Rev. 06/2020

Chicago Public Schools
School Enrollment Form

*School Name*____

Student Information Student's siblings' names if currently enrolled in CPS: ________________ ________________ ________________	____________ Student ID#	**School Use Only:** **Prevent duplicate student records. Search in SIS for an existing Student ID <u>before</u> creating a new one.**
	Legal Last Name ____ Legal First Name ____ Legal Middle Name ____ Generation (Jr., etc) ____ Legal Sex (F/M/X/N) ____ Birth date *(mm/dd/yyyy)* ____ Registration Grade Level *(when first entering CPS)* ____ Affirmed Gender* (F/M/N) ____ Affirmed First Name* ____ Affirmed Middle Name* ____ *Optional. For more information regarding affirmed gender and affirmed name, please visit: Supporting Gender Diversity Toolkit	
Personal Information	Y / N Birth Certificate on File ____ Birth Verification Type ____ *** Birth Country** ____ Birth State ____ Birth City ____ * Complete if student was <u>not</u> born in the United States (US) or one of its Territories: **Date of first enrollment in any US School:** ____________ **Full Years completed school in US:** ____________ **School Use Only: Note that "*Date of first enrollment in any US School*" becomes a required field in SIS if "*Birth Country*" is <u>not</u> the US or one of its Territories.**	
Student Address/Phone Physical (Home) Address Mailing Address *(if different than Home)*	Street Number and Name ____ Apt. ____ City ____ State ____ Zip Code ____ Street Number and Name ____ Apt. ____ City ____ State ____ Zip Code ____ Home Phone Number________________	
Demographic, Home Language, Parent/Guardian Contacts, Emergency/Health Information	Federal Ethnic and Race Categories: *(Enter information into SIS from the Race and Ethnicity Survey form)* Home Language Survey: *(Enter information into SIS from the Home Language Survey form)* Parent/Guardian Contacts: *(Enter information into SIS from the Request for Emergency and Health Information form)* Emergency/Health Information: *(Enter information into SIS from the Request for Emergency and Health Information form)*	
Enrollment **Enrollment Status Codes:** 01 – No Former School 02 – Chicago Public School (to incl. Charter/Contract) 03 – Chicago Private School 04 – IL Public Schl, not Chicago 05 – IL Private Schl, not Chicago 06 – US Public Schl, not Illinois 07 – US Private Schl, not Illinois 08 – Not in USA	*School Transferring From (*(if not a Chicago Public, Charter or Contract School)* ____ City and State ____ *Is the student in good standing? __Y / N__ *(Instructions to school: for out-of-state public school or any private school students, a certification of "good standing" should be received from the Parent/Guardian. Refer to CPS Policy 10-0623-PO1 for more information.)* Last Chicago Public, Charter, or Contract School Attended ____________ Is the student receiving any type of Special Education services? __Y / N__ *(Instructions to school: if yes, please notify the Case Manager.)* Student Enrolled by ____________ *(Print Name and Relationship)* Signature of Parent/Guardian ________ Date of Enrollment ________ **School Use Only:** Enrollment Status Code *(insert a # from the left)* ____ Grade Level____ Homeroom/Division #____	

Must have an original signature; an electronic signature is not acceptable.

Rev. 07/2017 Chicago Public Schools

Request for Emergency and Health Information

School Name: ____

PARENTS/GUARDIANS: The school must have on file emergency information that can be used to contact you. Please print clearly. Whenever there is a change in this information, immediately notify the school in writing.

______________ ____ ____________
Student ID# Last Name First Name Middle Name Homeroom #

________________ ____ ______________
Birth Date (mm/dd/yyyy) Student Home Address Student Home Phone #

Confidential Information Box 1	**Confidential Information Box 2**
Complete this box only if (1) it reflects your child's current living situation; OR (2) it reflects your living situation if you are a youth not living with a Parent or Guardian. (Your answer will help school staff with enrollment and may enable the student to receive additional services.) Check one box: ☐ in a car/park/other public place ☐ doubled-up ☐ in a hotel/motel ☐ in a shelter ☐ in transitional housing	Is there a current Order of Protection or No Contact Order which concerns this student? ☐ Yes ☐ No
School Note: If any box is checked, see the CPS Policy 702.5.	**School Note: If "Yes," follow CPS Policy 704.4 procedures. Enter information in *Legal Alert* field and update contact information, as needed, in SIM.**

Parent/Guardian and Emergency Contact Information: Add extra contacts on the back of this form, if needed.

	Parent/Guardian Contact	**Parent/Guardian Contact**
Contact Name		
Relationship to Student		
Check all that apply:	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pickup	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pickup
Home Address, *if different from student's*		
Home Phone Number, *if different from student's*		
Cell Phone Number		
Email Address		
Name and Address of Employer		
Work Phone Number		
* Communication Language		
* CPS communicates via phone calls. Select the language that should be used to communicate with you. Languages available for mass communication at this time are English and Spanish (note: other languages upon availability).		

List the name of a relative or neighbor who can also be notified in an emergency and has permission to pick up the student:

____
Name Home Address Telephone # Relationship

Family Doctor's Name, Address, and Phone Number: I authorize you to call my family doctor, if necessary, in an emergency.

____

Student Health Insurance: (select only one of the three)

☐ Illinois Medical Card/All Kids: provide student's medical ID # ______________________________*(9-digit number located on back of card)*

☐ No Insurance: are you interested in applying for the Illinois Medical Card/All Kids? ☐ Yes ☐ No

☐ Private/Employer Health Insurance: no additional information needed

Children of Military Personnel *(optional)*

As the Parent or Guardian, are you a member of a branch of the armed forces of the United States? ☐ Yes ☐ No

If yes, are you either deployed to active duty or expect to be deployed to active duty during the school year? ☐ Yes ☐ No

I certify that the information on this form is correct:

____**(Parent/Guardian Signature)**____________________**(Date)**

CPS FAMILY INCOME INFORMATION FORM 2021-2022

Parents - Please return form to school by September 30, 2021.

