EST. 1999

PRAIRIE CROSSING CHARTER SCHOOL

CREATING NATURAL LEADERS

2017 -2018 Student Medical and Health Checklist

All student medical documents are due to the school office by August 1st, 2017

In order to provide a safe and healthy environment for your child, PCCS strictly adheres to state law in maintaining health and medical records. Carefully read the list below and provide the office with all required paperwork for your child. If you have any questions please contact Jessica Loustaunau at 847-548-5262 or jloustaunau@pccharterschool.org.

State Health Forms

❑ **Proof of School Dental Examination Form**

Required for all kindergarten (KDG), second (2nd), and sixth (6th) grade students.

❑ **Eye Examination Report**

Required for all kindergarten (KDG) students.

❑ **Certificate of Child Health Examination (Physical Form)**

Required for all kindergarten (KDG) and sixth (6th) grade students.

❑ **Immunization Records**

Required for all kindergarten (KDG) and sixth (6th) grade students.

School Medical Forms

*Due to school **office** by August 1, 2017. Please do not send forms or medications to the classroom teacher.*

Please note that with the exception of the *Sports Physical, Concussion Information Sheet,* and *Students with Diabetes,* ALL forms must be filled out appropriately even if they do not apply to your child. If the form doesn't apply to your child, there is a place at the top of the form to indicate that it doesn't apply.

❑ **Sports Physical**

By law, PCCS is required to have a valid physical dated within one (1) year on file for each student participating in interscholastic sports. A standard physical form completed by a physician is sufficient, but for students in 5th – 8th grades you may submit a sports physical, provided by your child's physician, prior to trying out for any sport at PCCS. A sports physical is

valid only in regards to interscholastic sports, not as the record of examination and immunizations required for all sixth graders.

❑ **Concussion Information Sheet**

Beginning with the 2017-18 school year, the state requires this form to be signed by any student participating in interscholastic sporting events or practices. The parent's/guardian's signature is also required.

❑ **School Medication Authorization Form** (for all prescription and nonprescription medications except for asthma inhalers and emergency epinephrine injectors)

Your child's pediatrician must fill out the **School Medication Authorization Form** for each prescribed or over-the-counter medication that your child needs to take during the school day. This form also needs to be signed by the parent/guardian. A new form must be filled out for each new school year.

Note: State law now requires a physician's signature for over-the-counter and prescription medication. No medication will be administered to your child unless the completed form has been provided to school administration.

Medication should be brought to the school office in the original container, properly labeled and accompanied by the following information:

Prescription Medications

a. Student name and prescription number

b. Name and dosage of medication

c. Date and number of refills

d. Licensed physician's name

e. Pharmacy name, address, and phone number

f. Name or initials of pharmacist

g. Administration route or other directions

Nonprescription Medications

Student's first and last name on the original container.

Students with Allergies

❑**Allergy History Form**

Record all student allergies (hay fever, food, etc.)

❑ **Allergy Emergency Action Plan and Treatment Authorization Form**

In the case of a severe or life-threatening allergy, your child's physician is additionally required to complete an **Allergy Emergency Action Plan and Treatment Authorization Form.**

This plan must be provided to school administration **prior to your child's first day of school.** The **Allergy Emergency Action and Treatment Authorization** form or your physician's standard Emergency Action Plan will be accepted.

If an epinephrine auto injector is prescribed, the Allergy Emergency Action and Treatment Form will indicate it. You do not need an additional School Medication Authorization Form for the epinephrine auto injector. Your child may carry and self-administer an epinephrine injector only when the Allergy Emergency Action and Treatment Authorization Form has been completed and signed by physician and the self-administration checkbox marked. The form must also be signed by the child's parent or guardian and provided to school administration before August 1st, 2017.

If an EpiPen® is required as part of the emergency action plan, please provide both injectors (one twin pack) to the school. Epinephrine has a short period of time in which it is active and both injectors may be needed before emergency services has arrived.

Epinephrine injectors should not be due to expire before the end of the school year.

Students with Asthma

❑ Asthma Management Plan

If your child has asthma, an Asthma Management Plan must be completed by your child's physician and provided to school administration before August 1st, 2017. An example of the plan can be viewed and printed here. The enclosed form or your physician's standard Asthma Management Plan will be accepted by the administration.

