/</td>
<td>20/</td>
</tr>
<tr>
<td>Both 20/</td>
<td>20/</td>
</tr>
<tr>
<td>Best corrected visual acuity</td>
<td></td>
</tr>
<tr>
<td>Right 20/</td>
<td>20/</td>
</tr>
<tr>
<td>Left 20/</td>
<td>20/</td>
</tr>
<tr>
<td>Both 20/</td>
<td>20/</td>
</tr>
</tbody>
</table>

Was refraction performed with dilation? □ Yes □ No

External exam (lids, lashes, cornea, etc.) □ Normal □ Abnormal □ Not Able to Assess □ Comments
Internal exam (vitreous, lens, fundus, etc.) □ Normal □ Abnormal □ Not Able to Assess □ Comments
Pupillary reflex (pupils) □ Normal □ Abnormal □ Not Able to Assess □ Comments
Binocular function (stereopsis) □ Normal □ Abnormal □ Not Able to Assess □ Comments
Accommodation and vergence □ Normal □ Abnormal □ Not Able to Assess □ Comments
Color vision □ Normal □ Abnormal □ Not Able to Assess □ Comments
Glaucoma evaluation □ Normal □ Abnormal □ Not Able to Assess □ Comments
Oculomotor assessment □ Normal □ Abnormal □ Not Able to Assess □ Comments
Other □ Normal □ Abnormal □ Not Able to Assess □ Comments

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 ________________________________  License Number ________________________________
Optometrist or physician (such as an ophthalmologist) who provided the eye examination □ MD  □ OD  □ DO

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 ___________ )
PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 655) 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):

<table>
<thead>
<tr>
<th>Student's Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Birth Date: (Month/Day/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Street</td>
<td>City</td>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Name of School:</td>
<td>ZIP Code</td>
<td>Grade Level:</td>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>Parent or Guardian:</td>
<td>Last Name</td>
<td>First Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student's Race/Ethnicity:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ White</td>
<td>□ Black/African American</td>
<td>□ Hispanic/Latino</td>
<td>□ Asian</td>
<td></td>
</tr>
<tr>
<td>□ Native American</td>
<td>□ Native Hawaiian/Pacific Islander</td>
<td>□ Multi-racial</td>
<td>□ Unknown</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

☐ Preventive Care — sealants, fluoride treatment, prophylaxis

☐ Pediatric Dentist Referral Recommended

Appointment Date: __________________________

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
DENTAL EXAMINATION WAIVER FORM

Please print:

<table>
<thead>
<tr>
<th>Student's Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Birth Date: (Month/Day/Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td>Street</td>
<td>City</td>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Name of School:</td>
<td>ZIP Code</td>
<td>Grade Level:</td>
<td>Gender: Male</td>
<td>Female</td>
</tr>
<tr>
<td>Parent or Guardian:</td>
<td>Last Name</td>
<td>First Name</td>
<td></td>
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</tr>
</tbody>
</table>

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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
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)
ALL KIDS SCHOOL-BASED DENTAL PROGRAM CONSENT FORM

PLEASE PRINT IN INK

NAME OF SCHOOL: ____________________________
GRADE: ____________________________

TEACHER: ____________________________
COUNTY: ____________________________

DO YOU HAVE A DENTIST? YES / NO
DENTIST'S NAME: ____________________________

EXAM DATE: __________ / __________ / __________

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

DO YOU HAVE A DENTIST? YES / NO
DENTIST'S NAME: ____________________________

EXAM DATE: __________ / __________ / __________

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

Please 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: ___ / ___ / ___

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):

**Medicaid/All Kids will be billed**

(9 DIGIT ID NUMBER ON BACK OF MEDI-CARD)

IS YOUR CHILD COVERED BY PRIVATE DENTAL INSURANCE: YES / NO

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
- Diabetes: YES / NO
- Hearing problems: YES / NO
- Seizures: YES / NO
- Asthma: YES / NO
- Heart Disease: YES / NO
- Thyroid: YES / NO
- Bleming disorders: YES / NO
- Ear Aches: YES / NO
- Hypothyroidism: YES / NO
- Tobacco / drug use: YES / NO
- Cancer: YES / NO
- Epilepsy: YES / NO
- Latex allergy*: YES / NO
- Allergies: YES / NO
- Cerebral Palsy: YES / NO
- Paining: YES / NO
- Pregnancy (within): 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 child have any known heart condition? YES / NO

DESCRIBE: ____________________________

Does 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: __________