Schools – Please enter into ODA by October 18, 2021

School Name *(Nombre de Escuela)*: ____________

The purpose of this form is for CPS to obtain information about families' income to determine school funding. CPS and your school may receive additional funding based on the number of low-income families enrolled. Please complete this form and return it to the school's main office. (El propósito de este formulario de CPS es obtener información sobre el ingreso de las familias para determinar los fondos escolares. CPS y su escuela pueden recibir fondos adicionales basados en la cantidad de familias de bajos recursos matriculadas. Por favor, complete este formulario y entréguelo a la oficina de la Escuela)

Part 1 – HOUSEHOLD INFORMATION (INFORMACIÓN SOBRE EL HOGAR)
List names of all members of your household living with you. *(Escriba los nombres de todas las personas que viven en su hogar.)*
**Foster Children (legal responsibility of welfare agency or court)*

Part 2: SNAP / TANF number of any member of your household *(go to step 6)*
***(N° de SNAP / TANF de cualquier integrante de su hogar** (pase al n°6))*

Part 3 – Homeless , Migrant, Runaway Child, or child enrolled in Head Start *(Niño sin Hogar, Emigrante, Fugitivo o Niño en el programa Head Start)*

Foster Child? (*¿Hijo de Crianza?*)	CPS Student? (*¿Estudiante de CPS?*)	All Household Member Names Last *(Apellido)* First *(Nombre)* MI *(Inicial)*	Date of Birth *(Fecha de Nacimiento)*	DHS Case Number *(Numero del Caso del DHS)*
☐	☐		/ /	
☐	☐		/ /	
☐	☐		/ /	
☐	☐		/ /	
☐	☐		/ /	
☐	☐		/ /	

☐ **Homeless** ☐ **Migrant** ☐ **Runaway** ☐ **Head Start**

Homeless, Migrant, Runaway or Head Start Liaison Signature

Date (*Fecha*)

Part 4 – List Household Members With Income (*SKIP THIS if you answered any of steps 2 or 3*) Enter the amount of income and how often it is received for each household member. *(Nombres de los integrantes de su hogar que perciben ingresos. Para cada uno, indique sus ingresos y cada cuánto los recibe. DEJE EN BLANCO si ha contestado la Sección 2 o 3 de esta solicitud.)*
Frequency *(Frecuencia)*: Weekly *(Semanalmente)* Every 2 Weeks *(Cada dos semanas)* Twice Monthly *(Dos veces al mes)* Monthly *(Mensualmente)* Annually *(Anualmente)*
OTHER INCOME can be but not limited to Welfare, Child Support, Retirement, Social Security, Worker's Comp. and Unemployment.

Household Member Names With Income First *(Nombre)* MI (Inicial) Last *(Apellido)*	Gross Income (before deductions) *(Ingresos Brutos)*	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually	Other Income *(Todos Otros Ingresos)*	Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually
	$	○	○	○	○	○	$	○	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	○
	$	○	○	○	○	○	$	○	○	○	○	○

Part 5 – *Opt In of information about other benefits.* *(Otros Beneficios)*

☐ **YES!** I am interested in applying for a waiver of instructional fees. **SI!** Me interesa aplicar por la exoneración del pago de enseñanza.

☐ **YES!** I am interested in applying for the Supplemental Nutrition Assistance Program (SNAP) and/or the Medicaid Program. ***SI!*** *Me interesa aplicar para el Programa de Asistencia de Nutrición Suplementaria (SNAP) y/o la Medicaid.*
Or call 773-553-5437

Signature (Firma):

Part 6 – Signature *(Firma)*

I certify that all above information is true and all income is reported. I understand that information gathered from this form will be used to calculate Federal funding eligibility for the school and that school officials.may verify (check) the information as being accurate; and that if I purposely give false information, I may be prosecuted. (Certifico que toda la información indicada arriba es verdadera y que he reportado todos nuestros ingresos. Entiendo que la escuela recibirá fondos del gobierno federal basado en la información en este formulario y que los funcionarios escolares puedan verificar la fidelidad de la información; y si doy información falsa intencionalmente, me pueden llevar a juicio).

Signature of adult household member *(Firma del miembro adulto del hogar)*

Parent / Guardian First Name *(Nombre del adulto del hogar)*

Parent / Guardian Last Name *(Apellido del adulto del hogar)*

Address *(Dirección postal o de domicilio)*

Zip Code *(Código Postal)*

Date *(Fecha)* / /

SCHOOL USE ONLY Initial Determination: ☐ **ELIGIBLE** (FREE OR REDUCED) ☐ **INELIGIBLE** (DENIED, N/A OR ?)

CONFIRMATION *(Only for those applications selected for verification)*	***Signature of Confirming Official :(REQUIRED)***	**Date:**

Part 7- Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Mark one or more racial identities: ☐ Asian ☐ White ☐ Black / African American ☐ American Indian / Alaska Native ☐ Native Hawaiian / Other Pacific Islander

INSTRUCTIONS FOR COMPLETING FAMILY INCOME INFORMATION FORM

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SNAP/TANF, FOLLOW THESE INSTRUCTIONS: Part 1: List all of the household members and date of birth (for students). (Attach another application if necessary.) **Part 2:** List the case number of any household member that corresponds with their name in Part 1. Do not use your Medicare card number. **Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. **Part 6:** Sign the Form. **Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A HOMELESS, MIGRANT, RUNAWAY, OR HEAD START CHILD, FOLLOW THESE INSTRUCTIONS: Part 1: List all of the household members and date of birth (for students). **Skip to Part 3:** Check the appropriate box; obtain date and signature of Homeless, Migrant, or Runaway Liaison/Coordinator. **Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. **Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS: If all children in the household are foster children: Part 1: List Students name, date of birth and check the box for "Foster Child" to the left of your foster child's name. **Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. **Part 6:** Sign the Form.
If some children in the household are foster children: Part 1: List Students name, date of birth and check the box for "Foster Child" to the left of your foster child's name. **Skip to Part 4:** Follow the instructions under ALL OTHER HOUSEHOLDS INSTRUCTIONS (Part 4) below. **Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. **Part 6:** Sign the Form**. Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS: Part 1: List all of the household members and date of birth (for students). **Skip to Part 4:** Follow these instructions to report total household income:
Column 1 **Name:** List the first and last name of **each** person in your household who receives income, related or not (such as grandparents, other relatives, or friends. Attach another sheet of paper if necessary.). ***Columns 2 & 3*** **Gross Income Amounts and Frequency:** The Gross Income is the amount earned before taxes and other deductions. It should be noted on pay stubs. This is not the same as take-home pay. List the amount each person receives from these sources. Round to the nearest dollar. **All other** sources of income should also be noted on this application. Next to each amount fill in the circle that indicates how often the person receives their stated income (weekly, every other week, twice a month, monthly, or annually). If you do not wish to disclose your income, please note "decline to answer" in this section. Be aware that if you are low-income, failure to share household income information could reduce the funds your school may otherwise receive. **Part 5:** If you are interested in sharing application information with Medicaid or SNAP agencies, check the box and sign. **Part 6:** Sign the Form. **Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

