C.U.S.D. 303

COMMUNITY UNIT SCHOOL DISTRICT 303
ST. CHARLES, ILLINOIS
PRESCHOOL SCREENING/EVALUATION REFERRAL FORM

Child's Full Name:
First: Middle: Last:

Date of Birth: / /

Home Phone Number: **Cell/Alternate Phone Number:**

Home Address: **City:** **Zip Code:**

Child Lives with: ☐ Mother and Father ☐ Mother only ☐ Father only ☐ Other: (If other – fill out information below)

Name: Relationship to Child: Phone Number:

☐ **BOY** (or) ☐ **GIRL**

Child's Race/Ethnicity:

Is a language other than English spoken in your home? ☐ No ☐ Yes (if yes, which Language/s)
Mark **ALL** that apply to your child: ☐ Hears/Exposed to Language ☐ Understands Language ☐ Speaks Language

Mother's Information	Father's Information
Name:	Name:
Age/Date of Birth:	Age/Date of Birth:
Occupation/Work Phone Number: Currently Employed: ☐ Yes ☐ No	Occupation/Work Phone Number: Currently Employed: ☐ Yes ☐ No
Years Education Completed: ☐ Less than 12 years ☐ High School/GED ☐ some college/Associate ☐ 4 years college ☐ 4+ years college ☐ Other:	Years of Education Completed: ☐ Less than 12 years ☐ High School/GED ☐ some college/Associate ☐ 4 years college ☐ 4+ years college ☐ Other:

List Brothers and Sisters Below

Name:	Birthdate:	Name:	Birthdate:
Name:	Birthdate:	Name:	Birthdate:
Name:	Birthdate:	Name:	Birthdate:

Siblings with Identified Disability/Special Help in School ☐ Yes ☐ No (If Yes, list below)

Others Living in the Home (List: example: Grandmother/Uncle/Cousin/etc.)

Total Number of People Living in Home

Check Approximate Total Family Yearly Income

☐ $6,000-8,100	☐ $16,500-18,500	☐ $32,900-37,000	☐ $65,900-74,300
☐ $8,100-10,000	☐ $18,500-20,600	☐ $37,100-41,300	☐ $74,300-82,600
☐ $10,200-12,300	☐ $20,600-24,600	☐ $41,300-49,200	☐ $82,600-above
☐ $12,300-14,400	☐ $24,600-28,800	☐ $49,200-57,600	
☐ $14,400-16,500	☐ $28,800-32,900	☐ $57,600-65,900	

Agencies Involved with Child and/or Family

☐ Early Intervention/CFC ☐ Head Start ☐ County Health Department ☐ DCFS Involvement
☐ Medicaid (if so, list parent's enrollment Number)
☐ Public Aid (if so, list IDPA Number)
☐ WIC/SNAP Benefits ☐ TANF Enrollment ☐ SSI Benefits ☐ Housing Subsidy/Section 8
☐ Foster Care/Ward of State ☐ Other:

Continued on back →

What is your neighborhood/elementary school? (indicate school (or) if unsure mark → ☐ I am not sure)

☐ Anderson School ☐ Bell Graham School ☐ Corron School ☐ Davis/Richmond School ☐ Ferson Creek School
☐ Fox Ridge School ☐ Lincoln School ☐ Munhall School ☐ Norton Creek School ☐ Wasco School ☐ Wild Rose School

Does your child have preschool/childcare experience? ☐ Yes ☐ No (If Yes, complete section below)

☐ Preschool Program ☐ Daycare/Childcare Center ☐ Home Childcare Setting ☐ HeadStart ☐ Other:	**Name/Address of preschool:**	**Attends preschool on these days:** ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat/Sun **Number of Hours per/day:**

Did/Does your child receive Early Intervention (or) Private Therapies/Services? ☐ Yes ☐ No

(If Yes, please indicate services below)

☐ Speech Therapy ☐ Developmental Therapy ☐ Occupational Therapy ☐ Physical Therapy
☐ Social Work ☐ Other:

Has anything happened recently which may have influenced your child/development (example: death/divorce/new baby/move)

☐ Yes ☐ No
(If Yes, explain)

Any health problems during pregnancy/at birth?

