2015-2016 Minimum Health Requirements for Chicago Public Schools

Medical Home

A medical home will allow your child and family to access better healthcare. The medical home is where you can access affordable, quality, culturally sensitive, competent and coordinated healthcare.

Most people who are found eligible for Medicaid must choose a Primary Care Provider (Medical Home). The Illinois Client Enrollment Broker will help you understand your healthcare choices, so that you can choose the best plan for you. http://illinoisceb.com/

If you are seeking a provider, you may call 311 or go to: www.cityofchicago.org and type in "Find a Community Health Center" in the Search box

The CPS Children and Family Benefits Unit (CFBU) provides application assistance for CPS families that are eligible for benefit programs such as medical insurance (e.g., All Kids).

For more information, please call: 773-553-KIDS (5437)

For more information regarding health requirements contact your School Nurse.

Evidence shows that healthy students have better attendance and perform better in school academically. The following health requirements apply to all children enrolled in a Chicago Public School. **Children must provide proof of required immunizations and health exams before October 15, 2015, or they will face exclusion from school.**

EXAMINATION REQUIREMENTS

Physical Examination requirements due upon enrollment, or by **10/15/15**

Physical Examination must be completed within one year prior to entry to:

- Preschool and kindergarten (physical exam and lead screening through age 6).
- 6th grade and 9th grade (ages 5, 11, 15 for un-graded programs).
- Any student entering CPS for the first time.

Vision Examination requirements due upon enrollment, **no later than 10/15/15**

- Entering the State of Illinois for the first time at any grade level.
- Entering kindergarten.

Dental Examination requirements due **5/15/16** for kindergarten, 2nd and 6th grade.

IMMUNIZATION REQUIREMENTS

Diphtheria, Pertussis (Whooping Cough), Tetanus (DTaP & Tdap)

- Four (4) or more doses. The first 3 doses with intervals of 4 weeks apart. The interval between the 3rd and 4th dose is at least 6 months.
- The last dose qualifying as a booster and received on or after the 4th birthday.
- One (1) dose of the Tdap vaccine for 6th to 12th grades.

Polio

- Three (3) or more doses of a polio vaccine with intervals of 4 weeks apart.
- The last dose qualifying as a booster and received on or after the 4th birthday.

Measles, Mumps, and Rubella

- One (1) dose required for preschool, & a second dose required for all students kindergarten to 12th grade.
- 1st dose received at 12 months or later.
- 2nd dose must be administered at least four weeks (28 days) after 1st dose.

Hepatitis

- Three (3) doses required for all students.
- 1st dose at birth.
- 2nd dose received no less than 28 days or 4 weeks after 1st dose.
- 3rd dose received no less than 2 months after the 2nd dose and 4 months after the 1st dose.

Varicella (Chicken Pox)

- Two (2) doses of varicella are required for kindergarten, 1st grade, 6th grade, 7th grade, 9th, and 10th grades. The first dose on or after the first birthday and the second dose no less than four weeks (28 days) after the first dose.
- One (1) dose required on or after the first birthday for Prek, 2nd, 3rd, 4th, 5th, 8th, 11th, & 12th grades.

Haemophilus Influenzae, Type B (HIB)

- Three (3) doses required for primary series.
- If none received before age 15 months, only one (1) dose required from age 15 months to 59 months of age. Not required age 5 years or older.

Pneumococcal Disease (PCV)

- Four (4) doses required for primary series.
- If none received before age 24 months, only one (1) dose required from age 24 to 59 months of age. Not required age 5 years or older.

NEW: Meningitis (MCV4)

- One (1) dose of the meningitis vaccine for 6th grade.
- Two (2) doses of the meningitis vaccine for 12th grade.
- If the 1st dose was given at age 16 or older; only one (1) dose will be required for 12th grade.

Chicago Public Schools

Office of Student Health and Wellness
42 West Madison • Chicago, Illinois 60602
Telephone: 773-553-3520 • Fax: 773-553-1883

Office Use Only
Reviewed by: _____
Follow up: _____
Documents received: _____

Student Medical Information 2015/2016 School Year

INFORMATION MUST BE UPDATED AND SUBMITTED **ANNUALLY** AT THE BEGINNING OF THE SCHOOL YEAR

PLEASE PRINT ALL INFORMATION and RETURN FORM TO SCHOOL

SCHOOL NAME: **Scammon Elementary**

Student Name: _____ Date of Birth: _____ Grade: _____

Student ID: _____ Medicaid Number: _____

To ensure the safety of your child during the school day, extracurricular activities, on any field trip, and when being transported by CPS it is important that the school is aware of any health conditions that may impact your child. We are asking you to please complete this form. For confidentiality purposes, this information will only be shared with relevant CPS staff. Thank you for your cooperation in this important matter.

Please check below if applicable:

- ☐ Food Allergies: (Type) _____
- ☐ Other Allergies: (Type) _____
- ☐ Asthma
- ☐ Diabetes: Type 1 ☐ Type 2 ☐
- ☐ Seizures
- ☐ Other Medical Condition

  _____

  _____
- ☐ My child has **NO** allergies, medical conditions and/or does not take any medications during school hours
- ☐ My child has a primary healthcare provider (e.g., Doctor, Nurse Practitioner, Physician Assistant, etc.)

For the medical condition identified above which requires prescribed medication during school hours, please provide written verification from your healthcare provider with diagnosis, type of medication, dosage, and time to be given. An Emergency Action Plan (Allergy, Asthma, or Diabetes) can also be requested from your healthcare provider. Your child may qualify for a **504 Accommodation Plan** due to his/her condition. Please make sure you follow up with your school nurse and/or case manager once you have submitted this form.

Parent Name: (Please Print): _____ Date: _____

Parent Signature: _____

Phone Number: _____ Email: _____

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

DCFS

State of Illinois
Certificate of Child Health Examination

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

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

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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

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

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

Date of Disease **Signature** **Title** **Date**

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

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

																					Code:
Date																					
Age/ Grade																					**P = Pass** **F = Fail**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**U = Unable to test** **R = Referred**
Vision																			**G/C = Glasses/Contacts**
Hearing																			

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

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

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

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

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

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

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed ☐** **Test performed ☐**

Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____

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

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**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 ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)