INSTRUCCIONES PARA LLENAR LA SOLICITUD

SI SU HOGAR RECIBE BENEFICIOS DE SNAP/TANF, SIGA ESTAS INSTRUCCIONES: Sección 1: Escriba el nombre de cada persona en su hogar y fecha de nacimiento (de alumnos). (Adjunte otra solicitud, si es necesario.) **Sección 2:** Escriba el número de caso correspondiente a cada persona que recibe SNAP/TANF. No escriba el número de la tarjeta médica. **Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de All Kids (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 6:** Un miembro adulto del hogar **debe** firmar la solicitud. **Sección 7:** Marque los cuadritos que corresponda a su identidad racial y étnica.

SI USTED ESTÁ APLICANDO DE PARTE DE UN NIÑO(A) SIN HOGAR, EMIGRANTE, FUGITIVO(A) o NIÑO EN EL PROGRAMA HEAD START, SIGA ESTAS INSTRUCCIONES: Sección 1: Escriba el nombre de cada persona en su hogar y fecha de nacimiento (de alumnos). **Avance a Sección 3:** Marque el cuadrito que corresponda y obtenga la fecha y firma del coordinador escolar de alumnos sin hogar, emigrantes o fugitivos. **Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de All Kids (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 7:** Marque los cuadritos que corresponda a su identidad racial y étnica.

SI USTED ESTA APLICANDO DE PARTE DE UN HIJO DE CRIANZA, SIGA LAS SIGUIENTES INSTRUCCIONES: Si todos los niños en el hogar son hijos de crianza: Sección 1: Escriba el nombre, fecha de nacimiento y marque el cuadrito "Hijo de Crianza" al lado del nombre de su(s) hijo/a(s) de crianza. **Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de All Kids (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 6:** Un miembro adulto del hogar **debe** firmar la solicitud. **Si algunos, pero no todos, los niños en el hogar son hijos de crianza: Sección 1** Escriba el nombre, fecha de nacimiento y marque el cuadrito "Hijo de Crianza" al lado del nombre de su(s) hijo/a(s) de crianza. **Avance a Sección 4: Siga las instrucciones bajo TODOS LOS DEMÁS HOGARES (Sección 4) más abajo. Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de All Kids (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 6:** Un miembro adulto del hogar **debe** firmar la solicitud. **Sección 7:** Marque los cuadritos que corresponda a su identidad racial y étnica.

TODOS LOS DEMÁS HOGARES, SIGAN ÉSTAS: Sección 1: Escriba el nombre de cada persona en su hogar y fecha de nacimiento (de alumnos). (Adjunte otra solicitud, si es necesario.). **Avance a Sección 4:** Siga estas instrucciones para reportar el ingreso total de su hogar:
Columna 1 **Nombre:** Escriba nombre y apellido de **cada** persona que vive en su hogar que recibe ingresos, sea pariente o no (tales como abuelos, otros parientes o amigos. Si es necesario, puede adjuntar una hoja adicional.). ***Columnas 2 & 3*** **Ingreso Bruto y cada cuánto es recibido:** El Ingreso Bruto es la cantidad ganada antes de restar impuestos y otras deducciones. Esa suma se encuentra generalmente en el talón del cheque de pago. No es lo mismo que el dinero que se lleva a la casa. Escriba la cantidad que cada persona recibe de estas fuentes de ingreso. No incluyan los centavos. **Todas** las fuentes de ingreso deben ser anotadas en esta solicitud. Al lado de la cantidad, marque el cuadrito que indica la frecuencia con que la persona recibe el ingreso (semanalmente, cada dos semanas, dos veces por mes, mensualmente o anualmente). **Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de Medicaid (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 6:** Un miembro adulto del hogar **debe** firmar la solicitud. **Sección 7:** Marque los cuadritos que corresponda a su identidad racial y étnica.

Home Language Survey 2021

07.2021 | Office of Language and Cultural Education

Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.
This form must be kept in the student's folder.

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 who need to be assessed for English language proficiency and may be eligible for English Learner services.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME
SCHOOL NAME		
STUDENT ID #	NETWORK	ROOM #

English — If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

1. Is a language other than English spoken in your home?	☐ Yes	☐ No	Language
2. Does the student speak a language other than English?	☐ Yes	☐ No	Language

Spanish/Español — Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la competencia de su niño en inglés.

1. ¿Se habla algún otro idioma que no sea inglés en su hogar?	☐ Sí	☐ No	Lenguaje
2. ¿Habla el estudiante algún otro idioma que no sea inglés?	☐ Sí	☐ No	Lenguaje

Chinese / 中文 — 如果兩個問題中有任何一題的答案為 "是"，根據法律要求，學校將評測您子女的英語水平。

1. 您的家庭是否說英語之外的其他語言？	☐ 否	☐ 是	語言
2. 您的子女是否說英語之外的其他語言？	☐ 否	☐ 是	語言

Arabic / العربية — إذا كانت الإجابة على أي من السؤالين نعم، فإن القانون تطلب من المدرسة تقييم إتقان طفلك للغة الإنجليزية .

