Allen – Otter Creek C.C.S.D. #65
Ransom Grade School

400 S. Lane Street
Ransom, Illinois 60470

Lindsey Paul
Principal
815-586-4611

Dear Parents/Guardians,

Before we realize it, it will be August and time for school to start. Registration materials, including supply lists for the 2023-2024 school year, are enclosed in this packet and will be available to be printed online Friday, July 14th at www.ransomgradeschool.net. Completed forms and fees may be mailed to the school at any time or brought to the school Tuesday-Thursday from 9:00 am- 1:00 pm, starting Tuesday, July 18th. All forms must be completed, and fees paid on or before Friday, August 11th or a $10.00 fee for each student not registered will be added. The school will not be open for evening registration. Our first day back to school will be Wednesday, August 16, 2023 and you will receive all information regarding that during the summer months.

If you have any questions about any form, please call the school or email Mrs. Kostal at ckostal@ransomgradeschool.net. The administration and faculty are looking forward to another successful year. Enjoy your summer!

Required Physical Forms:
Kindergarten: Physical, Dental, and Vision Exam Forms
Second Grade: Dental Exam Form
Sixth Grade: Physical and Dental Exam Forms
All Student Athletes are required to have a current sports physical

Sincerely,

Mrs. Lindsey Paul

RGS 2023-2024

These dates are subject to change

Day	Date	Time	Event	Notes
Wed.	Aug. 16	8:30	Teacher Institute	No student attendance
Wed.	Aug. 16	5:30-6:30	Welcome Back Night	Welcome in gym; Rotate through classrooms to meet teachers and drop off supplies
Thurs.	Aug. 17	8:30-2:20	First Day for Students	Students dismissed at 2:20
	Aug. 17-Sept. 1	2:20 Dismiss	Early Dismissal Days	Students dismissed at 2:20 Teacher Training
Mon.	Sept. 4		Labor Day	No School
Thurs.	Sept. 7	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Thurs.	Sept. 21	2:20 Dismiss	Professional Development	Students dismissed at 2:20
Fri.	Sept. 29	11:30 Dismiss	School Improvement Day	Students dismissed at 11:30
Thurs.	Oct. 5	11:30 Dismiss	Faculty Meeting	Students dismissed at 11:30
Fri.	Oct. 6		County Institute	No Student Attendance
Mon.	Oct. 9		Columbus Day	No Student Attendance
Fri.	Oct. 13		End of 1st Quarter	Report Cards at P/T Conferences
Wed.	Oct 18	2:20 Dismiss	P/T Conferences	Students dismissed at 2:20, Conferences 2:30-5:30
Wed.	Oct. 25	2:20 Dismiss	P/T Conferences	Students dismissed at 2:20, Conferences 2:30-5:30
Tues.	Oct. 31	2:20 Dismiss	Halloween	Students dismissed at 2:20
Thurs.	Nov. 2	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Fri.	Nov. 10	11:30 Dismiss	School Improvement Day	Students dismissed at 11:30
Thurs.	Nov. 16	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Tues.	Nov. 21	2:20 Dismiss	Last Day prior to Break	Students dismissed at 2:20
Wed-Fri.	Nov. 22-24		Thanksgiving Break	No School
Thurs.	Dec. 7	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Fri.	Dec. 15		End of 2nd Quarter	Report Cards go home the following week
Thurs.	Dec. 21	6:00	Winter Program	Students dismissed at 2:20
Fri.	Dec. 22		Last Day prior to Break	Students dismissed at 2:20
Mon.-Fri.	Dec. 25-Jan. 6		Winter Break	No School
Mon.	Jan. 8		School Resumes	
Fri.	Jan. 12	11:30 Dismiss	School Improvement Day	Students dismissed at 11:30
Mon.	Jan. 15		Martin Luther King Jr. Day	No School
Thurs.	Jan. 18	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Thurs.	Feb. 1	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Thurs.	Feb. 15	2:20 Dismiss	Professional Development	Students dismissed at 2:20
Fri.	Feb. 16		P/T Conferences	No Student Attendance
Mon.	Feb. 19		President's Day	No School
Thurs.	Feb. 29	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Fri.	March 1		End of 3rd Quarter	Report Cards go home the following week
Thurs.	March 14	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Thurs.	March 28	11:30 Dismiss	School Improvement	Students dismissed at 11:30
Thurs.	March 28	11:30 Dismiss	Last Day Prior to Break	Students dismissed at 11:30
Fri.-Fri.	March 29-April 5		School not in Session	No School- Spring Break
Mon.	April 8		School Resumes	
Thurs.	April 18	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Thurs.	May 2	2:20 Dismiss	Faculty Meeting	Students dismissed at 2:20
Thurs.	May 16	2:20 Dismiss	Professional Development	Students dismissed at 2:20
Thurs.	May 23	11:30 Dismiss	Tentative Last Day of School	Students dismissed at 11:30, Report Cards go home
Fri.	May 24	Tentative	Teacher Institute	Tentative (without 5 Emergency Days)
Mon.	May 27		Memorial Day	No School
Mon.	June 3		Last Day if all 5 Emergency Days are Used	

