Freshman Health Forms

Township High School District 113

Dear Parent or Guardian,

On behalf of Health Services, we would like to extend a warm welcome to you and your incoming freshman student. The following documents are included in this packet:

1. **State of Illinois Child Health Examination Form:**
   - Physical must be dated within one year of school start date. Forms dated before 8/13/2024 will not be accepted.
   - All immunizations must be up to date with the Illinois state requirements.
     - For religious or medical exemption documentation requirements please visit your school's health services website.
   - **This is an Illinois State Requirement.** If we do not receive this form or immunizations are noncompliant your student will be subject to **exclusion from school on October 15th, 2025.**

2. **District 113 Emergency Information form.**
   - Important contact information in the event that a parent or guardian cannot be reached.

3. **District 113 School Medication Authorization Form.**
   - This form must be completed each school year for medication to be dispensed by the school nurse for **all** medications, prescriptions and over-the-counter non-prescriptions.
   - Students are **not** permitted to carry medication during the school day, **except inhalers, auto injectable epinephrine, seizure and diabetes medications.**
   - All medication must be dropped off by a parent/guardian in the original prescription bottle.
   - Make an appointment for any medication drop off before school starts.
   - Parent/Guardian and physician signature are required.
   - See Procedure for Medication administration for more information.

4. **Emergency Action Plans**
   - If your student has a life-threatening allergy or chronic health condition that could potentially require emergency care, please complete and submit the appropriate emergency action plan. Plans can be found on the Health Services Web Pages.
   - **Deerfield High School Health Service**
   - **Highland Park High School Health Service**
   - Parent/Guardian and physician signature required.
   - Form must be renewed each school year.

Freshman Health Forms

Township High School District 113

5. Dental Form

- 9th graders are required to submit a state dental examination form. The form must be dated on or after **November 15th, 2024**.

6. Deadline for health forms: May 1st, 2025.

Submit Health Forms in the following ways:

Deerfield High School:

- Email: dhshealthservices@dist113.org
- Mail: 1959 Waukegan Road, Deerfield, IL 60015 ATTN: School Nurse
- In person: During School hours in Health Services Office B108
- Fax: Deerfield Health Services 224-632-3206

Highland Park High School:

- Email: hphshealthservices@dist113.org
- Mail: 433 Vine Ave. Highland Park, IL 60035 ATTN: School Nurse
- In person: During School Hours at Health Services Office A128
- Fax: HPHS Health Services 224.765.2708

✓ **Please submit health forms by May 1st, 2025.**

Please contact your student's respective Health Services Office with any further questions.

Deerfield High School,
Health Service: Phone 224.632.3200, Fax 224.632.3206
Deerfield High School Health Services Website
School Nurses: Sharon Urban, MSN, RN, PEL-CSN, surban@dist113.org
Alison McTague, MSN, M. Ed., RN, PEL-CSN, amctague@dist113.org

Highland Park High School,
Health Service: Phone 224.765.2200, Fax 224.765.2708
Highland Park High School Health Service Website
School Nurses: Suzy Spychala, M. Ed., BSN, RN, PEL-CSN, sspychala@dist113.org
Alexandra Powell, BSN, RN, PEL-CSN, apowell@dist113.org

Formularios de Salud para el 9º grado

Township High School District 113

Estimados padres o tutores:

En nombre de Servicios de Salud, deseamos hacerle llegar una cálida bienvenida a usted y a su hijo ingresante en 9º grado. En este paquete se incluyen los siguientes documentos:

1. Formulario de Examen de Salud Infantil del Estado de Illinois:

- El examen físico debe estar actualizado dentro del año de la fecha de comienzo de clases: No se aceptarán formularios con fecha anterior al 13/8/2024.
- Las vacunas deben estar actualizadas según los requisitos del estado de Illinois.
  - Para conocer los requisitos de documentación de exención médica o religiosa, visite el sitio web de servicios de salud de su escuela.
- **Este es un requisito del Estado de Illinois.** Si no recibimos este formulario o las vacunas no cumplen con los requisitos, su hijo podrá ser **excluido de la escuela el 15 de octubre de 2025.**

2. Formulario de Información de Emergencia del Distrito 113.

- Información importante de contacto en caso de que no se puedan comunicar con un padre o tutor.