Prescribed asthma inhalers will be indicated on the Asthma Management Plan. You do not need to submit an additional School Medication Authorization for an asthma inhaler. Your child may carry and self-administer an asthma medication (inhaler/nebulizer) only when the Asthma Management Plan has been completed and signed by physician and the self-administration checkbox marked.

Students with Seizures

❑ Seizure Action Plan

If your child has seizures, your child's physician is required to complete a Seizure Action Plan. This plan must be provided to school administration before August 1st, 2017. Your child's physician will provide and complete this form in conjunction with you. Please make sure, if medication is needed during school hours, the Prescription Medication Physician Authorization form is completed and signed by both physician and parent.

Students with Diabetes

❑ Diabetic Care Plan

If your child has diabetes, your child's physician is required to complete a Diabetic Care Plan. This plan must be provided to school administration before August 1st, 2017. Your child's **physician will provide** and complete this form in conjunction with you.

Sick Day Guidelines: Making the right choice!

Dear Parents:

To help prevent the spread of illness, we would like to give you some guidelines to help with your decision on whether or not to send your child to school. We ask that you keep your child home if he or she:

- Has a fever of 100.0 (oral) degrees or higher
- Has been vomiting
- Has a persistent cough (dry or productive)
- Has diarrhea (three or more episodes in 24 hours)
- Has open and draining sores
- Has symptoms that prevent him or her from participating in school, such as:
    - o Excessive tiredness or lack of appetite
    - o Headaches, body aches, earaches
    - o Severe sore throat (*could be strep-throat even without fever. Other symptoms of strep throat in children are headache & stomach upset. Contact your pediatrician to assess for diagnosis of strep throat*).

If your child has recently been ill, please be aware of the following guidelines before having your child return to school, athletic or social activities:

- They should feel fit for at least 24 hours.
- Be free of fever for at least 24 hours **(without medication)**
- Be free of vomiting and or diarrhea for at least 24 hours.
- If strep throat, they must be on the appropriate antibiotic for at least 24 hours.
- If conjunctivitis, they must be on the appropriate eye drops for at least 24 hours or cleared by a physician.
- Rash illnesses should be assessed by a doctor. If chicken Pox is suspected, keep home for at least 5 days after the appearance of the rash or until all blisters have scabbed over.

To keep children healthy, make sure they have plenty of rest and a nutritious diet. Show your child the proper way to wash their hands and to do it frequently throughout the day. Make sure to use soap & water and to rub hands together for at least 20 seconds. Limit touching areas such as the eyes, nose or mouth. Teach your child to cover coughs and sneezes with a tissue or their arm. Minimize the time your child spends with others who are ill. Avoid sharing personal items such as hats, brushes, combs, lip balms or towels.

Please notify the school if your child has been diagnosed with an infectious condition such as strep throat, chickenpox, scarlet fever, pertussis, head lice, etc.

Thank you for your cooperation.

Adapted from information provided by Lake County Health Department/Community Health Center

March 28, 2016

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

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

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries —** At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

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

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

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

☐ **Other** — periodontal, orthodontic

Please note _____

Signature of Dentist _____ Date of Exam _____

Address _____ Telephone _____
Street City ZIP Code

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

IOCI 0600-10 Printed by Authority of the State of Illinois

Instrucciones para días de enfermedades: Tomando la decisión correcta!

Estimados Padres:

Para poder prevenir la propagación de enfermedades le estamos proveyendo instrucciones para ayudarlo a decidir si debe mandar a su hijo (a) a la esuela. Pedimos que mantenga a su hijo (a) en su casa si tiene alguno de los síntomas siguientes:

- Tiene 100.0 grados o mas de fiebre (calentura) oral
- Tiene vómitos
- Tiene una tos seca persistente
- Tiene diarrea (3 veces o mas en 24 horas)
- Tiene lesiones con pus
- Tiene síntomas que previenen que su hijo (a) participe en actividades escolares como:
    - o Cansancio o falta de apetito
    - o Dolor de cabeza, cuerpo, o de oídos
    - o Dolor de garganta severa (podría tener dolor de garganta aunque no tenga fiebre, otros síntomas de dolor de garganta en los niños dolor de cabeza y de estomago. Llame al pediatra para que determine si su hijo (a) tiene dolor de garganta).