هل تُستخدم لغة أخرى غير اللغة الإنجليزية في منزلك؟	☐ نعم	☐ لا	اللغة
هل يتحدث الطالب لغة أخرى غير اللغة الإنجليزية ؟	☐ نعم	☐ لا	اللغة

Polish/Polski — Jeśli udzielili Państwo twierdzącej odpowiedzi na którekolwiek z powyższych pytań, przepisy wymagają aby szkoła sprawdziła poziom znajomości języka angielskiego waszego dziecka.

1. Czy mówi się w domu językiem innym niż angielski?	☐ Tak	☐ Nie	Język
2. Czy uczeń mówi innym językiem niż angielski?	☐ Tak	☐ Nie	Język

Signature of School Official ____________ Date ____________ Parent/Guardian Signature ____________ Date ____________

Must have an original signature; an electronic signature is not acceptable.

OFFICE USE ONLY

If the parent/guardian does not speak English and the school does not have staff who speaks the parent/guardian's language, identify the language spoken by the parent/guardian through any assistance available in the school, i.e. using interpretation services from a vendor.

If the language is not included on the list of languages available on Aspen, enter "Other."

If the language spoken by the parent/guardian is not included on either page of this form, please visit the OLCE KC Page, Forms, and click on "Home Language Survey in Additional Languages" which will take you to ISBE's HLS page.

ASPEN REGISTRATION PROCESS

All five fields have to be entered on Aspen: date, answer to question 1, Home language, answer to question 2, and Native language.

When a language other than English is reported for only one of the questions on the form, that Non-English language has to be listed as both Home and Native Language in Aspen.

If there are two languages other than English listed, enter the language identified in question 2 as both Home and Native language.

English can be entered as the Home language ONLY if both questions are answered No and English is listed for both questions.

Home Language Survey 2021

07.2021 | Office of Language and Cultural Education

Chicago Public Schools

Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.
This form must be kept in the student's folder.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME
SCHOOL NAME		
STUDENT ID #	NETWORK	ROOM #

Bosnian/Serbian(Latin) Bosanski/Srpski

Ukoliko ste na bilo koje od ovih pitanja odgovorili sa „Da", škola će biti zakonski dužna da procijeni nivo znanja engleskog jezika kod vašeg djeteta.

1. Da li se u kući govori na stranom jeziku (različitom od engleskog)? ☐ DA ☐ NE Jezik

2. Da li učenik govori neki drugim jezikom (različit od engleskog)? ☐ DA ☐ NE Jezik

Romanian/Română

Dacă ați răspuns afirmativ la oricare dintre întrebări, prin lege, instituția de învățământ trebuie să evalueze cunoştințele de limbă engleză ale copilului dvs.

1. In familia dvs. se vorbeşte şi altă limbă decât engleza? ☐ Da ☐ Nu Limba

2. Studentul vorbeşte şi altă limbă decât engleza? ☐ Da ☐ Nu Limba

Urdu / اردو

اگر کسی بھی سوال کا جواب ہاں میں ہے تو ، قانون کے تحت اسکول سے آپ کے بچے کی انگریزی زبان کی مہارت کا اندازہ لگانا پڑتا ہے ۔

کیا آپ کے گھر میں انگریزی کے علاوہ کوئی دوسری زبان بولی جاتی ہے ؟ ☐ ہاں ☐ نہیں زبان

کیا طالب علم انگریزی کے علاوہ کوئی دوسری زبان بول سکتا ہے ؟ ☐ ہاں ☐ نہیں زبان

Assyrian

ܘܐܢ ܕܦܘܢܝܐ ܕܗܐ ܚܕ ܫܘܐܠܐ ܐܝܬܘܢ ܐܝܢ، ܡܕܪܫܬܐ ܐܠܝܨ ܠܦܘܪܫܢܐ ܕܩܢܘܢܐ ܠܡܦܩܕܘܬܐ ܕܝܕܥܬܐ ܕܠܫܢܐ ܐܢܓܠܝܙܝܐ (ܐܢܓܠܝܐ) ܕܝܠܘܟܘܢ.

ܐ. ܐܢܬܘܢ ܠܫܢܐ ܚܪܢܐ ܡܢ ܐܢܓܠܝܙܝܐ ܕܡܡܠܠܝܬܘܢ ܒܒܝܬܐ ܕܝܠܘܟܘܢ؟ ☐ ܐܝܢ ☐ ܠܐ ܠܫܢܐ

ܒ. ܐܝܢܐ ܬܠܡܝܕܐ ܡܡܠܠ ܠܫܢܐ ܚܪܢܐ ܡܢ ܐܢܓܠܝܙܝܐ ؟ ☐ ܐܝܢ ☐ ܠܐ ܠܫܢܐ

Gujarati / [ગુજરાતી]

તમારા બાળકના અંગ્રેજી ભાષાના કૌશલ્ય માટે આકારણી કરાવવા માંગે છે. જો બન્નેમાંથી કોઈ એક પ્રશ્નનો જવાબ પણ હા માં હોય તો, કાયદો શાળા પાસે

1. શું આપના ઘરમાં અંગ્રેજી સિવાયની ભાષા અન્ય કોઈ ભાષા બોલ આવે છે? ☐ ના ☐ હા ભાષા

2. શું વિદ્યાર્થીઓ અંગ્રેજી સિવાયની કોઈ ભાષા બોલે છે? ☐ ના ☐ હા ભાષા

Yoruba / Yorùbá

Tí ìdáhùn sí ìbéèrè nàá bá jẹ́ Bẹ́ẹ̀ni, òfin bèèrè pé kí ilé-ẹ̀kọ́ nàá ṣe ìgbéléwọ̀n bí ọmọ rẹ ṣe gbọ́ èdè Gẹ̀ẹ́sì si.

