

February, 2012

Dear Parent or Guardian,

We are looking forward to the arrival of your child as a student at Fenwick High School for the 2012-2013 school year. The State of Illinois requires a physical examination when entering high school. I am sending you the current state health form which is required to be filled out by you and your physician. **A completed state health form must be returned to Fenwick prior to the beginning of the school year.**

Sports Physicals: A physical examination is required for every year that a student participates in sports. Before a child can try out, practice or compete in sports, a current physical examination is required. A physical examination on the state required health form will meet the sports physical requirement for the freshmen year of school, if it was completed after **June 1, 2012.**

A physical examination on a sports physical form will not count for a ninth grade physical examination.

Health History: The health history section of the health examination form is required by the state to be completed by a parent or guardian. All of the required information must be completed. This includes allergies and medication.

Health Examination Form: The State of Illinois requires that the immunization section, the health history section and the physical examination section of the required health examination form be completed and dated within one year prior to the first day of school.

Immunization section: This section needs to have the required immunization dates and needs to be signed and dated by a physician or health care provider.

1. If your physician does not have the required immunization dates you will need to include a copy of your child's immunization record.
2. You can include a copy of your own authorized record of the immunization dates from another physician.
3. You can also obtain a copy of your child's immunization record by requesting a copy of your child's fifth grade health examination from the school your child attended.

Health History section: This section must be filled out completely and signed by a parent or guardian.

1. In the left top box write in your child's allergies or write none in the box.
2. In the right top box list all medications taken by your child that are prescribed or taken on a regular basis or write none in the box.
3. Circle yes or no after the health questions.
4. Sign and date the bottom of the health history section.

Physical Examination section: This section will need to be filled out by a physician, physician's assistant or an advanced practice nurse.

1. The Diabetes screening section of the physical examination will need to be completed.
2. The results of the physical examination will need to be recorded.
3. The physical education box must be checked before a student can participate in physical education at school.
4. The interscholastic sports box must be checked before a student can participate in interscholastic sports.

5. The physician, physician's assistant or advanced practice nurse that completed the physical examination will need to sign and date the health form.

Sports Physicals: A physical examination is required for every year a student participates in interscholastic sports.

1. **No athlete can participate (tryout, practice or compete) in interscholastic sports without a current physical examination being on file in the health office.**
2. A ninth grade physical examination on the required state form will count as a sport physical for the entire freshmen year, if the physical was completed after **June 1, 2012.**
3. **A physical examination on a sports physical form will not count for a ninth grade physical examination.**

Medication Policy: Students are allowed to carry and administer their own medication in school and at school related activities, if they have a Medication Authorization Form, on file in the health office. The State of Illinois requires that students are allowed to self-administer medication for Asthma or self-administer an epinephrine auto-injector (EpiPen) for allergies. Students carrying Asthma medication are required to have a Medication Authorization Form, on file in the health office. Students carrying EpiPen are required to have a Medication Authorization Form, an Emergency Action Plan and an Allergy History Form, on file in the health office. Medication Authorization Forms and Emergency Action Plans need to be renewed every year.

A completed health examination form needs to be in the health office before school starts in August. The school nurse needs to know which students have medical concerns and which students may require medication for allergies. She needs to know which students may need help during the school day. She needs to inform teachers about students that may need help in the classroom.

An appointment for the school physical needs to be made early so that the physical examination can be completed before school starts in August. After the health form is complete, please send the health form to Fenwick High School and mark it to the attention of the school nurse. You can also drop off the health form at the reception desk at the school entrance.

PLEASE NOTE: The Illinois school code requires that a child entering ninth grade must have a completed health form on file for the 2012–2013 school year. **A completed state health form must be returned to Fenwick prior to the beginning of the school year.** The immunization section, health history section and physical examination section which includes Diabetes screening are all required to be filled out on the health form. Students who do not have a completed health form on file in the health office by **October 15, 2012** will not be allowed to attend classes, sports or other school related activities until their health form is completed and on file in the health office.

Thank you for your cooperation in these matters. The process of getting the health examination form filled out can be difficult. If you have any questions or concerns, please call Mrs. Rudnik at (708) 386-0127 ext. 170.

Sincerely,
Karen Rudnik, R.N.
School Nurse



**State of Illinois
Certificate of Child Health Examination**

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011



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

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

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

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

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

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

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

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

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

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

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

Student's Name	Birth Date	Sex	School	Grade Level/ ID #
Last _____ First _____ Middle _____	Month/Day/ Year _____			

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

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

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

HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ (Blood test required if resides in Chicago.)				
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____				
Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____				

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

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal Exam	
Cardiovascular/HTN			Nutritional status	
Respiratory		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist) <input type="checkbox"/> Controllor medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting	DIETARY Needs/Restrictions
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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** (for one year) Yes No Limited

Print Name _____	(MD,DO, APN, PA) Signature _____	Date _____
Address _____		Phone _____

(Complete both sides)

IMMUNIZATION REQUIREMENTS FOR THE SCHOOL YEAR 2012-2013

SCHOOL LAW: The State of Illinois requires that a complete health examination be given within one year prior to entering the ninth grade. The immunization section of the health form needs to have the required immunization dates and needs to be signed and dated by a physician or health care provider.