Si su hijo (a) ha estado enfermo recientemente, por favor siga las siguientes pautas antes de mandarlo a la escuela, actividades atléticas o sociales:

- Deben sentirse bien por lo menos 24 horas.
- No haber tenido fiebre por 24 horas (sin haber tomado medicamentos)
- Si es dolor de garganta deben de estar en antibiótico apropiado por 24 horas
- Si es conjuntivitis, debe de estar recibiendo el antibiótico en gotas apropiado por 24 horas o tener permiso de un medico
- Si es varicela, mantenga a su hijo (a) en su casa por 5 días o hasta que las lesiones se hayan secado.

Para mantener a los niños saludables ellos necesitan suficiente descanso y una dieta nutricional. Asegurándose que su hijo (a) practique buen lavado de manos con frecuencia. Lave las manos usando jabón, usando mucha fricción por 20 segundos y enjuagar las manos bajo agua corriente. Trate de mantener sus manos alejadas de ojos, nariz y boca. Enseñe a su hijo (a) a cubrir sus tos de estornudar con una pañuelos desechables (kleenex) o con su brazo. Trate de evitar que su hijo (a) no pase mucho tiempo con personas enfermas. Evite compartir objetos personales tales como gorras, cepillos del cabello, peines y toallas.

Por favor notifique a la escuelas si su hijo (a) ha sido diagnosticado con una condición infecciosa tal como dolor de garganta, varicela, fiebre escarlentina, tos ferina, piojos, etc.

Gracias por su cooperacion.

Basada en la información de el Departamento de Salud y el Centro de Salud Comunitario

March 28, 2016

State of Illinois
Department of Public Health

DENTAL EXAMINATION WAIVER FORM

Please print:

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

I am unable to obtain the required dental examination because:

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

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

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

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

Signature _____ Date _____

State of Illinois
Eye Examination Report

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

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

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

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

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

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

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

Was refraction performed with dilation? ❑ Yes ❑ No

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

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

Diagnosis

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

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

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

2. Preferential seating recommended: ❑ No ❑ Yes

   Comments _____

   _____

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

   ❑ Other _____

4. _____

5. _____

Print name _____ License Number _____

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

Address _____

_____

Phone _____

Consent of Parent or Guardian

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

_____
(Parent or Guardian's Signature)

_____
(Date)

Signature _____ Date _____

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

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

State of Illinois
Illinois Department of Public Health

Eye Examination Waiver Form

Please print:

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

School Name _____ Grade Level_____ Gender: ❑ Male ❑ Female

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

Phone_____
(Area Code)

Parent or Guardian _____
(Last) (First)

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

I am unable to obtain the required vision examination because:

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

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

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

_____

_____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois IOCI 13-378

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

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

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

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

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

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

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

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

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

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

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

Address **Phone**

State of Illinois
Certificate of Child Health Examination

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

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

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

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

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

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

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

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

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

INSTRUCTIONS FOR COMPLETING

ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM

Who may use the *Certificate of Religious Exemption to Required Immunizations and/or Examinations Form:*

- Parents or legal guardians who are requesting a religious exemption to immunizations or examinations **must** use this form for students entering kindergarten, sixth, or ninth grades.
- A separate form must be used for **each child** with a religious exemption enrolled to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school.
- This form may not be used for exemptions from immunizations and/or examination for personal or philosophical reasons. Illinois law does not allow for such exemptions. (See excerpts below from Public Act 099-0249 enacted August 3, 2015 at page bottom.)

When use of this form becomes required: October 16, 2015

How to complete the *Certificate of Religious Exemption to Required Immunizations and/or Examinations Form*:

- Complete the Parent/Guardian sections, which include key information about the student and the school the student will be entering, and the immunizations or examinations for which religious exemption is being requested. Provide a statement of religious belief(s) **for each vaccination/examination requested**.
- The form must be signed by the child's parent or legal guardian **AND** the child's health care provider* responsible for performing the child's health examination.
- Submit the completed form to local school authority on or before October 15th of the school year, or by an earlier enrollment date established by a school district.