☐ Yes ☐ No (If Yes, explain)

Age of Mother birth of first child:

Age of Mother at birth this child:

Any current medical/health problems regarding your child?

☐ Yes ☐ No (If Yes, explain)

Does child have access to healthcare and routine doctor visits? ☐ Yes ☐ No

Family Doctor: (list)

Please indicate any areas of concern/worry about your child: ☐ No Concerns – Just checking development

☐ Learns slowly compared to same age children
☐ Has no/limited language/words/communication
☐ Understanding/Comprehension Language
☐ Challenging Behavior/Does not listen
☐ Can be quiet/shy around others
☐ Has limited experience with other children
☐ Appears to sad/depressed often
☐ Doesn't play with toys like same age children
☐ Self-Help/Functional Skills
☐ Vision/Hearing: (List)
☐ Motor Skills (small objects/using crayons/jumping/running)
☐ Other: (list)

If necessary, please describe/explain below:

How did you hear about our Developmental Screening and/or Early Childhood Program? (List below)

Please bring this form *completed* along with any other forms sent with this packet to your scheduled appointment.

Should you need help/support completing any paperwork please contact the Early Childhood Office at (331) 228-4834

FORM: ELL 1a Eng. Office Use: Forward copy to ELL Coordinator/ELL Teacher if another language is present
Revised: 3/16 ELL Teacher: Place copy in student's ELL folder

Community Unit School District 303

Home Language Survey/Race and Ethnicity Data

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students that need to be assessed for English language proficiency.

Student's Name: _____ Grade: _____

School: _____ Phone Number_____

1. Is a language other than English spoken in your home?

_____No _____Yes*** What language? _____

PLEASE EXPLAIN: _____

_____

2. Does your child speak a language other than English?

_____No _____Yes*** What language? _____

*****IF THE ANSWER TO EITHER OF THE ABOVE QUESTIONS IS "YES," THE LAW REQUIRES THE SCHOOL TO ASSESS YOUR CHILD'S ENGLISH LANGUAGE PROFICENCY.**

3. I prefer school communications in: ☐ English ☐ Spanish ☐ My Home Language

Part A. Is your child Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) **Choose only one**.

_____No, not Hispanic/Latino _____Yes, Hispanic/Latino

Part B. What is your child's race? Choose one or more.

☐ **American Indian or Alaska Native:** A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.

☐ **Asian:** A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **Black or African American:** A person having origins in any of the black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander:** A person having origins in any of the original people of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **White:** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

_____ _____
Signature of Parent/Guardian Date

_____
Print Name

23 IL Adm. Code 228.15

Office Staff: Copy and give to ELL Teacher/Coordinator
ELL Teacher: Place copy in student's ELL folder

Community Unit School District 303

Extended Home Language Survey

To be completed if you answered "yes" to questions 1 or 2 on the Home Language Survey.

Student's Name: _____

Parent's Name(s): _____ Entering Grade: _____

Date of Entry into U.S. Schools: _____ Birth Date: _____

Student Place of Birth (City, State, Country): _____

Where outside the United States did your child attend school?

Country: _____ City: _____

STUDENT'S EDUCATION

	Pre-K	K	1	2	3	4	5	6	7	8
School years completed **outside of the U.S.**										
School years completed **within the U.S.**										
Years in Bilingual/ESL classes										
Years in special education classes										

LANGUAGE USE:

1. What was the first language your child learned? _____

2. List all of the languages normally spoken in your home. _____

_____

3. What language do you (parent) use most frequently to speak to your child? _____

4. What language does your child use most often when he/she speaks to you? _____

Speaks to his/her siblings? _____ Speaks to his/her friends? _____

6. Does your child read in another language other than English? ☐ Yes ☐ No

What language? _____

7. Does your child write in another language other than English? ☐ Yes ☐ No

What language? _____

_____ _____

Signature of Parent/Guardian Date

Community Unit School District 303

New Student Registration Information

This form must be completed, signed and returned to the school for each student.