1. Njẹ́ ẹ n sọ èdè miran yatọ si Èdè-Gẹ̀ẹ́sì ninu idile yin bí? ☐ Bẹ̀ẹ́kọ́ ☐ Bẹ́ẹ̀ni Èdè

2. Ṣe akẹ́kọ̀ọ́ nàá n sọ èdè miran yatọ sí èdè-Gẹ̀ẹ́sì bí? ☐ Bẹ̀ẹ́kọ́ ☐ Bẹ́ẹ̀ni Èdè

Korean / [한국어]

위 질문 중 하나라도 "예"로 답하신 경우에는, 관련법에 따라 학교는 귀 자녀의 영어 언어 능력 평가해야 합니다.

1. 가정에서 사용하는 언어 중에서 영어를 제외한 다른 언어가 있습니까? ☐ 아니오 ☐ 예 언어

2. 학생이 영어 이외에 다른 언어를 구사합니까? ☐ 아니오 ☐ 예 언어

Tagalog

Ayon sa batas, kung "Oo" ang sagot sa parehong tanong, kailangan suriin ng paaralan ang kakayahan at kaalaman na mag-aaral sa wikang Ingles.

1. May iba pa bang lengguwahe bukod sa Ingles na ginagamit sa iyong tahanan? ☐ Oo ☐ Hindi Lengguwahe

2. May ginagamit ba na ibang lenggguwahe ang mag-aaral bukod sa Ingles? ☐ Oo ☐ Hindi Lengguwahe

Signature of School Official	Date	Parent/Guardian Signature	Date

Must have an original signature; an electronic signature is not acceptable.

ENGLISH

Race and Ethnicity Survey

Student's Name:
Gender:
Birth Date:

School Name:
School ID:

INSTRUCTIONS: Please answer the questions below. 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.)

Durkin Park Elementary • 8445 S. Kolin Avenue • Chicago, Illinois 60652
Tel. (773) 535 - 2322 • Fax (773) 535-2299
www.durkinpark.com

Daniel J. Redmond
Principal

Leopoldo Acosta
Assistant Principal

Dear Parents,

Please indicate below the language in which you prefer to receive your child's report card. Also, write your child's name and room number. Finally, please sign the form and return to your child's teacher.

Language of preference:____

Child's name: ___________________________________ Room: _______________

Signature ______________________________________ Date: ________________

****

Estimados Padres:

Tenga la bondad de anotar en la parte inferior, el idioma en el cual quisiera recibir las calificaciones de su hijo/a. Además, anote el nombre de su hijo/a y el número de aula. Por último, sírvase a firmar este formulario y regresarlo al maestro/a.

Idioma de preferencia: ____

Nombre del niño/a _____________________________ Salón: _________________

Firma _______________________________________ Fecha: _________________

****

اولياء امور الطلبه الاعزاء .
اذا اردتم اختيار شهاده طفلك / طفلتك باللغه العربيه
الرجاء التوقيع على هذا الاستبيان وكتابه اسم الطالب
و غرفه الصف و التاريخ . و اعاده الطلب الى مدرسه الصف .
وشكرا للتعاون .

Must have an original signature; an electronic signature is not acceptable.

42 W. Madison Street • Chicago, Illinois 60602
Telephone: 773/553-1600

School Messaging Consent Form

Dear Parent/Guardian/Student if age 18 or older,

Your school and the district will periodically want to send information regarding school or district events, updates or initiatives. We will utilize the phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, COVID 19 information and screenings, and more. To ensure you receive periodic school or district related notifications and reminders, your consent is needed below.

In the event of an emergency, whether or not consent is on file, you will be informed by all contact information provided. Emergency calls include weather closures, health risks, threats, unexcused absences, and other situations affecting the health or safety of students and faculty. Emergency calls will be sent to all the phone numbers, including cellular numbers, listed on the student's record. Please make sure these numbers are updated with the school.

*****Please fill out and return this form to ensure you receive informational calls and texts*****

By signing this form, you are authorizing Chicago Public Schools to use an automated system to periodically deliver automated informational calls or text messages to the phone number(s) provided below. If you change your phone number or no longer wish to receive automated calls and texts, you agree to inform Chicago Public Schools immediately. By signing below, you agree that this consent will remain valid and you will continue to receive automated phone calls and text messages unless or until you revoke your consent. Standard messaging rates and data may apply.

Instructions: Check Box for Consent or Do Not Consent

☐ I CONSENT as outlined in the above section.
☐ I DO NOT CONSENT as outlined in the above section.

______________________________	______________________________
Signature of Parent/Guardian/Student if age 18 or older	Printed Name of Parent/Guardian/Student if age 18 or older
Student's Name	Student ID #
Date	School

Phone Number 1 for Messages: (_____) ______ - _________

Phone Number 2 for Messages: (_____) ______ - _________

E-mail Address: ____

Doctor must complete report, parents please return report to your child's school or

State of Illinois
Eye Examination Report

send report to Katheryn Stafford-Hudson, kgstafford-h@cps.edu or fax 773-535-8677

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15th 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 child beginning school.

Student Name: ______________________________ Birth Date: ____________ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: ______________________________ Phone: ______________
(Last) (First) (Area Code)

Address: ______________________________ County: ______________
(Number) (Street) (City) (Zip Code)

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

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	❑	❑	❑	______
Internal Exam (media, lens, fundus, etc.)	❑	❑	❑	______
Neurological Integrity (pupils)	❑	❑	❑	______
Binocular Function (stereopsis)	❑	❑	❑	______
Accommodation and Vergence	❑	❑	❑	______
Color Vision	❑	❑	❑	______
IOP (glaucoma)	❑	❑	❑	______
Oculomotor Assessment	❑	❑	❑	______
Other: ______	❑	❑	❑	______

Diagnosis

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

Other: ______________

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses 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: ______________
Optometrist or Physician Who Provides Eye Examinations

Address: ______________

____

Signature: ______________
Optometrist or Physician Who Provides Eye Examinations

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)

Phone: ______________

Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible

Vision Services Consent, Release of Liability, and Authorization Form

Please Print: Parent Email Address ____________________________

Student Name: ____________________________________ Student's Date of Birth__________________________ ☐ Male ☐ Female

School Name: _____________________________________Student ID# ____________________________Grade: _________Room# ___________

Parent/Guardian Name: ____________________________Home Address: ________________________________Phone: ______________________

Medicaid/Medical Card/ALLKids recipient #____ Race/Ethnicity________________

Private Vision Insurance: ___________________Group ID____________ ID#_____________ Cardholder Name:______________ Birth Date________

Private Medical Insurance: _________________ Group ID ____________ ID# _____________ Cardholder Name: _______________

As the parent/guardian of the above name student, I understand that my child will receive a comprehensive eye exam to determine if he/she needs prescription glasses or other treatment by a vision care professional (Provider)

I further understand that this eye exam may be performed by an Optometrist; an Ophthalmologist; qualified specialist; or an intern, a resident, or a student clinician or technician under the supervision of an Optometrist, Ophthalmologist, or another qualified specialist, and I consent to have my child receive a vision exam and/or treatment.