Allen – Otter Creek CCSD #65
Schedule of Fees for 2023-2024 School Year

Fee	Grade	Amount
Book rental	K-8	$65.00
**Milk fee (1/2 pt. daily)	K	$63.00
Breakfast	K-8	$1.35
Lunch	K-3	$2.85
Lunch	4-8	$3.05
Lunch	Adult	$3.05
Milk ** Milk price is subject to change	K-8	$.35
Extracurricular fee	5-8	$25.00/activity. Not to exceed $50 per student per year or $100 per family per year
Uniforms	5-8	Uniform Cost for Replacement if damaged or lost Softball $30.00 Baseball $30.00 Girls BB $50.00 Shorts $50.00 Top Boys BB $50.00 Shorts Boys BB $50.00 Top Volleyball $52.00 Complete Uniform Soccer $30.00 Track $60.00 Complete Uniform
Art Fee	K-8	$6.00
Music Fee	K-8	$8.00
Student Locker Locks	5th grade and all new Jr. High students	$6.00
Fax	Individual request (No fee for community groups)	$3.00 first page + $1.00 each additional page
Laminate	Individual request (No fee for community groups)	$.50 / ft.
Athletic Admission	Adult Senior Visiting Student AOC Student/St. Mike's School with student ID	$3 $2 $2 $0

Registration Checklist

NEW students must provide the following:	
Certified copy of County Birth Certificate (hospital certificates will not be accepted)	
Race/ethnicity form	
Student Transfer form if student attended an Illinois public school last year	
Release of School Records form (forms available at the office)	
Required proof of residency (please see attached sheet)	
List of accepted proof of residence	
Custody documents when appropriate (forms available at the office)	
Individual Education Plan when appropriate	
ALL students must provide the following:	
Required proof of residency (please see attached sheet)	
List of accepted proof of residence	
Medication Form if medication will be distributed at school	
HIPPA Compliant Authorization Form	
Parent Signature Form	
Student information form	
Current medical and dental records (physicals for K,6,athletes) (dentals for K, 2, 6) Vision Exam (K)	
Allergy Information Letter	
Black Board Connect information sheet	
TeacherEase information sheet	
Parental Consent to Bill Medicaid	
Homeless Information Sheet	
Registered Sex Offender Notice	
SCHOOL will provide the following to parents:	
Handbook (a copy is included in the student planner)	
Fee total for registration: (K=$128, 1st- 8th = $65)	
Supply list	
School Calendar	
**Free / reduced Lunch Application	
**Optional insurance application	
**Waiver of Fees Application will be provided upon request	
Informational letters	

**Forms will be provided at registration

Allen – Otter Creek CCSD #65 New Student Registration Form

Legal name – First:		Middle:	Last:	
Entry Date at AOC:				
Grade upon entry:				
Gender:				
Date of Birth:				
Race:				
Language other than English spoken at home:				
Language other than English spoken by the student				
Optional: Parent/guardian is a member of a branch of the armed forces of the United States and is either deployed to active duty or expects to be deployed to active duty during the school year.				
Social Security Number:				
Doctor's Name:				
Doctor's Phone Number:				
Allergies or medical alerts:				
Does student have an IEP?		504 Plan?		
Information	Mother	Father	Emergency 1	Emergency 2
Name of:				
Student lives with (mark all that apply)				
Street address			X	X
City			X	X
State			X	X
Zip Code			X	X
Home phone				
Work phone				
Cell phone				
e-mail			X	X
Employer			X	X
Employer's city			X	X
Work position			X	X

In case of emergency, the school has permission to call the emergency contacts listed above who will take responsibility for my child. I, the undersigned, do hereby authorize school officials to contact the persons named on this card, and if in the judgment of the school, a physician is needed and we cannot be contacted, the school is directed to call the above listed doctor. If transportation is needed for our child, in case of emergency, we agree that she/he may be transported in a privately owned car or ambulance. I will not hold the school district financially responsible for the emergency care and/or transportation for said child.