Religious Exemption from Immunizations and/or Examination Form Process:

- The local school authority is responsible for determining whether the information supplied on the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form constitutes a valid religious objection.
- The local school authority shall inform the parent or legal guardian, at the time that the exemption is presented, of exclusion procedures, should there be an outbreak of one or more diseases from which the student is not protected, in accordance with the Illinois Department of Public Health (IDPH) rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
- Exempting a child from health, dental, or eye examination does not exempt the child from participation in the program of physical education training provided in Section 27-5 through 27-7 of the Illinois School Code [105 ILCS 5/27-5 through 105 ILCS 5/27-7]. A separate request for exemption from physical education, if desired, would need to be presented.

Excerpt from Public Act 099-0249 enacted August 3, 2015:

Children of parents or legal guardians who object to health, dental, or eye examinations or any part thereof, or to immunizations or to vision and hearing screening tests on religious grounds shall not be required to undergo the examinations or immunizations if the parents or legal guardians present to the appropriate local school authority a signed Certificate of Religious Exemption detailing the grounds for objection and the specific immunizations and/or examinations to which they object. The grounds for objection must set forth the specific religious belief(s) that conflict with the examination, immunization, or other medical intervention. The certificate will be signed by the parent or legal guardian to confirm their awareness of the school's exclusion policies in the case of a vaccine preventable disease outbreak or exposure. The certificate must also be signed by the child's health care provider responsible for performing the child's examination for entry into kindergarten, sixth or ninth grade. This signature affirms that the provider educated the parent or legal guardian about the benefits of immunization and the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.

The religious objection provided need not be directed by the tenets of an established religious organization. However, general philosophical or moral reluctance to allow physical examinations, eye examinations, immunizations, vision and hearing screening or dental examinations will not provide a sufficient basis for an exception to statutory requirements. The local school authority is responsible for determining if the content of the Certificate of Religious Exemption constitutes a valid religious objection.

The local school authority shall inform the parent or legal guardian of exclusion procedures in accordance with IDPH's rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690) at the time the objection is presented.

ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION
TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM

PARENT OR LEGAL GUARDIAN - COMPLETE THIS SECTION

Note: *This form is required for all students entering kindergarten, sixth or ninth grades when parent(s) or legal guardian(s) is requesting a religious exemption on or after October 16, 2015. This form also must be submitted to request religious exemption for any student enrolling to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school on or after October 16, 2015.*

This form may NOT be used for personal or philosophical reasons. Illinois law does not allow for such exemptions.

Student Name:(last, first, middle) _____ **Parent/Guardian Name**: _____	**Student Date of Birth**: Month Day Year _____ **Gender**: ☐M ☐F	**School Name:** _____ **City:** _____	**Grade:** _____
Address: _____ _____	**Telephone Number(s)**: _____ _____	**Exemption requested for** (mark all that apply): ☐ **Hepatitis B** ☐ **DTaP** ☐ **Polio** ☐ **Hib** ☐ **Pneumococcal** ☐ **MMR** ☐ **Varicella** ☐ **Td/Tdap** ☐ **Meningococcal** ☐ **Health Exam** ☐ **Eye Exam** ☐ **Dental Exam** ☐ **Vision/Hearing Tests** ☐ **Other (indicate below)** _____	

To receive an exemption to vaccination/examination, a parent or legal guardian must provide a statement detailing the religious beliefs that prevent the child from receiving each required school vaccinations/examination being requested.
In the space provided below, state each vaccination or examination exemption requested and state the religious grounds for each request. If additional space is needed, attach additional page(s).

_____

_____

_____

_____

_____

_____

_____

_____

Religious Exemption Notice:
No student is required to have an immunization/examination that is contrary to the religious beliefs of his/her parent or legal guardian. However, not following vaccination recommendations may endanger the health or life of the unvaccinated student, others with whom they come in contact, and individuals in the community. In a disease outbreak, or after exposure to any of the diseases for which immunization is required, schools may exclude children who are not vaccinated in order to protect all students.
I have read the Religious Exemption Notice (above) and have provided requested information for each vaccination/examination being requested for religious exemption.

_____
Signature of parent or legal guardian (required) Date

HEALTH CARE PROVIDER* – COMPLETE THIS SECTION

Provision of information: I have provided the parent or legal guardian of the student named above, with information regarding ***1) the required examinations, 2) the benefits of immunization, and 3) the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.*** *I understand that my signature only reflects that this information was provided; I am not affirming the parent or legal guardian's religious beliefs regarding any examination, immunization or immunizing agent.*

_____
Signature of health care provider*

Date: _____
(Must be within 1 year prior to school entry)

Health Care Provider Name:

Address:

Telephone #: _____

*Health care provider responsible for performing child's health examination includes physicians licensed to practice medicine in all of its branches, advanced practice nurses, or physician assistants.