3. Formulario de Autorización de Medicamentos Escolares del Distrito 113.

- Este formulario debe ser completado cada año escolar para la medicación que administrará el enfermero escolar para **todos** los medicamentos, medicamentos con receta y medicamentos de venta libre sin receta.
- Los estudiantes **no** pueden llevar medicación durante la jornada escolar, **salvo inhaladores, epinefrina autoinyectable, medicamentos para las convulsiones y la diabetes.**
- Los medicamentos deben ser entregados por un padre/tutor en el envase original del medicamento.
- Haga una cita para entregar medicación antes del comienzo de clases.
- Se requiere la firma del padre/tutor y médico.
- Para más información, ver el Procedimiento para la administración de medicación.

4. Planes de Acción de Emergencia

- Si su hijo tiene una alergia o enfermedad crónica con riesgo de vida que potencialmente podría requerir atención de emergencia, complete y entregue el

Formularios de Salud para el 9º grado

Township High School District 113

plan de acción de emergencia correspondiente. Los planes se pueden encontrar en las páginas web de Servicios de Salud.

- **Servicio de Salud de Deerfield High School**
- **Servicio de Salud de Highland Park High School**
- Se requiere la firma del padre/tutor y médico.
- El formulario debe renovarse cada año escolar.

5. Formulario Dental

- A los estudiantes de 9º grado se les requiere entregar un formulario de examinación dental estatal. El formulario debe ser fechado el **15 de noviembre de 2024** o después.

6. Plazo para los formularios de salud: 1 de mayo de 2025.

Entregue los formularios de salud de las siguientes formas:

Deerfield High School:

- Correo electrónico: dhshealthservices@dist113.org
- Correo: 1959 Waukegan Road, Deerfield, IL 60015 ATTN: School Nurse
- Personalmente: Durante el horario escolar en la Oficina B108 de Servicios de Salud
- Fax: Deerfield Health Services 224-632-3206

Highland Park High School:

- Correo electrónico: hphshealthservices@dist113.org
- Correo: 433 Vine Ave. Highland Park, IL 60035 ATTN: School Nurse
- Personalmente: Durante el horario escolar en la Oficina A128 de Servicios de Salud
- Fax: HPHS Health Services 224.765.2708

✓ **Entregue los formularios de salud para el 1 de mayo de 2025.**

Comuníquese con la respectiva Oficina de Servicios de Salud de su hijo si tiene preguntas.

Formularios de Salud para el 9º grado

Township High School District 113

Deerfield High School,
Services de Salud: Teléfono 224.632.3200, Fax 224.632.3206
Sitio web de Servicios de Salud de Deerfield High School
Enfermeras Escolares:
Sharon Urban, MSN, RN, PEL-CSN, surban@dist113.org
Alison McTague, MSN, M. Ed., RN, PEL-CSN, amctague@dist113.org

Highland Park High School,
Services de Salud: Teléfono 224.765.2200, Fax 224.765.2708
Sitio web de Servicios de Salud de Highland Park High School
Enfermeras Escolares:
Suzy Spychala, M. Ed., BSN, RN, PEL-CSN, sspychala@dist113.org
Alexandra Powell, BSN, RN, PEL-CSN, apowell@dist113.org

State of Illinois

Certificate of Child Health Examination

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

Street Address, City, ZIP Code	Parent/Guardian	Telephone (home/work)

HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	☐ Yes ☐ No	**List:**	**MEDICATION** (Prescribed or taken on a regular basis)	☐ Yes ☐ No	**List:**

Diagnosis of Asthma?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ Yes ☐ No		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Diabetes?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Seizures? What are they like?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____

Ear/Hearing problems?	☐ Yes ☐ No	
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No	

☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Additional Information:

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ **Date:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric **DT** (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

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 _____

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

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

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease _____ Signature _____ Title _____

3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

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

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

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

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ B/P _____

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm**.

