



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>

Student Information

Student's Name: _____

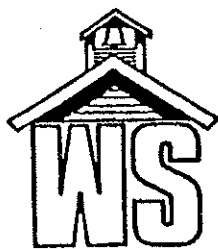
Grade: _____

Please circle the sports you are interested in trying out for this year:

Baseball/ Softball	Soccer	Cross Country
Basketball	Cheerleading	Volleyball
Bowling	Track and Field	Golf

Office Use Only:

Physical On File	
All Sports Forms Signed	
Added to Sports List	



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Agreement to Participate

To be completed by the student-participant and submitted to the Superintendent

Student: _____

Sport or Activity: _____

In consideration of the Whiteside School District 115 permitting me to participate in the above sport or activity, I agree as follows:

1. I will abide by all conduct rules and will behave in a sportsmanlike manner.
2. I will follow the coach/sponsor's instructions, playing techniques, training schedule and safety rules for the above sport or activity.
3. I acknowledge that I am aware that participation in the above sport or activity may involve **many risks of injury**. A serious injury may result in physical impairment or even death. I hereby assume all the risks associated with participation and agree to hold Whiteside School District 115, its employees, agents, coaches, School Board members, and volunteers harmless from any and all liability, actions, causes of action, debts, claims, or demands of any kind and nature whatsoever which may arise by or in connection with my participation in the above activity or sport. The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees, and for all members of my family.

Student Signature: _____

Date: _____

To Be Completed By The Parent/Guardian:

I, _____ am the parent(s)/guardian(s) of the above named student. I have read the above Agreement to Participate and understand its terms. I understand that all sports can involve many **RISKS OF INJURY**. In consideration of the School District permitting my child/ward to participate in the above sport or activity, I agree to hold Whiteside School District 115, its employees, agents, coaches, School Board members and volunteers harmless from any and all liability, actions, causes of action, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with the participation of my child/ward in the above sport or activity. I understand and accept the selection process and the expectations as set forth by the coach of this activity. I will provide transportation to and from practices and scheduled events when needed. I assume all responsibility and certify that my child is in good physical health and is capable of participation in the above mentioned sport/activity.

Signature of Parent(s)/Guardian(s): _____

Date: _____



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Medical Authorization Form

To be submitted to the Superintendent

Student:				Grade:		
Sport/Activity:						
Home Address:						
Home Phone:			Birth Date:			

To whom it may concern: In the event reasonable attempts to contact me at the locations listed below have been unsuccessful, I, as parent or legal guardian of the above student, do hereby authorize (1) the treatment by a qualified and licensed medical doctor of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed; and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence.

Name and relation to student (please print):			
Address:			
Home Phone:		Business Phone:	
Emergency contact:			
Home Phone:		Business Phone:	
Physician's name:		Physician's Phone:	

Please list specific medical allergies, medicines, or other conditions on other side of this form.

Signed :	
Date:	

Whiteside School District #115 maintains Students Accident Insurance coverage on all students while in attendance at school, school-sponsored events and activities, including school athletics. Submission of claims is the responsibility of the parent. This insurance carries a deductible of the greater of \$0 or the amount paid or payable for the same injury by any other plan on which the student is covered.



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Certificate of Physical Fitness for Participation in Athletics –2023-2024

To be submitted to the Superintendent

Student:	Grade:
Sport or Activity:	

I am the parent(s)/guardian(s) of the above student. I certify that my child/ward is in good physical health and is capable of participation in the above mentioned sport or activity. No need exists to limit his/her participation. I assume full responsibility for his/her physical condition and participation. I will notify you of any changes in his/her physical condition. I have completed and submitted the **Authorization for Medical Treatment** form allowing the school to seek medical treatment for my child in the event of a medical emergency when reasonable attempts to contact me are unsuccessful. If my child requires or may need medication while participating in athletics, I have completed and submitted the **School Medication Authorization Form**.