I further understand that neither the school nor the Board of Education of the City of Chicago (Board) are supervising or overseeing any services (such as an eye exam) or materials (such as eye glasses) that may be furnished to my child and that the Board and the school will have no responsibility for the quality of any such services or materials.

In consideration for the services and materials that my child will receive, I hereby agree to indemnify, release and hold harmless, and defend the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers, representatives, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuries, damages to me or my child, both known and unknown, foreseen and unforeseen, arising in connection with my child's receipt of services and materials, whether or not said claims, losses, injuries, damages, or liabilities result in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives. I further agree to release and hold harmless the Providers and Co-Sponsors, their employees, officers, volunteers, agents and representatives from and against any and all claims, demands, actions, complaints, suits or other forms of liability that will arise out of or by reason of, or be caused by any performance of services provided by such Providers or the quality of the eyeglasses or any other materials furnished by them under the Program, unless attributed to their willful or wanton misconduct. In the event that one provision of this form is held unenforceable, that provision shall be severed and the remainder of the form shall remain in effect.

I understand that the Provider will bill any government or private insurance Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable private insurance for any reimbursable services and/or materials.

If you DO NOT want your child to receive the following services, please check the appropriate box. Please note services will be performed unless indicated otherwise.

If your child has an allergy, please consult your primary care physician before selecting dilation

I understand that as part of this eye exam, pharmaceutical agents (eye drops) will be used for the purpose of dilating my child's eyes. These drops are an important part of an eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops include blurred vision and sensitivity to light, both of which could restrict my child's mobility making it unsafe for him/her to travel unassisted or to operate a vehicle for the rest of the day.

☐ **At this time I DO NOT consent for my child's eyes to be dilated**

I understand that by refusing dilation I may limit the doctor's ability to detect and treat certain conditions.

I understand that my child may be selected to be photographed, video taped, audio taped or interviewed as part of promotional documentation for the Vision Program. I consent to the use of my child's photograph, voice or likeness by the Board or the Provider or CDPH, but not the use of my child's last name. I understand there is no compensation, monies, or reimbursement for my child's participation.

☐ **At this time I DO NOT consent for my child to be photographed or interviewed**

By signing below, I understand that I am giving my authorization to the City of Chicago Department of Public Health (CDPH) and the Board of Education of the City of Chicago (Board) to release and furnish information regarding past vision screening data in my child's education record to Providers to ensure that the Providers can effectively provide services. I authorize the Providers to release and furnish reports to my child's school, including written and verbal reports concerning the results of any eye exam, for inclusion in my child's education record. I also authorize CDPH to release to the Board, my child's information, the date and type of vision services provided, whether my child was recommend for follow-up services, and other information the State of Illinois requests the Board to report. I understand that such records will be subject to the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinois Department of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization.

This authorization is valid for one year. I may revoke this authorization at any time by sending written notification to CDPH, my child's school, or the Board Office of Student Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

*****Please sign and date both signature lines. Complete the medical history on reverse side of this form.*****

Parent/Guardian Signature:____**Date:**__________________________

I hereby give my consent for this child to be examined by a Provider for an eye exam and prescription eyeglasses, if prescribed during the eye exam. This consent does not authorize any treatments or service beyond what is stated. I understand my consent will be valid for one year from the date of signature.

Parent/Guardian Signature: ____ **Date:**______________________________

Must have an original signature; an electronic signature is not acceptable

Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible

Student Medical History Form

Please Print:

Student's Name:_____________________________________ School Name: ____________________________________

Student's Date of last Eye Exam: _________________ Does your child currently wear glasses or contacts? ☐ Yes ☐ No

How did you find out about the Vision Program? (Check all that apply)

School staff   Failed Vision Screening Letter   Friend   Other_________________________________

Does your child have any of the following conditions: (Check all that apply)

☐ Asthma ☐ Behavioral problems ☐ Attention Deficit Disorder ☐ Glaucoma
☐ Neurological problems ☐ Endocrine problems ☐ High Blood Pressure ☐ Musculoskeletal problems
☐ Heart Disease ☐ Mental Health illness ☐ Gastrointestinal problems ☐ Genitourinary problems
☐ Hearing/Ear problems ☐ Diabetes ☐ Other Condition ____________________________

Is your child taking any medications? ☐No ☐Yes
List medications:

____

____

Does your child have allergies? ☐No ☐Yes
List allergies:

____

____

Does your child use eye drops? ☐No ☐Yes
List eye drops:

____

____

Has your child ever had eye surgery? ☐No ☐Yes
If yes, please explain:

____

____

Has s/he had any of the following?