☐ No test needed ☐ Test performed **Skin Test:** Date Read _____ Result: ☐ Positive ☐ Negative mm _____

Blood Test: Date Reported _____ Result: ☐ Positive ☐ Negative Value _____

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		**Endocrine**	☐	
Ears	☐	Screening Result:	**Gastrointestinal**	☐	
Eyes	☐	Screening Result:	**Genito-Urinary**	☐	LMP:
Nose	☐		**Neurological**	☐	
Throat	☐		**Musculoskeletal**	☐	
Mouth/Dental	☐		**Spinal Exam**	☐	
Cardiovascular/HTN	☐		**Nutritional Status**	☐	
Respiratory	☐	☐ Diagnosis of Asthma	**Mental Health**	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			**Other**	☐	

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone

State of Illinois

Certificate of Child Health Examination

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

Street Address | City | ZIP Code | Parent/Guardian | Telephone (home/work)

HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.

ALERGIAS (Alimentos, drogas, insectos, otro)	☐ Sí ☐ No	**Anote todas las alergias:**	**MEDICAMENTOS** (Recetados o tomados con regularidad)	☐ Sí ☐ No	**Anote todos los medicamentos:**

¿Tiene diagnóstico de asthma?	☐ Sí ☐ No		¿Tiene pérdida de funciones en uno de los órganos?(Ojos/Oídos/Riñones/Testículos)	☐ Sí ☐ No	
¿Despierta el niño tosiendo en la noche?	☐ Sí ☐ No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Tiene defectos de nacimiento?	☐ Sí ☐ No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Tiene retrasos del desarrollo?	☐ Sí ☐ No		¿Ha tenido heridas graves o enfermedades?	☐ Sí ☐ No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique.	☐ Sí ☐ No		¿Prueba positiva de TB (Pasado o Presente)?	☐ Si* ☐ No	*Si contestó sí, refiera al departamento de salud local
¿Tiene diabetes?	☐ Sí ☐ No		¿Enfermedad de TB (Pasado o Presente)?	☐ Si* ☐ No	
¿Tiene heridas en la cabeza/golpe/desmayo?	☐ Sí ☐ No		¿Usa tabaco (tipo, frecuencia)?	☐ Sí ☐ No	
¿Tiene convulsiones? Cómo se manifiestan?	☐ Sí ☐ No		¿Toma alcohol/drogas?	☐ Sí ☐ No	
¿Tiene problemas cardiacos/Dificultad para respirar?	☐ Sí ☐ No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	☐ Sí ☐ No	
¿Tiene soplo en el corazón/presión arterial alta?	☐ Sí ☐ No				
¿Tiene mareos o dolor de pecho al hacer ejercicios?	☐ Sí ☐ No				

¿Problemas con los ojos/visión? _____ ☐ Lentes ☐ Lentes de Contacto Último examen _____

¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee) _____

¿Tiene problemas de los oídos/no oye bien?	☐ Sí ☐ No	
¿Tiene problemas de los huesos/articulaciones/heridas/ escoliosis?	☐ Sí ☐ No	

☐ Dental ☐ Frenos ☐ Puente ☐ Placas ☐ Otro

Información Adicional:

La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.

Firma del Padre/ Tutor: _____ **Fecha:** _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric **DT** (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				**Comments:** * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature _____ Title _____ Date _____

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

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

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Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** _____ **Result** _____

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☐ No test needed ☐ Test performed **Skin Test:** Date Read _____ Result: ☐ Positive ☐ Negative mm _____

Blood Test: Date Reported _____ Result: ☐ Positive ☐ Negative Value _____

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		**Endocrine**	☐	
Ears	☐	Screening Result:	**Gastrointestinal**	☐	
Eyes	☐	Screening Result:	**Genito-Urinary**	☐	LMP:
Nose	☐		**Neurological**	☐	
Throat	☐		**Musculoskeletal**	☐	
Mouth/Dental	☐		**Spinal Exam**	☐	
Cardiovascular/HTN	☐		**Nutritional Status**	☐	
Respiratory	☐	☐ Diagnosis of Asthma	**Mental Health**	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			**Other**	☐	