Parent(s) signature(s): _____

MEDICATION FORM

Student: _____ Date of Birth: _____

TO BE COMPLETED BY THE PHYSICIAN OR AUTHORIZED PRESCRIBER

Name of Medication: _____

Reason for taking: _____

Form of medication/treatment:

_____ Tablet/Capsule _____ Liquid _____ Inhaler _____ Other

Instructions (schedule and dose to be given):

Start: _____

Stop: _____

Restrictions and/or important side effects:

Specail storage requirements: _____

FOR INHALER OR EPI-PEN USE ONLY

This student is both capable and responsible for self-administering this medication:

This student may carry this medication on them:

PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

TO BE COMPLETED BY PARENT/GUARDIAN

I give my permission for (name of child) _____ to receive the above medication at school according to standard school policy. I understand the medication will be in its original container.

HIPAA-Compliant Authorization

I hereby authorize Allen – Otter Creek CCSD #65 and

_____ (insert name, address, phone of health care provider)

_____ (insert name, address, phone of health care provider)

_____ (insert name, address, phone of health care provider)

to exchange immunization records, medication information, and/or vision & hearing results in order to provide school personnel and medical professionals with information needed for educational evaluations, program planning, health assessments, medical evaluation and treatment, and _____ (other).

This authorization is valid for one calendar year and will expire one year from the date of signature. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____

Parent Signature Date

PARENT SIGNATURE FORM

Student's Name: _____ Grade: _____

Please write YES or NO, or provide the requested information, in each space below:

_____ My child's picture and name may be published in newspapers.

_____ My child's picture may appear on the district's web site with no name given.

_____ Work and projects produced by my child may be posted along with a first name on the district's web site.

_____ My child has adequate accident and hospitalization insurance with _____ (company name). Additional insurance through a provider approved by Allen – Otter Creek CCSD is not desired for the school year.

_____ I, the parent / guardian for the above named student, agree to hold the Allen – Otter Creek CCSD #65, its Board of Education, officers, and employees harmless from any liability whatsoever by reason of participation in any and all school sponsored extracurricular and co-curricular activities during the school year.

_____ I, the parent / guardian for the above named student, have read and discussed the Allen – Otter Creek Handbook with the student.

_____ I, the parent / guardian for the above named student, have read and discussed the Allen – Otter Creek Computer Code of Ethics found in the Handbook with the student. The student understands and will abide by the Allen – Otter Creek Computer Code of Ethics. We understand that any violation of this policy is unethical, and in relation to the use of the Internet, may even constitute a criminal offense. Should our child commit any violation, his/her access privileges may be revoked and district disciplinary action and/or appropriate legal action may be taken.

As the parent or guardian of this student, I have read the Allen – Otter Creek School District Computer Code of Ethics and understand that access to a computer is designated for educational purposes and that the District has taken available precautions to eliminate controversial material. However, I also recognize it is impossible for the Allen – Otter Creek School District to restrict access to all controversial materials and I will not hold said district or the Illinois State Board of Education responsible for materials acquired on the Internet or through sources not sanctioned by the District. Further, I accept full responsibility for supervision if and when my child's use is not in a school setting. I hereby give my permission to grant computer access for my child and certify that the information contained on this from is correct.

Parent/Guardian's signature _____ date _____

Student's signature in acknowledgment of computer use agreement and Student Handbook receipt and discussion _____

Student's Name: _____ **SIS ID:** _____
(pre-printed by school district) (pre-printed by school district)

INSTRUCTIONS: This form is to be filled out by the student's parents or guardians, and both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student 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**

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.

Part B. What is the student'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 peoples 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.)

Note: Data collected on this form must be maintained by the school district for three years. However, when there is litigation, a claim, an audit, or another action involving this record, the original responses must be retained until the completion of the action.