Student Name_____Grade_____Date_____

MILITARY CHILDREN INFORMATION: This information will help identify Illinois military families. Answering these voluntary questions will help schools get U.S. Department of Defense assistance for children whose parent/guardian serves in the military, National Guard or Reserve.

Does this student's parent or guardian serve in the military, including National Guard or Reserve?

☐ YES ☐ NO

Is the parent or guardian currently serving on active duty or expected to be deployed this year?

☐ YES ☐ NO

Has the parent or guardian returned from deployment in the past six (6) months?

☐ YES ☐ NO

FIELD TRIPS: From time to time we may take educational field trips in the surrounding area. Your signature gives permission for the student listed above to attend educational field trips in Community Unit School District 303. **You will be notified before each trip.**

DISTRICT'S AUTHORIZATION FOR ELECTRONIC NETWORK ACCESS: I have read the District's policy regarding Access to Electronic Networks (http://district.d303.org/6235-access-electronic-networks) and the District's Authorization for Electronic Network Access (6:235 AP1) and understand that failure of any student to follow the terms of this policy and administrative procedure will result in the loss of privileges, disciplinary action and/or appropriate legal action.

PARENT/STUDENT ACKNOWLEDGEMENT OF STUDENT HANDBOOK: I understand that all students will be held accountable for their behavior and will be subject to the guidelines and the disciplinary consequences outlined in the student handbook and discipline procedures found on the District's website at http://district.d303.org/student-handbooks.

FERPA (Family Educational Rights and Privacy Act) gives custodial and non-custodial parents certain rights with respect to their children's education records, unless a school is provided with evidence that there is a court order or State law that specifically provides to the contrary. Both custodial and non-custodial parents have the right to inspect and review education records, seek to amend education records believed to be inaccurate, and consent to the disclosure of personally identifiable information from education records, except as specified by law. When a student reaches 18 years of age, he or she becomes an "eligible student," and all rights under FERPA transfer from the parent to the student. The term "education records" is defined as those records that contain information directly related to a student and which are maintained by an educational agency or institution or by a party acting for the agency or institution.

Parent Signature:_____Date:_____

Student Signature:_____Date:_____

Community Unit School District 303
School Health Services

Dear Incoming Early Childhood and Pre-Kindergarten Parents:

Your child's health is very important to the educational process, thus the state of Illinois requires a full health examination for students entering an Illinois school for the first time.

Completed physical forms and required immunizations **must be on file at the school where your child will be attending prior to the start of school** for all incoming Early Childhood and Pre-Kindergarten children. Students who fail to submit the required health forms can not attend school until health requirements are met. All health forms may be accessed on the CUSD 303 website at www.d303.org in the **"For Parents"** section under **Forms**.

Please note the following health requirements:

THE PHYSICAL EXAMINATION:

- The examiner must be a Physician licensed to practice medicine in all of its branches, a licensed Physician's Assistant, or an Advanced Practice Nurse. An examination by a Chiropractor is not acceptable.
- The Health History portion on the back of the Certificate of Child Health Examination form must be filled out and signed by the parent or guardian prior to your child's examination.
- Inform your health care provider about any known illnesses, health or physical concerns that might be important in determining your child's physical condition.
- The physical examination must include an evaluation of all body systems including:
  - Height, weight, blood pressure, diabetes screening/BMI
  - Lead screening required for children age six years or younger for admission into preschool or kindergarten programs.
- Medications, diet restrictions, allergies, special equipment or other needs must be listed by the examiner.

REQUIRED IMMUNIZATIONS:

Evidence of immunity against the following diseases must be submitted according to the following schedule:

- 4 doses of DPT (Diphtheria, Pertussis, Tetanus)
- 3 doses of Polio
- 1 dose of MMR (given on or after first birthday)
- 1 dose of Varicella (given on or after first birthday or written statement by healthcare provider verifying proof of chickenpox disease
- 3 dose series of Hepatitis B received at proper intervals
- HIB vaccine appropriate to age
- Pneumococcal vaccine appropriate to age

All health forms may be accessed on the CUSD 303 website at www.d303.org in the "**For Parents**" section under **Forms**. All forms are also available through your child's school.