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone

Township High School District 113
Emergency Information

Please Check School of Attendance: ☐ **Deerfield High School** ☐ **Highland Park High School**

1. Name of Student: _____ CLASS: ◯FR. ◯SO. ◯JR. ◯SR.
2. Address: _____ City: _____
3. Name of Parent/Guardian: _____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____
4. Name of Parent/Guardian: _____

   Home Phone: _____ Work Phone: _____ Cell Phone: _____
5. Student's Primary Care Provider: _____ Phone: _____
6. Student's Dentist: _____ Phone: _____
7. Known Allergies: Identify by Name and Describe Reaction in Detail

   medication(s): _____ reaction: _____

   food: _____ reaction: _____

   other: _____ reaction: _____
8. Known Health Conditions: _____
9. Medications your student takes:

   prescription: _____

   non-prescription: _____
10. In case of illness or emergency, whom may we contact if unable to reach parent/guardian?

    Name: _____ Relationship: _____Phone: _____

    Name: _____ Relationship: _____Phone: _____
11. ***Your signature on this form authorizes release of this information, by the school nurse as a health alert to academic, activity, & athletic staff.***

    Parent/Guardian Signature: _____ Date: _____

REV. 11/2015

Township High School District 113
Información de Emergencia

Por favor indique escuela a la que asiste: ☐ **Deerfield High School** ☐ **Highland Park High School**

1. Nombre del estudiante: _____ Grado: ◯ 9 ◯ 10 ◯ 11 ◯ 12
2. Dirección: _____ Ciudad: _____
3. Nombre del Padre o Tutor: _____

   Teléfono de la casa: _____ Teléfono del trabajo: _____ Celular: _____
4. Nombre del Padre o Tutor: _____

   Teléfono de la casa: _____ Teléfono del trabajo: _____ Celular: _____
5. Nombre del proveedor de cuidado primario del estudiante: _____ Teléfono: _____
6. Nombre de dentista del estudiante: _____ Teléfono: _____
7. Alergias conocidas: identifíquelas por nombre y describa en detalle la reacción

   medicamento(s): _____ reacción: _____

   comida: _____ reacción: _____

   otro tipo: _____ reacción: _____
8. Condiciones de Salud Conocidas: _____
9. Medicamentos que toma su estudiante:

   medicina con receta: _____

   medicina sin receta: _____
10. ¿En caso de emergencia o enfermedad, a quienes pudiésemos llamar si no podemos localizar al padre/tutor?

    Nombre: _____ Relación: _____Teléfono: _____

    Nombre: _____ Relación: _____Teléfono: _____
11. ***Su firma en esta forma autoriza a la enfermera de la escuela a dar a conocer esta información al personal académico, de actividades y de deportes como una alerta de salud.***

    Firma de Padre/Tutor: _____ Fecha: _____

REV. 11/2015

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 and 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 be 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*
School: *Name*	*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 the dentist:

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

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Silver Diamine Fluoride ☐ Restoration of teeth due to caries

Oral Health Status *(check all that apply)*

☐ Dental Sealants Present on Permanent Molars

☐ 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 first molars.

☐ 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.

☐ 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 the appointment date or date of the most recent treatment.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date: _____

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date: _____

☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date: _____

Office Address: _____ Office Phone: _____

Signature of Dentist: _____ License #: _____ Date: _____

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

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Estado de Illinois
Departamento de Salud Pública de Illinois

FORMULARIO DE PRUEBA DE EXAMEN DENTAL ESCOLAR

Ley de Illinois (Código de Examen de Salud Infantil, 77 Ill. Adm. Código 665) establece que todos los niños en el jardín de infantes y en segundo, sexto y noveno grado de cualquier escuela pública, privada o parroquial deben tener un examen dental. El examen debe haberse realizado en los 18 meses anteriores al 15 de mayo del año escolar. Un dentista autorizado debe completar el examen, firmar y fechar este formulario de prueba de examen dental escolar. Si no puede obtener este examen obligatorio para su hijo, complete un formulario de exención de examen dental por separado.