Parent(s)/Guardian(s) Name:			
Home Address:			
Telephone Number:	Business Phone:		
Child/Ward's Date of Birth:			
Physician's Name:	Telephone Number:		

Medical History:

	Yes	No		Yes	No
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other		

- Injuries and/or operations during the past year? (include dates)

- Has your child/ward's physical activity been restricted during the past year? (Reason and Duration)

- Is your child/ward taking any medication? Yes No

If yes, why?	Name of medication:
Signature of Parent(s)/Guardian(s);	
Date:	

Concussion Information Sheet

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents, and students is the key to student-athlete's safety. The district will follow the graduated return to school protocol developed by the Sports Concussion Institute.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours, IHSA Policy requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with the state law, all IHSA member schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:

<http://www.cdc.gov/ConcussionInYouthSports/>

Student-athlete Name Printed

Students-athlete Signature

Date

Parent or Legal Guardian Printed

Parent or Legal Guardian Signature

Date

Adapted from the CDC and the 3rd International Conference on Concussion in Sport Document Created 7/1/2011

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a “ding” or a bump on the head can be serious. You can’t see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

<p>Symptoms may include one or more of the following:</p>	
<ul style="list-style-type: none"> ● Headaches ● “Pressure in head” ● Nausea or vomiting ● Neck pain ● Balance problems or dizziness ● Blurred, double, or fuzzy vision ● Sensitivity to light or noise ● Feeling sluggish or slowed down ● Feeling foggy or groggy ● Drowsiness ● Change in sleep patterns 	<ul style="list-style-type: none"> ● Amnesia ● “Don’t feel right” ● Fatigue or low energy ● Sadness ● Nervousness or anxiety ● Irritability ● More emotional ● Confusion ● Concentration or memory problems (forgetting game plays) ● Repeating the same question/comment

<p>Signs observed by teammates, parents and coaches include:</p>
<ul style="list-style-type: none"> ● Appears dazed ● Vacant facial expression ● Confused about assignment ● Forgets plays ● Is unsure of game, score, or opponent ● Moves clumsily or displays incoordination ● Answers questions slowly ● Slurred speech ● Shows behavior or personality changes ● Can’t recall events prior to hit ● Can’t recall events after hit ● Seizures or convulsions ● Any change in typical behavior or personality ● Loses consciousness



Pre-participation Examination



To be completed by athlete or parent prior to examination.

Name _____ School Year _____
Last First Middle

Address _____ City/State _____

Phone No. _____ Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____ Phone No. _____

Address _____ City/State _____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.
 Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other:		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other:		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	Yes	No
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an Inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	Yes	No
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____



Pre-participation Examination



PHYSICAL EXAMINATION FORM

Name _____
Last First Middle

EXAMINATION		Last		First		Middle	
Height	Weight	<input type="checkbox"/> Male	<input type="checkbox"/> Female				
BP	Pulse	Vision R 20/	L 20/	Corrected	<input type="checkbox"/> Y	<input type="checkbox"/> N	
MEDICAL:		NORMAL:		ABNORMAL FINDINGS:			
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)							
Eyes/ears/nose/throat • Pupils equal • Hearing							
Lymph nodes							
Heart • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)							
Pulses • Simultaneous femoral and radial pulses							
Lungs							
Abdomen							
Genitourinary (males only) ^b							
Skin • HSV, lesions suggestive of MRSA, tinea corporis							
Neurologic ^c							
MUSCULOSKELETAL:							
Neck							
Back							
Shoulder/arm							
Elbow/forearm							
Wrist/hand/fingers							
Hip/thigh							
Knee							
Leg/Ankle							
Foot/toes							
Functional • Duck-walk, single leg hop							

Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
 Consider GU exam if in private setting. Having third party present is recommended.
 Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes _____ No _____ Limited _____ Examination Date _____

Additional Comments:

Physician's Signature _____ Physician's Name _____

Physician's Assistant Signature* _____ PA's Name _____

Advanced Nurse Practitioner's Signature* _____ ANP's Name _____

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

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

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

HEAD CIRCUMFERENCE if <2-3 years old: _____ HEIGHT: _____ WEIGHT: _____ BMI: _____ I/P: _____

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMD > 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				
Urinalysis				
		Sickle Cell (when indicated)		
		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		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication:			Other	
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)				
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				

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
Certificate of Child Health Examination**

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#											
Last	First	Middle		Month/Day/Year														
Address				Parent/Guardian	Telephone # Home	Work												
Street				City	Zip Code													
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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumococcal Conjugate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MMR Measles Mumps, Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Varicella (Chickenpox)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningococcal conjugate (MCV4)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RECOMMENDED, BUT NOT REQUIRED Vaccines / Dose																		
Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HPV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> 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.