Vision Therapy	☐ No	☐Yes	Eye Injury	☐ No	☐ Yes	Trouble finishing work	☐ No	☐ Yes
Eye patch	☐ No	☐ Yes	Eye Infection	☐ No	☐ Yes	Lack of confidence	☐ No	☐ Yes
Eye Surgery	☐ No	☐ Yes	Itching/Burning	☐ No	☐ Yes	Difficulty sitting still	☐ No	☐ Yes
Pain in eyes	☐ No	☐ Yes	Eye Discharge	☐ No	☐ Yes	Avoids reading/writing	☐ No	☐ Yes
Difficulty Tracking	☐ No	☐ Yes	Tearing/Watering	☐ No	☐ Yes	Difficulty paying attention	☐ No	☐ Yes
Lazy/Wandering Eye	☐ No	☐ Yes	Light sensitivity	☐No	☐ Yes	Reads below grade level	☐ No	☐ Yes
Blurred/Double Vision	☐ No	☐ Yes	Redness	☐ No	☐ Yes	Poor handwriting	☐ No	☐ Yes
Loses place while reading	☐ No	☐ Yes	Drooping Lid	☐ No	☐ Yes	Frustrates easily	☐ No	☐ Yes

Other____

Does your child have an IEP (Individualized Education Plan)? ☐ No ☐ Yes

Is the child performing at: ☐ above grade level ☐ grade level ☐ below grade level

If below grade level, please select the class (Check all that apply)
☐ Reading ☐ Writing ☐ Math ☐ Social Studies ☐ Other_____________________

Is the child currently receiving any of the **services** below? (Check all that apply)
☐ Special Education ☐ Tutoring ☐ Speech Therapy ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)

List any of your child's Hobbies or Special Interests: ____

Is there anything else you would like us to know about your child? ____

Does your child's immediate family member have any of the following? (Check all that apply and the relationship to child)

☐ Wears glasses ☐ Wandering Eye ☐ Diabetes ☐ Cardiovascular problems
☐ Glaucoma ☐ Blindness ☐ Musculoskeletal problems ☐ Neurological problems
☐ Lazy eye ☐ Macular Degeneration ☐ Heart Disease ☐ Mental Health illness
☐ High Blood Pressure

School Based Oral Health Program
Dental Consent, Release of Liability and Authorization Form

Student Name:________________________________Student's Date of Birth____________________ ☐ Male ☐ Female

School Name:______________________________________Student ID#________________Grade:________Room# __________________

Parent/Guardian Name:__________________________________Home Address: ____

Phone Number:____________________Zip Code:____________Medicaid/ALL KIDS - 9 Digit Recipient #___________________________________

As the parent/guardian of the above named student, I understand that through the City of Chicago Department of Public Health and the Chicago Public School's **SCHOOL-BASED ORAL HEALTH PROGRAM** (the "**PROGRAM**"), licensed dentists will be coming to my child's/ward's school in the near future to provide a **DENTAL EXAM/SCREENING and as needed a DENTAL CLEANING, FLUORIDE TREATMENT** and **DENTAL SEALANT(S)** at **NO COST** to students or their families in the school. Dental sealants, in addition to regular brushing and flossing, protect your child's/ward's teeth from **DECAY**. Dental Sealants are thin, plastic coatings put on the tops of the back-teeth to SEAL OUT food and germs. Sealants are applied on teeth that appear not decayed, and they don't hurt. **PROGRAM SERVICES DO NOT INCLUDE DRILLING OR SHOTS.**

I understand that in consideration for my child's/ward's participation in the **PROGRAM**, and as evidenced by my signature below, I hereby release and hold harmless the **CITY OF CHICAGO**, its departments, including the Department of Public Health, and its employees, officers, volunteers, agents and representatives, and **THE BOARD OF EDUCATION OF THE CITY OF CHICAGO**, its members, trustees, agents, officers, contractors, volunteers and employees from any liability which may accrue to me or to my child/ward, for any and all losses, injuries, damages to me or my child/ward, both known and unknown, foreseen and unforeseen, arising in connection with my child's/ward's participation in the **PROGRAM** whether or not said losses, injuries, damages, or liabilities result in whole or part from the negligence of the **CITY OF CHICAGO**, its departments, including the Department of Public Health, its employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives.

I further understand that as evidenced by my signature below, I acknowledge that a licensed dentist providing medical or dental care, treatment, diagnosis, or advice without charge on behalf of the City of Chicago Department of Public Health is not liable for civil damages resulting from his or her acts or omissions in providing such medical or dental care, treatment, diagnosis, or advice under the Program except for willful or wanton misconduct. To authorize dental providers and the Chicago Department of Public Health to share information relating to PROGRAM dental services provided to your child/ward, please sign the Authorization Form that is on the other side of this page. This signed consent form is valid for **365** days from the date that it is signed by the child's/ward's parent or guardian.

Race: (Please check one) X White X Black X Asian / Pacific Islander X American Indian/ Native Alaskan **Hispanic** (Please check one) Yes No

MEDICAL INFORMATION: Has your child/ward ever had any of the following: **YES or NO** If YES: Please check the appropriate condition below:

Asthma Diabetes Currently has Heart Murmur Rheumatic Fever or Rheumatic Heart Disease Epilepsy Blood Disorder / Disease Hepatitis

Is your child/ward taking any medication? If YES, Please list medication: ____

Does your child/ward have any Allergies? If YES, Please list Allergies: ____

Any other medical related conditions? If YES, Please list the conditions: ____

As the parent or guardian of the above - named child or ward, I consent for my child or ward to participate in the SCHOOL-BASED ORAL HEALTH PROGRAM, which includes a dental exam/screening and as needed a dental cleaning, fluoride treatment and dental sealant(s) and the receiving of Quality Assurance exams. I authorize the dental provider to use my child's or ward's Medicaid, ALL KIDS number for billing purposes only. **I understand that if I fail to sign this Dental Consent Form and Release of Liability, my child or ward will not receive any services under this program.**

Please sign both sides:

Parent/Guardian ____________________ **Date:** __________

School - Based Oral Health Program Authorization Form – HIPAA

Student Name:___________________________________ Student Date of Birth: ______________________

School Name:__________________________Parent/Guardian Name: _________________________________

By signing below, I understand that I am giving my authorization to the dental provider and the City of Chicago Department of Public Health to use and/or disclose my child's/ward's protected health information, to the following person(s) or organization(s) for the purposes of reports, documentation of oral health trends, and Medicaid and grant billing: City of Chicago, Department of Public Health, 333 S. State Street, 2nd Floor, Chicago, Il 60604; Individual School Principal; Illinois Department of Healthcare and Family Services, 201 So. Grand Avenue East, Springfield, Il, 62763; Illinois Department of Public Health - Oral Health Division, 535 W. Jefferson Street, 2nd Floor, Springfield, Il, 62761, Chicago Public Schools, Office of Student Health and Wellness, 42 West Madison, Garden Level, Chicago Illinois 60602. Federally Qualified Health Centers (FQHC), Oral Health Forum (OHF), 1100 West Cermak Road, Suite 518, Chicago, Il 60608. Infant Welfare Society of Chicago (IWS), 3600 W Fullerton Ave, Chicago, Oak Park-River Forest Infant Welfare Clinic**,** 320 Lake Street, Oak Park, Il 60302 and Chicago Public School approved Dental Vans.