Este examen importante le permitirá saber si hay algún problema dental que requiera la atención de un dentista. Los niños necesitan una buena salud bucal para hablar con confianza, expresarse, estar sanos y preparados para aprender. La mala salud bucal se ha relacionado con un menor rendimiento escolar, malas relaciones sociales y menos éxito en etapas posteriores de la vida. Por este motivo, le agradecemos que contribuya a la salud y bienestar de su hijo.

Para que complete el padre o tutor (en letra de imprenta):

Nombre del estudiante:	Apellido	Nombre	Segundo Nombre	Fecha de nacimiento: (Mes/Día/Año)
Dirección:	Calle	Ciudad		Código postal
Nombre de la escuela:		Código postal	Nivel de estudios:	Género: ☐ Masculino ☐ Femenino
Padre o tutor:	Apellido		Nombre	

Raza/Origen étnico del estudiante:

☐ Blanco ☐ Negro/Afroamericano ☐ Hispano/Latino ☐ Asiático
☐ Nativo americano ☐ Nativo de Hawái/Islas del Pacífico ☐ Multirracial ☐ Desconocido
☐ Otro

To be completed by dentist:

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

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Silver Diamine Fluoride ☐ 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:

Office Address _____ Phone Number _____

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

Procedures for Administering Medication
In Township High School District 113
(Deerfield High School & Highland Park High School)

1. Only those medications necessary to maintain the student's critical health and well-being will be administered during school hours or during school activities.

2. All medications given to students must be prescribed by a licensed prescriber on an individual basis determined by the student's health status. All approved orders for medication administration will be renewed each school year.

3. A Township High School District 113 **School Medication Authorization Form** must be completed and signed by the student's licensed prescriber and the parent/guardian in order for medication, non-prescription or prescription, to be given. Permission renewal is required each school year.

   Exception: Asthma inhalers must have the pharmacy label attached and parent/guardian written permission on file in the health service.
   With proper authorization: A student may possess an epinephrine auto-injector, an emergency rescue inhaler for asthma, emergency seizure medication, and/or medication prescribed for the treatment of diabetes for immediate use at the student's discretion.

   The School District and its employees and agents, shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication or use of epinephrine auto-injector or the storage of the medication by school personnel. A student's parent/guardian must indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising from the self-administration of medication or use of an epinephrine auto-injector, or the storage of the medication by school personnel.

4. The parent/guardian of the student must assume the responsibility of informing the school nurse in writing of any change in the student's health. Change in medication administration will be through a revised order or other written authorization from the licensed prescriber as approved by the school nurse.

5. The school nurse will review the written order and consult with the parent or the licensed prescriber for additional information as necessary. The school nurse retains the discretion to deny requests for the administration of medication. This decision may be appealed to the building Assistant Principal or Principal.

6. Medication must be brought to Health Services by the parent/guardian in the original package or appropriately labeled container. This pertains to refills of medication also.
   a. Prescription medication shall display:
      - *Student's name
      - *Prescription number
      - *Medication name and dosage

- *Administration route and/or other directions
- *Date and refill
- *Licensed prescriber's name
- *Pharmacy name, address & phone number
- *Name or initials of pharmacist

b. Over-the-counter medication brought to school must have the manufacturer's original label with the ingredients listed and the student's name affixed to the container.

7. The school nurse or any registered nurse approved by the school district may administer medication under these guidelines. Any employee may administer medications in emergency situations if, under the circumstances, the school nurse or emergency medical personnel cannot be available in sufficient time and the student cannot reasonably self-administer the medication.

8. Parents may administer medication **with approval** of the school nurse or the principal.

9. Each dose of medication shall be documented in the student's health record. The date, time, dosage, route and the signature of the person administering or supervising the student in self-administration must be documented.

10. Medication will be kept in a locked cabinet. Medication requiring refrigeration will be kept in a secure place. Expired medication will be discarded. Any medication that is not picked up at the end of the school year by the parent/guardian will be discarded.

11. The Health Service has a supply of acetaminophen, Benadryl, and ibuprofen available; however, only students who have filled out the proper Township High School District 113 "School Medication Authorization Form" will be eligible to have it administered.