Allen – Otter Creek CCSD #65
Ransom Grade School

400 S. Lane Street
Ransom, Illinois 60470

Lindsey Paul
Principal
815-586-4611

Dear Parent/Guardian:

It is our goal to ensure a safe and supportive environment for all of our students. The legislature passed Public Act 96-0349 to address safe and supportive environments for students with life-threatening allergies or chronic illnesses. Public Act 96-0349 requires our school district to annually inform parents of students with life-threatening allergies or life-threatening chronic illnesses of the applicable provisions of Section 504 of the Rehabilitation Act of 1973 and other applicable federal statutes, state statutes, federal regulations and state rules. The intent of this notice is to inform you of your student's rights and projections that promote safe participation in our school's programs.

If your student has a life-threatening allergy or life-threatening chronic illness, please notify either Cristyn Kostal or Lindsey Paul at (815) 586-4611. Section 504 protects students from discrimination due to a disability that substantially limits a major life activity. If a student is suspected of having a qualifying disability under Section 504, the school will convene a Section 504 team to determine eligibility and as needed, appropriate support and services to address the student's individual needs. Under Section 504, a student with a physical or mental impairment which substantially limits a major life activity, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, and learning, may meet the definition of a student with a disability. If the student has a qualifying disability, the 504 team will look at how the disability limits access to school programs and whether the student is eligible for protection from discrimination under Section 504. If the student is protected under Section 504, an individual Section 504 plan will be developed and implemented to provide the needed support so that the student can access his or her education as effectively as students without disabilities.

Not all students with life-threatening allergies and life-threatening chronic illnesses may be eligible under Section 504. Our school district also may be able to appropriately meet a student's needs through the Educational Support System with an Educational Support team plan and an Individualized Health Care Plan (IHCP).

Other students may not only be protected by Section 504, but may also be eligible for special education. The Section 504 coordinator or the nurse/DSP may help with referrals to the special education administrator for the school district. Thank you.

Sincerely,

Lindsey Paul

Mrs. Lindsey Paul
Principal

Allen – Otter Creek CCSD #65
Ransom Grade School

400 S. Lane Street
Ransom, Illinois 60470

Lindsey Paul
Principal
815-586-4611

Dear Parents/Guardians,

Keeping you informed is a top priority at Ransom Grade School. That's why we adopted Blackboard Connect, which allows us to send a telephone or text message to you providing important information about school events or emergencies. We anticipate using Blackboard Connect to notify you of school delays or cancellations due to inclement weather or sport event cancellations or changes. In the event of an emergency at school, you can have peace of mind knowing that you will be informed immediately by phone.

What you need to know about receiving calls sent through Blackboard Connect:

- Caller ID will display the school's main number when a general announcement is delivered.
- Blackboard Connect will leave a message on any answering machine or voicemail.

We are very excited to incorporate Blackboard Connect as a tool to improve parent communication and look forward to having the ability to deliver real time information to you.

Sincerely,

Lindsey Paul

Mrs. Lindsey Paul
Principal

BLACKBOARD CONNECT INFORMATION SHEET

Please update your file information:

Parent/ Guardian Name: _____

Children's names: _____

_____

_____

Home Phone Number _____

Cell Phone Number _____

Please indicate if the cell phone number can be used to text a message to you. Yes No

E-mail _____

Additional Phone Numbers: _____

_____

_____

Allen – Otter Creek CCSD #65
Ransom Grade School

400 S. Lane Street
Ransom, Illinois 60470

Lindsey Paul
Principal
815-586-4611

Dear Parents/Guardians,

TeacherEase, a student data management system at Ransom Grade School is available to parents on the Internet. This system will allow you to view your child's grades, lunch balances and attendance on-line. In order to provide this service, the school will need an active email account for your family. If you would like to take advantage of this service, please fill out the form below and return it to the school.

Parent Name:

_____

Email:

_____

Allen – Otter Creek CCSD #65
Ransom Grade School

400 S. Lane Street
Ransom, Illinois 60470

Lindsey Paul
Principal
815-586-4611

Medicaid Data Release Consent

This notification is provided to the parents/guardians of all special education students. We do so to avoid having to ask about family finances and insurance decisions.

If your child receives special education services and is also Medicaid eligible, the school district ca seek partial reimbursement for Medicaid for health services documented in your child's Individualized Education Program (IEP). Medicaid reimbursement is a source of federal funds approved by Congress to help school districts maintain and improve diagnostic and therapeutic services for students.

The reimbursement process requires the school district to provide Medicaid with your child's name, birthdate and Medicaid number. Federal law requires your written consent to release this data to Medicaid.

- Only data for Medicaid eligible students will be released.
- You can deny the district the right to release this date now or at any time in the future.
- Regardless of your decision the district must continue to provide, at no coas to youm the services listed in your child's IEP.