REQUIRED IMMUNIZATIONS: The Illinois Department of Public Health requires for adequate immunity, the following immunizations to comply with Illinois School Code.

1. Diphtheria/Pertussis/Tetanus Has received 3 or more doses of DTP/DTaP or Td, with the last doses being a booster and having been received on or after the 4th birthday. The first two doses in the series must have been received no less than four weeks apart (28 days).The interval between the second and third or final dose must be at least six months. **Students entering grades 7th thur 12th, who have not already received a Tdap immunization are required to receive 1 Tdap dose regardless of the interval since the last DTaP, DT, or Td dose.**
2. POLIO (IPV/OPV) Has received four or more doses of any combination of IPV and OPV, or three or more doses of all-IPV or all-OPV, at intervals of no less than four weeks (28 days) apart, with the last dose having been received on or after the 4th birthday.
3. MEASLES Has received two doses of measles vaccine, with the first dose on or after the 1st birthday, and the second dose no less than 4 weeks (28 days) after the first dose, had physician diagnosed measles disease , or laboratory evidence of measles immunity. A diagnosis of measles disease made by a physician on or after July 1, 2002 must be confirmed by laboratory evidence.
4. RUBELLA Has received one dose of rubella vaccine on or after the 1st birthday (usually given as MMR), or has laboratory evidence of rubella immunity. Disease history is not acceptable.
5. MUMPS Has received one dose of mumps vaccine on or after the 1st birthday (usually given as MMR), had physician diagnosed mumps disease, or has laboratory evidence of mumps immunity.
6. HEPATITIS B Has received three doses of hepatitis B vaccine, at the appropriate intervals or has laboratory evidence of prior or current hepatitis B infection. The first two doses must have been received no less than four weeks apart (28 days) and the interval between the second and third dose must be at least two months. The interval between the first and third dose must be at least four months.
7. VARICELLA Has received one dose of varicella vaccine on or after the 1st birthday, had physician diagnosed varicella disease, has statement from a health care provider (including a school health care professional or health official) verifying that a parent's or legal guardian's description of varicella disease history is indicative of past infection, or has laboratory evidence of immunity to varicella. Varicella is required for incoming freshmen and sophomores only.

INCOMPLETE IMMUNIZATIONS: The immunization record may need a note from a physician or parent to be complete. The following reasons are acceptable under state law.

- a. A physician's note with the date that the child's immunizations will be completed.
- b. A physician's note stating that the child's immunizations are complete.
- c. A physician's note with the date that a childhood disease was experienced conferring natural immunity.
- d. A physician's note designating that a select immunization is medically contraindicated.
- e. A note from a parent or legal guardian with the specific religious belief which conflicts with the required immunization.

SCHOOL EXCLUSIONS: Private, parochial and public schools are required to exclude children from school if the immunization section of their health examination form is not complete. Students who are not in compliance on **October 15, 2012** will not be allowed to attend classes, sports or other school related activities until their immunization record is complete and on file in the health office. Students will be allowed to attend classes if a physician's note is on file with the date the required immunization will be completed.

Re: **Tdap Immunization (defined as tetanus, diphtheria, acellular pertussis)**

Dear Parent or Legal Guardian:

Illinois is seeing an increase in pertussis (whooping cough) cases for 2011, and the northeastern portion of Illinois is seeing the largest amount of activity (1,019 cases). To prevent further cases of pertussis, the State of Illinois is requiring students to have a Tdap immunization.

Beginning with the 2012-2013 school year, the State of Illinois is requiring that students entering 7th through 12th grade, who have not already received a Tdap immunization, must receive 1 Tdap immunization, regardless of the interval since the last DTaP, DT or Td.

If a Tdap immunization has already been given but not recorded as a Tdap on the health form,

- a note from the doctor stating that a Tdap immunization was given, with the date it was given, will be required to be on file in the health office.
- You can call your doctor and have the doctor fax a note to the school.

If a Tdap immunization was not given,

- Make an appointment to have a Tdap immunization given.
- After the immunization is given, a note from the doctor stating that a Tdap immunization was given, with the date it was given, will be required to be on file in the health office..

To prevent your child from getting pertussis and missing school, please take care of this as soon as possible.

Students who are not in compliance on **October 15, 2012** will not be allowed to attend classes, sports or other school activities until their immunization record is complete and on file in the health office.

Thank you for your cooperation. If you have any questions, please call Mrs. Rudnik at (708)386-0127 ext. 170. Notes can be faxed to Karen Rudnik at 708 386-3052.