12. The school nurse may administer an epinephrine auto-injector to any student with an unknown allergy having a first-time anaphylactic reaction, to a student with a known allergy who has forgotten his/her auto-injector or it is otherwise unavailable, or to a student with a known allergy.

13. The District 113 "School Medication Authorization Form" is available in Health Services and on the District Website.

Procedimientos para la Administración de Medicamento
En Township High School District 113
(Deerfield High School y Highland Park High School)

1. Sólo esos medicamentos necesarios para mantener la salud crítica y el bienestar del estudiante serán administrados durante horas escolares o durante actividades escolares.
2. Todos los medicamentos que sean dados a los estudiantes deben ser recetados por un prescriptor autorizado, de manera individualizada y estarán determinados por el estado de salud del estudiante. Todas las órdenes aprobadas para la administración de medicamento serán renovadas cada año escolar.
3. Un **Formulario de Autorización de Medicamentos Escolares** del Township High School District 113 debe ser llenado y firmado por el prescriptor autorizado y por el padre/tutor del estudiante, para que el medicamento, bien sea recetado o sin receta, sea dado. Cada año escolar se requiere renovar el permiso.

   Excepción: Los inhaladores para el asma deben tener la etiqueta de la farmacia pegada y el permiso por escrito del padre/tutor en el archivo de Servicios de Salud.

   Con autorización adecuada: Un estudiante puede poseer un auto-inyector de epinefrina, un inhalador de rescate para el asma para emergencia, medicación de emergencia para las convulsiones y/o un medicamento recetado para el tratamiento de la diabetes, para uso inmediato a discreción del estudiante.

   El Distrito Escolar, sus empleados y agentes, no incurrirán en responsabilidad alguna, por cualquier lesión causada debido a la auto administración de un medicamento, el uso de un inyector de epinefrina, o el almacenamiento del medicamento por parte del personal escolar, a excepción que dicha lesión sea causada por una conducta intencional y deliberada por parte de ellos. El padre/tutor del estudiante debe indemnizar y eximir de responsabilidad al Distrito Escolar, a sus empleados y agentes, de cualquier acusación, que venga a raíz de la auto administración de un medicamento, el uso de un inyector de epinefrina, o el almacenamiento del medicamento por parte del personal escolar, con la excepción de una acusación basada en una conducta intencional y deliberada.
4. El padre/tutor del estudiante debe asumir la responsabilidad de informar a la enfermera de la escuela, por escrito, de algún cambio en el estado de salud del estudiante. Un cambio en la administración de medicamento se hará a través de una revisión de la orden u otra autorización escrita del prescriptor autorizado, siempre y cuando la enfermera de la escuela lo apruebe.
5. La enfermera de la escuela revisará la orden escrita, y en caso necesario, para más información consultará con el padre/tutor o el prescriptor autorizado. La enfermera de la escuela se reserva el derecho de negar solicitudes para la administración de medicamento. Esta decisión puede ser apelada ante el Subdirector o el Director.
6. El medicamento debe ser traído a Servicios de Salud por el padre/tutor en el paquete original o en el recipiente debidamente etiquetado. Esto también aplica para medicamentos que sean surtidos nuevamente.
   a. El medicamento con receta debe indicar

- *Nombre del estudiante
- *Número de la receta medica
- *Nombre del medicamento y dosis
- *Forma de administrar el medicamento y/u otras instrucciones
- *Fecha y reabastecimiento
- *Nombre del prescriptor autorizado
- *Nombre de la farmacia, dirección y número de teléfono
- *Nombre o iniciales del farmacéutico

b. Los medicamentos sin receta que sean traídos a la escuela deben tener la etiqueta original del fabricante con la lista de ingredientes y el nombre del estudiante pegado al recipiente.