If your child has a medical condition that may impact any part of his or her school day, please contact the Certified School Nurse in your child's school so that adjustments or accommodations can be made.

Thank you for your cooperation with these important health matters.

Community Unit School District 303 School Health Services

STATE AND CUSD 303
MEDICAL/DENTAL/VISION REQUIREMENTS BY GRADE

*This table reflects the vaccines that are **mandated** in association with grades when a physical is required, a dental exam is required or a special vaccine is mandated. (Early Childhood, Kindergarten, Second, Sixth, Ninth and Twelfth grades). Students entering any other grade are subject to the minimum immunization requirements required for entry into a school in the State of Illinois. Your school nurse will review all vaccine and physical exam data for students to assure compliance.*

Care For Kids

CLICK HERE FOR HEALTH / DENTAL / EYE EXAM FORMS

	EC	Kdg	2nd	6th	9th	12th
Physical Exam	Due prior to the first day of attendance	Due prior to the first day of attendance		Due prior to the first day of attendance	Due prior to the first day of attendance	
	*Note: Diabetic and Lead screening are required. Parent must complete and sign Health History portion. A TB test is recommended for Early Childhood students.					
Dental Exam	Recommended but not required	Required	Required	Required	Required	
Vision Exam		Required	Required for transfer students new to Illinois			
IMMUNIZATIONS						
Diphtheria/ Tetanus/ Pertussis (DTP/DTaP)	4 doses (4th dose must be 6 mos or more after 3rd dose)	4 or more doses with last dose after 4th birthday		Required for students in grades sixth thru ninth (if not already received after age 4)		
Tetanus/ Diphtheria /Pertussis (Tdap)				1 dose required for students in grades six thru twelve (if not already received after age 10)		
Polio (IPV/OPV)	3 doses administered at proper intervals	3 or more doses with last dose after 4th birthday	Required for students in grades kindergarten thru twelfth (if not already received)			
Varicella	1 dose required after the age of 12 months	2 doses administered at proper intervals		2 doses administered at proper intervals (if not already received.)	2 doses administered at proper intervals (if not already received.)	
Hepatitis B	3 doses administered at proper intervals			3 doses administered at proper intervals (if not already received.)	3 doses administered at proper intervals (if not already received.)	3 doses administered at proper intervals (if not already received.)
Measles/Mumps / Rubella (MMR)	1 dose after the age of 12 months	2 doses of MMR or 2 doses of the measles, mumps and rubella live vaccines administered at proper intervals. Required for students in grades kindergarten thru twelve (if not already received).				
Haemophilus Influenzae Type B (Hib)	Primary series and booster administered at proper intervals or 1 dose after 15 months					
Pneumococcal	Primary series or a single dose between 24-59 months of age.					
Meningococcal (MCV)				1 dose required for students entering sixth grade received on or after their tenth birthday.		2nd dose or initial dose required after 16th birthday.

CLICK HERE FOR HEALTH / DENTAL / EYE EXAM FORMS

State of Illinois
Certificate of Child Health Examination

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

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

REQUIRED Vaccine / Dose	**DOSE 1** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:**		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR**

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

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

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

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

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

ALLERGIES (Food, drug, insect, other)	Yes No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes No	**List:**	
Diagnosis of asthma? 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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed ☐** **Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm_____**
Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ Value

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ **INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐**

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

Address **Phone**

Community Unit School District 303
Health Services Survey

In effort to best serve our students, we request that you provide current health information.

