



ST. TERESA CATHOLIC SCHOOL

1108 LEBANON AVENUE

BELLEVILLE, IL 62221

Dear Parents/Guardians:

Students entering **6th Grade** are required by the State of Illinois to have a Physical Examination/Immunization Record on file before the school year begins, or **no later than Sept. 1st of the current school year**. Additionally, a dental form will be required prior to May 15th of the current school year. The forms are being sent home now so that you may schedule these appointments. This physical *may* be used for your child's sports physical.

PLEASE NOTE:

The HEALTH HISTORY section on the form is to be completed by ***parents/guardians, signed, and dated.***

The IMMUNIZATION section is to be completed only by a health care provider.

The physician must sign, verifying that the immunizations were given and also sign indicating the physical exam was given. (Two signatures)

The state of Illinois now requires that all students be screened for diabetic risk factors and BMI, during their health physical.

PARENTS: Please fill out all the highlighted areas on the physical form and sign it.

If you have any questions or concerns, please contact me at the school office Monday thru Friday during school hours at 235-4066.

Sincerely,

Janine L. Gosebrink, RN, BSN
Nurse

Sandy Jouglard
Principal



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	
Street	City	Zip Code					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			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																		
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 influenzae type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Comments:

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
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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
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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?		Yes No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes No
Child wakes during night coughing?		Yes No	Hospitalizations? 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 disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes No	TB skin test positive (past/present)?	Yes*	No
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	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?		Yes No	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)					
Ear/Hearing problems?		Yes No	Parent/Guardian Signature		
Bone/Joint problem/injury/scoliosis?		Yes No	Date		

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		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> 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** _____



ST. TERESA CATHOLIC SCHOOL

1108 LEBANON AVENUE
BELLEVILLE, IL 62221

Dear Parents/Guardians:

Students entering **Kindergarten, Second, and Sixth Grades** are required by the State of Illinois to have a dental form submitted to school. The student must have had a dental exam within eighteen months prior to the deadline date. It will be required to be on file by **May 15th of the current school year.**

The forms are being sent home now so that you may schedule these appointments.

If you have any questions or concerns, please contact me at the school office Monday thru Friday during school hours at 235-4066.

Sincerely,

Janine L. Gosebrink, RN, BSN
Nurse

Sandy Jouglard
Principal

Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



To be completed by the parent (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Address (of parent/guardian):			

To be completed by dentist:

Oral Health Status (check all that apply)

- Yes No **Dental Sealants Present**

- 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 **Soft Tissue Pathology**

- Yes No **Malocclusion**

Treatment Needs (check all that apply)

- Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

- Restorative Care** — amalgams, composites, crowns, etc.

- Preventive Care** — sealants, fluoride treatment, prophylaxis

- Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____

Date _____

Address _____
Street City ZIP Code

Telephone _____