7. La enfermera de la escuela o cualquier enfermera titulada aprobada por el distrito escolar puede administrar medicamento bajo estas pautas. Cualquier empleado certificado pudiese administrar un medicamento en situaciones de emergencia, si por las circunstancias, la enfermera de la escuela o el personal médico de emergencia no está disponible en tiempo suficiente, y si bien el estudiante no puede auto administrarse el medicamento razonablemente.
8. El padre o tutor pudiese administrar medicamentos **con la aprobación** de la enfermera de la escuela o el director.
9. Cada dosis del medicamento deberá ser documentada en el registro de salud del estudiante. La fecha, hora, dosis, forma en que se administra el medicamento, así como también, la firma de la persona que está administrando o supervisando al estudiante auto administrarse el medicamento, debe ser documentado.
10. El medicamento será guardado en un gabinete bajo llave. El medicamento que requiere de refrigeración será guardado en un lugar seguro. Los medicamentos que estén expirados serán desechados. Cualquier medicamento que no sea recogido por el padre/tutor al final del año escolar será desechado.
11. Servicios de Salud tiene un suministro de acetaminofén, Benadryl e ibuprofeno disponible, sin embargo, sólo los estudiantes que hayan llenado el “Formulario de Autorización de Medicamentos Escolares” del Township High School District 113, serán elegibles para que les sean administrados estos medicamentos.
12. La enfermera de la escuela puede administrar un auto-inyector de epinefrina a cualquier estudiante con una alergia desconocida que está teniendo una reacción anafiláctica por primera vez, a un estudiante con una alergia conocida a quien se le ha olvidado su auto-inyector o no está disponible, o a un estudiante con una alergia conocida.
13. El “Formulario de Autorización de Medicamentos Escolares” del Distrito 113 está disponible en Servicios de Salud y en la página Web del Distrito.

Formulario de Autorización de Medicamentos Escolares R13

Township High School District 113

Todo medicamento debe estar etiquetado adecuadamente

☐ **Deerfield High School**
1959 N. Waukegan Rd. Deerfield, IL 60015
Teléfono: 224/632/3200; Fax: 224/632/3206

☐ **Highland Park High School**
433 Vine Ave. Highland Park, IL 60035
Teléfono: 224/765/2200; Fax: 224/765/2708

Nombre del Estudiante: _____
Apellido Primer Nombre

Grado: ◯9 ◯10 ◯11 ◯12 Fecha de Nacimiento: _____

Fecha de Comienzo: _____ Fecha de Descontinuación: _____

Diagnóstico/Razón: _____

Medicamento: _____

Diario: _____ Cuando sea necesario:_____ Emergencia: _____

1. Potencia: _____ Dosis: _____ Frecuencia: _____ Hora: _____
2. Forma de administrar: _____
3. Efectos secundarios por los cuales el estudiante debe tenerse en observación: _____

   _____
4. Otros medicamentos que el estudiante recibe: _____

Servicios de Salud almacena los medicamentos sin receta a continuación. Por favor provea el medicamento si su estudiante requiere una forma diferente a las tabletas.

❑ **Ibuprofeno (Advil)** 200 mg, 1-2 tabletas, cada 6 horas, según sea necesario

❑ **Acetaminofén (Tylenol)** 325 mg, 1-2 tabletas, cada 4-6 horas, según sea necesario

❑ **Acetaminofén Extra Strength (Tylenol Extra Strength)** 500 mg, 1-2 tabletas, cada 6 horas, según sea necesario

❑ **Difenhidramina (Benadryl)** 25 mg, 1-2 tabletas, cada 4-6 horas, según sea necesario

Por la presente solicito y concedo permiso a Township High School District 113 para que la enfermera de la escuela o cualquier enfermera registrada aprobada por el Distrito, o en el caso de una emergencia, otro miembro del personal, le administre medicamento a mi estudiante de acuerdo con las instrucciones anteriores. También renuncio a cualquier demanda contra el Distrito Escolar, los miembros de la Junta Educativa, sus empleados, y agentes, que surjan del almacenamiento,

administración, o de auto-administración de dicho medicamento, y aceptó mantener indemne e indemnizar al Distrito Escolar, los miembros de la Junta Educativa, sus empleados y agentes, ya sea en conjunto o separadamente, de y contra de cualquier y toda responsabilidad, reclamos, demandas, daños, o causas de acción o de lesiones, costos, y gastos, incluyendo honorarios de abogados, como resultado de o que surjan de la administración o la auto-administración de medicamento, a excepción de la conducta deliberada e injustificable.