Pre-participation Examination

To be completed by athlete or parent prior to examination.

Name _____ School Year _____
Last First Middle

Address _____ City/State _____

Phone No. _____ Birthdate _____ Age _____ Class _____ Student ID No. _____

Parent's Name _____ Phone No. _____

Address _____ City/State _____

HISTORY FORM

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.
☐ Medicines ☐ Pollens ☐ Food ☐ Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Have you or any family member or relative been diagnosed with cancer?		
52. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY	**Yes**	**No**
53. Have you ever had a menstrual period?		
54. How old were you when you had your first menstrual period?		
55. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete _____ **Signature of parent/guardian** _____ **Date** _____

Pre-participation Examination

PHYSICAL EXAMINATION FORM

EXAMINATION		
Height Weight	☐ Male ☐ Female	
BP / (/) Pulse	Vision R 20/ L 20/	Corrected ☐ Y ☐ N
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart [a] • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)[b]		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic [c]		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/Ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

[a] Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
[b] Consider GU exam if in private setting. Having third party present is recommended.
[c] Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

On the basis of the examination on this day, I approve this child's participation in interscholastic sports for 395 days from this date.

Yes No Limited Examination Date

Additional Comments:

Physician's Signature

Physician's Assistant Signature*

Advanced Nurse Practitioner's Signature*

*effective January 2003, the IHSA Board of Directors approved a recommendation, consistent with the Illinois School Code, that allows Physician's Assistants or Advanced Nurse Practitioners to sign off on physicals.

IHSA Steroid Testing Policy Consent to Random Testing

(This section for high school students only)
2012-2013 school term

As a prerequisite to participation in IHSA athletic activities, we agree that I/our student will not use performance-enhancing substances as defined in the IHSA Performance-Enhancing Substance Testing Program Protocol. We have reviewed the policy and understand that I/our student may be asked to submit to testing for the presence of performance-enhancing substances in my/his/her body either during IHSA state series events or during the school day, and I/our student do/does hereby agree to submit to such testing and analysis by a certified laboratory. We further understand and agree that the results of the performance-enhancing substance testing may be provided to certain individuals in my/our student's high school as specified in the IHSA Performance-Enhancing Substance Testing Program Protocol which is available on the IHSA website at www.IHSA.org. We understand and agree that the results of the performance-enhancing substance testing will be held confidential to the extent required by law. We understand that failure to provide accurate and truthful information could subject me/our student to penalties as determined by IHSA.

A complete list of the current IHSA Banned Substance Classes can be accessed at
http://www.ihsa.org/initiatives/sportsMedicine/files/IHSA_banned_substance_classes.pdf

Signature of student-athlete Date Signature of parent-guardian Date

Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- Headaches
- "Pressure in head"
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- "Don't feel right"
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays in coordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can't recall events prior to hit
- Can't recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2012 Reviewed 4/24/2013

Concussion Information Sheet

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The Return-to-Play Policy of the IESA and IHSA requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with state law, all schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

Student/Parent Consent and Acknowledgements
By signing this form, we acknowledge we have been provided information regarding concussions.

Student

Student Name (Print): _____ Grade: _____

Student Signature: _____ Date: _____

Parent or Legal Guardian

Name (Print): _____

Signature: _____ Date: _____

Relationship to Student: _____

Each year IESA member schools are required to keep a signed Acknowledgement and Consent form and a current Pre-participation Physical Examination on file for all student athletes.

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2012 Reviewed 4/24/2013

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PRAIRIE CROSSING CHARTER SCHOOL

CREATING NATURAL LEADERS

_____ _____/___/_____ _____

Student Name DOB Date

____ My child will not need any prescription or over the counter medications during the school day. (Please proceed to *Allergy History Form*.)