When considering your decision, please note that this program has no impact on current of future Medicaid benefits for you, the student or your family. Under federal law, your decision to participate in this program CANNOT:

- Decrease lifetime coverage or any other public insurance benefit,
- Result in the family paying for services that would otherwise be covered by Medicaid,
- Increase you premiums or lead to discontinuation of benefits or insurance, or
- Result in the loss of eligibility for home and community-based waivers.

Your consent allows us to recover a portion of the costs associated with providing health services to your child.

☐ I approve of the district releasing data to Medicaid.

☐ I do not approve of the district releasing data to Medicaid.

Child's Name: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____

GETTING YOUR CHILD IN SCHOOL

If you:

- Live in a shelter or motel
- Share housing with relative because you lost your housing
- Live in a campground, car, old building or other temporary shelter
- Don't have a permanent address

You have the right to:

- Enroll your child in school immediately even without school or medical records
- Get help from the district liaison with immunizations and/or medical records
- Choose your child's old school or school closest to where you are living now
- Get transportation to school for your child
- Dispute enrollment or transportation decision
- Participate in your child's education

For Help, Call Lindsey Paul at 815-586-4411.

Your School District Homeless Education Liaison

Or call the Illinois State Board of Education
1-800-215-6379

Project Coordinated by the Adult Learning Resource Center in Partnership with ROE #26 – Hancock/McDonough, Macomb
Supported 100% through a Grant from The Illinois State Board of Education under the
McKinney-Vento Homeless Assistance Act.

McKinney-Vento Homeless Program

LaSalle, Marshall, Putnam, Woodford Counties

Lisa Leamy, Homeless Liaison
541 Chartres Street
LaSalle, IL 61301
Telephone: (815) 228-0305
Fax: (815) 434-0026

DECLINATION OF OFFERED SERVICES

_____ (Student Name)

Even though the above-named student is entitled through provisions made by the McKinney-Vento Homeless Education Assistance Act to have offered to him/her free school breakfasts and/or lunches on identified student attendance days, the above-named student and/or his/her parent/guardian declines to take advantage of the afore-mentioned meals.

_____(Student Signature)_____(Date)

_____(Parent Signature)_____(Date)

_____(Witness Signature)_____(Date)

Witnessing Agency_____

Effective: 08/2006 for all school districts in LaSalle, Marshall, Putnam, and Woodford Counties

Information Available to Parents Regarding Registered Sex Offenders (P.A. 94-994)

P.A. 94-994 makes several changes to the sex offenders' registration law [730 ILCS 150/3] and the information sex offenders must provide upon registration that is available to the public. Link to P.A. 94-994: http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=094-0994&GA=094

Per P.A. 94-994, during either school registration or parent-teacher conferences, a principal or a teacher must notify the parents of children attending the school that they may access information regarding registered sex offenders that is available to the public. This law is intended to increase awareness of the Illinois Sex Offender Registry (I-SOR) and to encourage parents to review the information available to them

The Illinois Sex Offender Registry is available through a link on the Illinois State Police website, at http://www.isp.state.il.us/. Individuals may search the database by name, zip code or county. Access is free.

Notice to Parents/Guardians and Students of Their Rights Concerning a Student's School Records

This notification may be distributed by any means likely to reach the parents/guardians.

The District maintains two types of school records for each student: *permanent* record and *temporary* record. These records may be integrated.

The *permanent record* shall include:

- Basic identifying information, including the student's name and address, birth date and place, gender, and the names and addresses of the student's parent(s)/guardian(s)
- Academic transcripts, including grades, class rank, graduation date, grade level achieved, and scores on college entrance examinations
- Attendance record
- Accident and health reports
- Record of release of permanent record information in accordance with 105 ILCS 10/6(c)
- Scores received on all State assessment tests administered at the high school level (that is, grades 9 through 12)

The *permanent record* may include:

- Honors and awards received
- School-sponsored activities and athletics

No other information shall be kept in the permanent record. The permanent record shall be maintained for at least 60 years after the student graduated, withdrew, or transferred.