Para Medicamento de Asma/Auto inyectores de Epinefrina/Medicamento de Diabetes/ Medicamentos de Emergencia para Convulsiones* Solamente: Le doy mi consentimiento a mi estudiante de poseer y auto-administrarse sin supervisión de (ponga un círculo al medicamento aplicable) medicamento de asma/auto inyectores de epinefrina/medicamento de diabetes/ medicamentos de emergencia para convulsiones: ____ sí ____ no.

***** *El estudiante debe estar autorizado para auto-administrarse insulina de acuerdo con el plan individual de salud del estudiante, plan de la Sección 504, o un plan de cuidado de la diabetes.*

_____	_____
Firma del Padre/Tutor	Firma del Prescriptor con Licencia
_____	_____
No. de Emergencia del Padre/Tutor	Dirección/Teléfono
Fecha _____	Fecha _____

<u>El medicamento no puede ser dado a menos que esta forma sea llenada en su totalidad y firmada por el prescriptor con licencia y el padre/tutor</u>

**La firma del prescriptor con licencia no es requerida para la auto-administración de inhaladores de asma de un estudiante.*

REV. 12/2022

School Medication Authorization Form

R13

Township High School District 113

All Medication Must be Properly Labeled

☐ **Deerfield High School**
1959 N. Waukegan Rd. Deerfield, IL 60015
Phone: 224/632/3200; Fax: 224/632/3206

☐ **Highland Park High School**
433 Vine Ave. Highland Park, IL 60035
Phone: 224/765/2200; Fax: 224/765/2708

Student Name: _____
Last First

Grade: ◯ Fr. ◯ So. ◯ Jr. ◯ Sr Date of Birth: _____

Start Date: _____ Discontinuation Date: _____

Diagnosis/Reason: _____

Medication: _____

Daily: _____ PRN: _____ Emergency: _____

1. Strength: _____ Dosage: _____ Frequency: _____ Time: _____
2. Route of administering: _____
3. Side effects student should be observed for: _____

   _____
4. Other medication student is receiving: _____

Health Services stocks the Over the Counter medications below. Please provide medication if your student requires a different form than tablets.

❑ **Ibuprofen (Advil)** 200 mg, 1-2 tabs, every 6 hours, as needed

❑ **Acetaminophen (Tylenol)** 325 mg, 1-2 tabs, every 4-6 hours, as needed

❑ **Acetaminophen Extra Strength (Tylenol Extra Strength)** 500 mg, 1-2 tabs, every 6 hours, as needed

❑ **Diphenhydramine (Benadryl)** 25 mg 1-2 tabs, every 4-6 hours, as needed

I hereby request and grant permission for Township High School District 113 school nurse or any registered nurse approved by the District, or in the case of an emergency, another staff member, administer medication to my student according to the above instructions. I further waive any claims against the School District, members of the Board of Education, its employees, and agents arising out of the storage, administration, or self-administration of said medication, and agree to hold harmless and indemnify the School District, the members of the Board of Education, its employees and agents,

either jointly or severally, from and against any and all liability, claims, demands, damages, or causes of action or injuries, costs, and expenses, including attorneys' fees, resulting from or arising out of the administration or self-administration of medication, except for willful and wanton conduct.

For Asthma Medication/Epinephrine Auto-Injectors/Diabetes Medication/Emergency Seizure Medication* Only: I consent to my student's possession and unsupervised self-administration of (circle applicable medication) asthma medication/epinephrine auto-injectors/diabetes medication/ emergency seizure medication: _____yes _____ no.

** A student must be authorized to self-administer insulin in accordance with the student's individual health care plan, Section 504 plan, or diabetes care plan*.

_____ Parent/ Guardian signature

_____ Licensed Prescriber signature

_____ Emergency No. of Parent/Guardian

_____ Address/Phone

Date _____

Date _____

<u>Medication cannot be given unless this form is completed in its entirety and signed by the licensed prescriber and parent/guardian</u>

**The licensed prescriber signature is not required for a student's self-administration of asthma inhalers.*

REV. 12/2022