CDPH and dental providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization. This Authorization is voluntary, and I may refuse to sign it. I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re- disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA) and federal privacy regulations. I may revoke this Authorization in writing by sending notice to the HIPAA Privacy Officer, City of Chicago, Department of Public Health, 333 S. State Street, 2nd Floor, Chicago, Il 60604. Revocation is not effective with respect to actions taken prior to the revocation. This authorization is valid for **365** days from the date that it is signed by the child's/ward's parent or guardian.

Please sign both sides

Parent/Guardian [ ] Date [ ]

HEALTHCARE PROVIDER STATEMENT FOR FOOD SUBSTITUTION

This form must be completed if a parent/student is requesting menu substitutions be made in the dining center for a student's food allergy or intolerance

CHILD'S NAME:	DATE:

Dear Parent/Guardian:

Your child's school participates in a federally-funded School-Based Child Nutrition Program that requires CPS to offer meals and/or milk to students. However, when a disability (for example, a food allergy) or special dietary need or restriction documented by a healthcare provider exists, reasonable menu accommodations must be made. Please provide your contact information and ask your child's healthcare provider to complete this form. **Please return the completed form to your child's School Nurse along with a Food Allergy Action Plan** (found at cps.edu/OSHW). Contact food@cps.edu with any additional questions:

______________________________	______________________________
Parent/Guardian Name	School Name
______________________________	______________________________
Parent/Guardian Phone Number	Address (Street)
______________________________	______________________________
Parent/Guardian Email	Address (City, State, Zip Code)

*Healthcare providers' note: **Food allergies** are a "disability" under the Americans with Disabilities Act. If the child has a food allergy, please check "Yes" for question 1 below.*

PHYSICIAN STATEMENT

---

1. Does child have a disability that requires food accommodation?
   - ☐ No — If **no**, go to item 2 below.
   - ☐ Yes — If **yes**, provide the follow information and complete items 3, 4, and 5

   a) What is the disability? ______________________________

   b) What major life activity is affected? ______________________________

   c) What does the disability mean for the child's diet? ______________________________

2. Child has no disability, but requires a special diet. Identify the medical problem that warrants the child's special diet and complete item 3, 4, & 5 below.

3. List **specific** foods to be omitted:

4. List **specific** acceptable food substitutions. Please attach a menu if applicable:

5. ______________________________ ______________________________
   Signature of Health Care Provider **Date**

Parent/Guardian: Return this form to your School Nurse

- -

FOR SCHOOL USE ONLY: Please scan and email this form to food@cps.edu.

School Nurse Signature: ______________________________

Date reviewed: ______________________________

Date scanned to food@cps.edu: ______________________________

Office of Student Health and Wellness
42 West Madison • Chicago, Illinois 60602
Telephone: 773-553-3560 • Fax: 773-553-1883

Student Medical Information 2021 – 2022

This form must be updated and returned to school each school year.

Please let your school know about your child's health and health care. This is a good way to keep your child safe. The information is **CONFIDENTIAL** and will be shared only with CPS staff who need to know (Nurse, Principal, Designee, or Clerk).

____________________ ____________ ______________
Student Name Date of Birth Student ID Number

____________________________ ______________
School Grade

1. Please indicate your child's health status below

☐ *My child has no known health conditions*

My Child has a known condition(s). Please check all that apply:

☐ *Allergies (food or other) – please specify:* ____________________
☐ *Asthma* *Year Diagnosed* ________
☐ *Diabetes – please circle one:* *Type 1* *Type 2* *Year Diagnosed* ________
☐ *Seizures/Epilepsy* *Year Diagnosed* ________
☐ *Sickle Cell Disease* *Year Diagnosed* ________
☐ *Other:* __________________ *Year Diagnosed* ________

2. My child has a primary doctor.	YES	NO

If yes, please provide the healthcare provider's name and phone number:

*Name:*____________________ *Phone number:* ________________

☐ *I give permission for my child's school nurse or designee to talk to the doctor about my child's health.*

3. My child is covered by health insurance.	YES	NO

If your child needs health insurance call Healthy CPS 773-553-KIDS (5437)

This Form is **NOT** the same as a "**Plan of Care**" (detailed medical care instructions to keep your child safe). If your child has a health condition that may require action at school, please provide school with documentation from your physician and schedule an appointment with your school nurse. Complete a "Medical Plan of Care Form" at: www.cps.edu/oshw (or get it from the school nurse), and return it to school. **If your child has a health condition, please schedule an appointment with the school nurse.**

Parent Name: __________________________ Date: ____________

Parent Signature: ________________________________

Phone Number: ______________ Email: ____________________

Must have an original signature; an electronic signature is not acceptable.

PLEASE RETURN THE FORM TO THE SCHOOL NURSE

IF THE STUDENT HAS A HEALTH CONDITION PARENTS MUST SCHEDULE A MEETING WITH THE SCHOOL NURSE

Nurses Use Only
Reviewed by:
Date and Initial

Revised April 25, 2019

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			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)	☐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.		
Bone/Joint problem/injury/scoliosis?	Yes No		**Parent/Guardian Signature**		**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		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

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

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

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

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

Address **Phone**

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and 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:	Gender: ☐ Male ☐ Female
Parent or Guardian: Last Name	First Name		

Student's Race/Ethnicity:

- ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
- ☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
- ☐ Other________________________________

To be completed by 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). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

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

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

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

Additional comments: ____

Signature of Dentist ______________________________ License #:________________ Date:____________________

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

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