2017 – 2018 School Medication Authorization Form

(For all prescription or non-prescription medications except for epinephrine injector or asthma inhaler)

Prairie Crossing Charter School policy states that, except for the limited exceptions recognized in the policy, no student shall possess or consume, and no Prairie Crossing Charter School employee shall administer to any student, or supervise any student's self-administration of, any prescription or nonprescription medication on school grounds or at a school-related function unless and until the student's parent/guardian has completed and signed this "School Medication Authorization Form" and returned that form and a prescription for the medication from a licensed medical provider to the Building Principal or his or her designee. All medication must be in the original labeled container as dispensed or manufacturer's labeled container and the label must contain the student name, name of the medication, directions for use, and date. Notwithstanding the foregoing, no school employee is prohibited from providing emergency assistance to a student, including administering medication to a student in an emergency situation.

This form must be completed annually by both a licensed prescriber and the parent/guardian of the student. The parent/guardian must notify Prairie Crossing Charter School immediately of any changes required for the administration of medication by delivering a new form completed by the parent/guardian and the licensed prescriber indicating the changes. Please see Prairie Crossing Charter School's medication policy for a full description of medication guidelines.

ALL MEDICATIONS MUST BE TURNED INTO THE OFFICE. NO MEDICATIONS ARE TO BE TURNED INTO A TEACHER.

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PRAIRIE CROSSING
CHARTER SCHOOL
CREATING NATURAL LEADERS

PRESCRIPTION MEDICATION PHYSICIAN AUTHORIZATION FORM

(Only one medication per form) ***This form must be renewed at least once a year.***

Student's name: _____ Grade: _____ Birth date: _____

Diagonosis:_____

Name of medication: _____ Duration of medication: _____

Dosage: _____ Time to be taken: _____

Are there any side effects to this medication? No Yes If yes, please specify: _____

_____

Self-Administration Consent (if applicable)

I certify that _____ has been instructed in the use and self-administration of the medication described above. He/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Prescriber's Signature: _____ Date:_____
(Original signature or signature/address stamp only)

_____

I give permission for my child, _____, to carry the medication described above. I will notify the school of changes in medication for my child's condition. I indemnify and hold harmless the school district and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the self-administration of medication by the student.

_____ _____
Parent/Guardian Signature Date

1531 Jones Point Road
Grayslake, IL 60030-3536

847-543-9722 Phone
847-543-9744 Fax

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PRAIRIE CROSSING
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CREATING NATURAL LEADERS

2017 -2018 Allergy History Form

_____ _____/____/_____ _____ _____
Student's name (Last) (First) (Middle initial) Birth date Grade Date

_____ **My child does not have any allergies. (Please proceed to the *Asthma Management Plan* form.)**

Please provide as much detail as possible about your child's present and past allergies. Thorough and accurate information will equip us to create a safe and healthy environment for your child.

1. When and how did you first become aware of the allergy?

2. When was the last time your child had an allergic reaction?

3. Please describe the signs and symptoms of the reaction.

4. What medical treatment was provided and by whom?

5. If medication is required while your child is at school, the enclosed Allergy Emergency Action Plan form must be completed by a licensed medical provider and parent/guardian.

_____ **My child does not need an Allergy Emergency Action Plan.**

6. Please describe the steps you would like us to take if your child is exposed to this allergen while at school.

_____ _____ _____
Parent/guardian name (please print) Parent/guardian signature Date

1531 Jones Point Road
Grayslake, IL 60030-3536

847-543-9722 Phone
847-543-9744 Fax

ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

Child's Photograph

NAME:_____ **D.O.B:**____/____/____

TEACHER:_____ **GRADE:**_____

ALLERGY TO:_____

Asthma: ☐ Yes (higher risk for a severe reaction) ☐ No

Weight: _____lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)
SKIN: Many hives over body

Or Combination of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Additional medications:
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis) → Use Epinephrine.

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY
Mouth: Itchy mouth
Skin: A few hives around mouth/face, mild itch
Gut: Mild nausea/discomfort

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

Other (e.g., inhaler-bronchodilator if asthma): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ Student may self-carry epinephrine ☐ Student may self-administer epinephrine

CONTACTS: Call 911 Rescue squad: (____)_____

Parent/Guardian: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Name/Relationship: _____ Ph: (____)_____

Licensed Healthcare Provider Signature:_____ Phone: _____ Date:_____
(Required)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Guardian Signature:_____ Date _____

INDIVIDUAL FOOD ALLERGY HEALTH CARE PLAN

General Plan:

- ☐ Epinephrine will be stored in the: Nurses office Class Room On Person
- ☐ Student's symptoms of an allergic reaction include_____
- ☐ Student can recognize an allergic reaction and knows when and how to seek help.