Sincerely,

Karen Rudnik, R.N.
School Nurse

MEDICATION POLICY FENWICK HIGH SCHOOL

Purpose The purpose of students taking medication in school is to help each student maintain an optimal state of health to enhance his or her education. Students should be able to self-administer their own medication with the least possible disruption to their education. Students should only be taking medication during school hours that is necessary to maintain them in school or in the event of an emergency. The intent of this policy is to assure safe administration of medications for those students who require them.

Medication Policy Students are allowed to carry and administer their own medication in school and at school related activities. Students self-administering medication in school and at school related activities need to follow the guidelines for self-administration of medication in school.

Guidelines for Medication Administered to Students in School

Medication administered to students in school, including over-the-counter (non-prescription drugs), shall be prescribed by a licensed prescriber on an individual basis as determined by the student's health status. A medication authorization form must be completed by a licensed prescriber and a parent or guardian and be on file in the health office before medication is administered to a student. Permission for administering medication needs to be renewed every year.

Guidelines for Self-Administration of Medication in School

Students that are self-administering their own medication in school need to have a medication authorization form on file in the health office. Permission for students to self-administer medication needs to be renewed every year. Students can bring prescription and over-the-counter medications to school if the medications are properly labeled. Prescription medication must be brought to school in containers which have been appropriately labeled by a pharmacist or licensed prescriber. Over-the-counter (non-prescription) medications shall be brought to school with the manufacturer's original label, with the ingredients listed and the student's name affixed to the container.

1. Students are allowed to carry their own medication on themselves or they can keep their medication in their locker if it is locked.
2. Student's can administer their own medication in the health office or in other areas of the school.
3. Students may keep medication in the health office if it has been determined that there are special circumstances that require it to be there. Students keeping medication in the health office must also have a medication authorization form on file with their medication.
4. Students are not allowed to give their medication to any other students, for any reason.

Guidelines for Administration of Medication in an Emergency in School

1. Students carrying medication that will need to be administered because of a possible emergency must have a medication authorization form on file in the health office. Their teachers will be informed about the possible emergency, the medication that will be needed and how they will be receiving their medication.
2. Students needing pain medication in school will be evaluated by the school nurse. Their parent or guardian will be called. The school nurse may administer a pain medication with a parent's or guardian's permission.

Guidelines for Self-Administering Medication During School Related Activities

1. Students needing to self-administer medication during school related activities need to have a medication authorization form on file in the health office.
2. If a student needs medication for pain during a school related activity, a parent or guardian must be called first. Medication can be given with a parent's or guardian's permission only.



Re: Medication Authorization Form, Emergency Action Plan, Allergy History Form

Dear Parent or Legal Guardian,

Students are allowed to carry and self-administer their own medications in school and at school related activities if they have a Medication Authorization Form on file in the health office.

The State of Illinois requires that students be allowed to self-administer medication for Asthma or self-administer an epinephrine auto-injector (EpiPen) for allergies in school. Students carrying Asthma medication are required to have a Medication Authorization Form on file in the health office. Students carrying EpiPen are required to have a Medication Authorization Form, an Emergency Action Plan and an Allergy History Form on file in the health office. Medication Authorization Forms and Emergency Action Plans need to be renewed every year.

Students who need to have medication administered to them and students keeping medication in the health office must have a Medication Authorization Form on file in the health office. This form needs to be renewed every year.

If your child will need to take medication during school or school related activities, please fill out the enclosed Medication Authorization Form as soon as possible and return it to the health office. This form needs to be filled out by the parent or guardian of the student and the physician who has ordered the medication.

All required forms can be found on the Fenwick Internet under Student Resources. Thank you for your cooperation. If you have any questions, please call Mrs. Rudnik at (708)386-0127 ext. 170.

Sincerely,

Karen Rudnik, R.N. School Nurse

FENWICK HIGH SCHOOL
Authorization of Medication to be Taken During School Hours
or at School Related Activities

The following section is to be completed by the PARENT/GUARDIAN:

Student's Name _____
Last First YR Birthday
_____ () _____

Physician's Name Address Telephone

I request that my child be assisted in taking the medication(s) described below at school by authorized persons or permitted to self-medicate her/himself as also authorized by me and my physician(see below). The school and its employees and agents are to incur no liability, except for willful and wanton conduct, as a result of any injury arising out of the administration or attempts at administration of said medication or from the self-administration of medication by the above named student. I indemnify and hold harmless the school and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or attempts at administration of said medication or from the self-administration of medication by the student.

_____ () _____ () _____ ()
Date Parent/Guardian Signature Home phone Work phone Emergency

.....
The following is to be completed by the PHYSICIAN:

Diagnosis for which medication is given: _____

Name of Medication _____ Form _____ Dosage _____

If the medication is to be given Daily, at what time? _____

If the medication is to be given "WHEN NEEDED", describe indications: _____

Is the child authorized to self-medicate her/himself? _____

Does the child understand the need for the medication and the necessity to report to school personnel any unusual side effects? _____

Intended effect of the medication : _____

List significant side effects: _____

Other medication child is taking: _____

Other information: _____

Date: _____ () _____
Physician's Signature Emergency Number