All information not required to be kept in the student permanent record is kept in the student *temporary record* and must include:

- A record of release of temporary record information in accordance with 105 ILCS 10/6(c)
- Scores received on the State assessment tests administered in the elementary grade levels (that is, kindergarten through grade 8)
- Information regarding serious infractions (that is, those involving drugs, weapons, or bodily harm to another) that resulted in expulsion, suspension, or the imposition of punishment or sanction
- Information provided under the Abused and Neglected Child Reporting Act (325 ILCS 5/8.6), including any final finding report received from a Child Protective Service Unit
- Completed home language survey

The *temporary record* may include:

- Family background information
- Intelligence test scores, group and individual
- Aptitude test scores
- Reports of psychological evaluations, including information on intelligence, personality and academic information obtained through test administration, observation, or interviews
- Elementary and secondary achievement level test results
- Participation in extracurricular activities, including any offices held in school-sponsored clubs or organizations
- Honors and awards received
- Teacher anecdotal records
- Other disciplinary information
- Special education files, including the report of the multidisciplinary staffing on which placement or nonplacement was based, and all records and tape recordings relating to special education placement hearings and appeals
- Verified reports or information from non-educational persons, agencies, or organizations
- Verified information of clear relevance to the student's education

The Family Educational Rights and Privacy Act (FERPA) and the Illinois Student Records Act afford parents/guardians and students over 18 years of age ("eligible students") certain rights with respect to the student's education records. They are:

5. **The right to prohibit the release of directory information concerning the parent's/ guardian's child.**

   Throughout the school year, the District may release directory information regarding students, limited to:

   Name
   Address
   Gender
   Grade level
   Birth date and place
   Parents'/guardians' names and addresses
   Academic awards, degrees, and honors
   Information in relation to school-sponsored activities, organizations, and athletics
   Major field of study
   Period of attendance in school

   Any parent/guardian or eligible student may prohibit the release of any or all of the above information by delivering a written objection to the Building Principal within 30 days of the date of this notice. No directory information will be released within this time period, unless the parents/guardians or eligible student is specifically informed otherwise.

   A photograph of an unnamed student is **not** a school record because the student is not individually identified. The District shall obtain the consent of a student's parents/guardians before publishing a photograph or videotape of the student in which the student is identified.

6. **The right to request that military recruiters or institutions of higher learning not be granted access to your secondary school student's name, address, and telephone numbers without your prior written consent.**

   Federal law requires a secondary school to grant military recruiters and institutions of higher learning, upon their request, access to secondary school students' names, addresses, and telephone numbers, unless the parents/guardians request that the information not be disclosed without prior written consent. If you wish to exercise this option, notify the Building Principal where your student is enrolled for further instructions.

7. **The right contained in this statement: No person may condition the granting or withholding of any right, privilege or benefits or make as a condition of employment, credit, or insurance the securing by any individual of any information from a student's temporary record which such individual may obtain through the exercise of any right secured under State law.**

8. **The right to file a complaint with the U.S. Department of Education concerning alleged failures by the District to comply with the requirements of FERPA.**

   The name and address of the Office that administers FERPA is:

   Family Policy Compliance Office
   U.S. Department of Education
   400 Maryland Avenue, SW
   Washington DC 20202-4605

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:** * indicates invalid dose		
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?	Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	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** **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 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**

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, 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, 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 require attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy, and 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
Name of School:	ZIP Code	Grade Level:	
Parent or Guardian: Last Name	First Name		

Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races

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To be completed by dentist

Date of Most Recent Examination:_____ (Check all services provided at this examination date)
☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ 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). Please 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:_____

Dental Office Address: _____ Office phone number: _____

Signature of Dentist _____ Date _____

State of Illinois
Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City		ZIP Code
Name of School:			ZIP Code	Grade Level:
Parent or Guardian:	Last Name		First Name	

Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid / All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid / All Kids.

☐ My child is enrolled Medicaid / All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid / All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Parent or Guardian Signature _____ 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

IOCI 0600-10

Printed by Authority of the State of Illinois

Revised 07/2021

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

Optometrist or physician (such as an ophthalmologist)
who provided the eye examination ❑ MD ❑ OD ❑ DO

Address _____

_____

Phone _____

Consent of Parent or Guardian

I agree to release the above information on my child or ward to appropriate school or health authorities.

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

State of Illinois
Illinois Department of Public Health

Eye Examination Waiver Form

Please print:

Student Name _____ Birth Date _____
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name _____ Grade Level_____ Gender: ❑ Male ❑ Female

Address _____
(Number) (Street) (City) (ZIP Code)

Phone_____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

❑ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ ALL KIDS.

❑ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

❑ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations:

_____

_____

Signature _____ Date _____

(Source: Added at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois

IOCI 13-378