Classroom Plan:

- ☐ Student may eat only those foods approved and/or provided by parent.
- ☐ Parent/Guardian must be advised of parties, events or projects involving food as early as possible.

Field Trip Plan:

- ☐ Prescribed medication & Emergency Action Plan must be reviewed and carried by a staff member.

Other Needs: _____

Parent/Guardian Plan:

- ☐ I give Health Services staff permission to communicate with the Health Care Provider about this medication.
- ☐ I assume responsibility for supplying medication that will not expire during the course of its intended use.
- ☐ I will provide medication in the original prescription container with instructions by our health care provider.
- ☐ If my child is authorized to self-carry, additional medication will be kept in the health office as recommended.

Parent/Guardian Signature: _____ **Date:** _____

Reviewed by School Nurse: _____ **Date:** _____

DOCUMENTATION

- Gather accurate information about the reaction, including who assisted in the medical intervention and who witnessed the event.
- Save food eaten before the reaction, place in a plastic zipper bag (e.g. Ziploc bag) and freeze for analysis.
- Follow-up:
  - — Review facts about the reaction with the student and parents and provide the facts to those who witnessed the reaction or are involved with the student, on a need-to-know basis. Explanations will be age-appropriate.
  - — Amend the Emergency Action Plan (EAP), Individual Health Care Plan (IHCP) and/or 504 Plan as needed.
  - — Specify any changes to prevent reaction.

LOCATION OF MEDICATION

- ☐ Student to carry
- ☐ Health Office/Designated Area for Medication
- ☐ Other: _____

This document is based on input from medical professionals including Physicians, APNs, RNs and certified school nurses. It is meant to be useful for anyone with any level of training in dealing with a food allergy reaction.

Student's name (Last) (First) (Middle initial)	Birth date	Grade	Date
_____	_____/____/_____	_____	_____

Asthma Management Plan

BELOW PERMISSION APPLIES ONLY TO SELF-ADMINISTRATION OF ASTHMA INHALERS

(To be completed by parent/guardian)

( ) No. ( ) Yes. The student is authorized by a physician to self-administer an asthma inhaler, and he/she understands the need for the medication, and the necessity to report to school personnel any unusual side effects. He/she is capable of using this medication independently.

Please note: All medication authorized for self-administration must be carried to school in a package with a prescription label including name of medication, prescribed dosage, and time/frequency of dosage.

Name of medication:

_____

I understand and acknowledge that I am primarily responsible for administering medication to my child. However, I give permission for Prairie Crossing Charter School and its employees and agents, on my behalf and stead, to administer or attempt to administer to my child (or allow my child to self-administer, while under the supervision of the employees and agents of Prairie Crossing Charter School) the above medication in the manner described above. I acknowledge that it may be necessary for the administration of medication to my child to be performed by an individual other than a school nurse, and specifically consent to such practice. I understand that nothing in this form or elsewhere prohibits or prevents a Prairie Crossing Charter School employee or agent from providing emergency assistance to my child, including administering medication to the student in an emergency situation. I understand, however, that I should not rely on Prairie Crossing Charter School for the availability of emergency medication for my child, and that there is no guarantee that emergency medication will be available or accessible for my child in an emergency situation. I understand that it is my responsibility to consult a licensed provider to obtain all necessary medication and to ensure that the student has access to any necessary medication at school.

I further acknowledge and agree that, when medication is administered or attempted to be administered pursuant to this Form, including any self-administration by my child, or when any emergency assistance, as described above, is administered or attempted to be administered to my child, I waive any claims I might have against Prairie Crossing Charter School, its employees and agents arising out of the administration or self-administration of said medication other than for willful and wanton conduct. In addition I agree to hold harmless and indemnify Prairie Crossing Charter School, its employees and agents, either jointly or severally, from and against any and all claims, damages, causes of action or injuries incurred or resulting from the administration, self-administration, or attempts at administration or self-administration of said medication other than a claim based on willful and wanton conduct.