1. **Has your child had a serious illness, injury or surgical procedure within the past year?** Yes ☐ No ☐
   If yes, please explain:

   Will your child require medication, restrictions, or accommodations at school? Yes ☐ No ☐

2. **Does your child have a known allergy/sensitivity that may impact him or her at school?** Yes ☐ No ☐
   If yes, please explain:

   Is your child's allergy considered life-threatening? Yes ☐ No ☐
   Please list all allergy medications your child has been prescribed:

   Will your child require medication, restrictions or accommodations at school? Yes ☐ No ☐

3. **Does your child have asthma?** Yes ☐ No ☐
   Is your child's asthma mild, moderate or severe? ***Please circle one***
   Is your child's asthma seasonal, exercise, illness, or allergy induced? ***Circle all that apply***
   Please list all medications your child takes for asthma:

   Will your child require medication, restrictions or accommodations at school? Yes ☐ No ☐

4. **Does your child have a history of seizures?** Yes ☐ No ☐
   If yes, please explain the nature of your child's seizure history:

   When did the last seizure occur?
   Please list any seizure medications your child currently takes:

   Will your child require medication, restrictions or accommodations at school? Yes ☐ No ☐

5. **Does your child have a history of cardiac concerns?** Yes ☐ No ☐
   If yes, please explain the nature of your child's cardiac history:

   Is your child currently under the care of a cardiologist? Yes ☐ No ☐
   Please list all cardiac medications your child takes:

   Will your child require medication, restrictions or accommodations at school? Yes ☐ No ☐

6. **Does your child have any other health concerns; physical, emotional or attention related, that could impact him or her while at school?** Yes ☐ No ☐
   If yes, please explain:

   Does your child take medication at home? If yes, please indicate: Yes ☐ No ☐

   Does your child require medication, restrictions or accommodations at school? Yes ☐ No ☐
   Please indicate:

7. **Does your child wear glasses/contacts and/or have a visual impairment?** Yes ☐ No ☐
   If yes, please explain the nature of the visual impairment:

8. **Does your child have a known hearing loss, ear tubes or frequent ear infections?** Yes ☐ No ☐
   If yes, please explain the nature and frequency of your child's hearing difficulty:

This information will be kept confidential and shared only with educational personnel on a need to know basis.
Please contact your school nurse if this information is not to be shared.
Health information and health forms are available under Parents/Forms/Health Forms at www.d303.org

Child's Name: _____ Grade: _____

Parent/Guardian Signature: _____ School Year: _____

Community Unit School District 303

Jennifer Mursu • Early Childhood Education Department • (331) 228-4834

To: Parents/Guardians
Regarding: Providing individual daily classroom snacks

Parents are asked to provide their child with a small, individually wrapped, healthy snack/drink each day for a classroom snack. The school district will not be providing a snack for students. Your child's snack will not be shared with other students. If your child is attending the Early Childhood Preschool for All Program, please contact the teacher for snack details.

We are committed to providing a safe and welcoming environment for all of the children in our school. Due to the number of allergies, all early childhood education classrooms have been designated as **a NUT- FREE** classroom.

While some allergic reactions can be mild, many students with severe food allergies experience serious, potentially life-threatening symptoms to eating (and in some cases touching and smelling) certain foods. Please be careful not to send foods into the classroom that contain nuts. Please refer to the ingredients and allergy information labeled on the packaging for details.

Suggestions for snacks:

No refrigerated food, unless a cold pack is included
Fruits
Vegetables
Whole grain cereals
Raisins
Cereal bars with no nuts
Foods that children can open independently

Please call the school's Health Office if you have any questions or concerns.

Thank you for helping to make this school year safe for all students.

Sincerely,

Early Childhood Department

PICK UP PERMISSION

School Year

For the safety and protection of your child we cannot release he/she for pick up unless you, the parent and/or guardian specifies.

Please list adults who have your permission to pick up your child at dismissal.

* If your spouse/ex-spouse **is not** allowed to transport your child, please check below and add their name and address.

☐ **CANNOT TRANSPORT MY CHILD!**

NAME	ADDRESS	PHONE
_____	_____	_____

Adults who **can** transport my child:

NAME	ADDRESS	PHONE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

_____ _____

Child's Name Date

_____ _____

Parent Signature Phone