_____	_____	_____
Parent/guardian name (print)	**Relationship to student**	**Date**
_____	_____	_____
Parent/guardian signature	**Emergency phone number**	**Alternate phone number**

Adapted from ISBE & IDHS Recommended Guidelines for Medication Administration in Schools (September, 2000).
1511080.1

Revised 03/2016 *PCCS: LEW, RN*

EST. 1999

PRAIRIE CROSSING CHARTER SCHOOL

CREATING NATURAL LEADERS

2017 - 2018 Student Asthma Management Plan

This form must be returned to the school office no later than August 1, 2017.

_____ _____/____/_____ _____ _____

Student's name (Last) (First) (Middle initial) Birth date Grade Date

_____ **My child does not have asthma.** (You do not need to fill out the following pages of asthma information.)

Symptoms of an asthma episode (circle all that may apply):

Wheezing Coughing Difficulty breathing Shortness of breath

_____

Other

Identify things that may trigger an asthma attack (circle all that may apply):

_____ _____

Abrupt temperature/weather change (specify) Exercise (specify)

_____ Respiratory infections Colds Prairie burns

Seasonal changes (specify)

My student is allergic to: **(circle all that may apply)**

Mold Dust Pollen

Animals (specify) _____ Foods (specify)_____

Other (specify)_____

Prevention: List any environmental control measures, dietary restrictions, or other factors needed to prevent an Asthma episode:

_____.

Instructions: If school is unable to reach parent in an emergency, permission is granted to contact physician listed on this form, or to transport student to the emergency room. I/we understand that the above and following information will be released to staff members as appropriate, with the expectations that confidentiality will be respected at all times.

_____

Parent/guardian signature Date

1531 Jones Point Road
Grayslake, IL 60030-3536

847-543-9722 Phone
847-543-9744 Fax

Visit us at prairiecrossingcharterschool.org

_____ _____/____/_____ _____ _____

Student's name (Last) (First) (Middle initial) Birth date Grade Date

Asthma Management Plan

To Be Completed by Physician

(Please fill out the entire form)

_____ _____ _____

Medication Dosage Frequency

❑ **Grades 5-8:** Student may self-carry inhaler.

❑ **Grades 5-8:** Student has been instructed in proper use of inhaler(s) and may self-administer as needed.

_____ _____

Date of order Expected side effects

_____

Other medications the student is receiving

****

Intervention Plan

Immediate action is necessary when the student has the following symptoms: _____

_____ and/or a peak flow reading of _____ or below.

Contact the parent if symptoms persist. If unable to reach parent, seek emergency care if any of the following occur:

★ No improvement of symptoms in _____ minutes after initial treatment

★ Peak flow of _____ or below.

★ Difficulty walking, talking, or breathing with chest/tracheal retractions; hunched position

★ Skin, lips, or fingernails are blue or gray

Physical Education/Sports (please check all that apply):

❑ Full participation at all times; no asthma-related restrictions.

❑ Participation with the following restrictions/modifications:_____

_____

❑ Allow student to self-pace. ❑ Built in rest periods as needed. ❑ Peak flow above _____.

❑ An inhaler is considered part of the student's PE uniform. If a student does not have his/her inhaler, he/she will receive a zero for participation that day.

_____ _____

Physician name (print) Physician's emergency phone number

_____ _____

Physician signature Date

1531 Jones Point Road
Grayslake, IL 60030-3536

847-543-9722 Phone
847-543-9744 Fax

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Seizure Action Plan

Effective Date

This student is being treated for a seizure disorder. The information below should assist you if a seizure occurs during school hours.

Student's Name | Date of Birth

Parent/Guardian | Phone | Cell

Other Emergency Contact | Phone | Cell

Treating Physician | Phone

Significant Medical History

Seizure Information

Seizure Type	Length	Frequency	Description

Seizure triggers or warning signs:

Student's response after a seizure:

Basic First Aid: Care & Comfort

Please describe basic first aid procedures:

Does student need to leave the classroom after a seizure? ❒ Yes ❒ No

If YES, describe process for returning student to classroom:

Basic Seizure First Aid

- Stay calm & track time
- Keep child safe
- Do not restrain
- Do not put anything in mouth
- Stay with child until fully conscious
- Record seizure in log

For tonic-clonic seizure:

- Protect head
- Keep airway open/watch breathing
- Turn child on side

Emergency Response

A "seizure emergency" for this student is defined as:

Seizure Emergency Protocol
(Check all that apply and clarify below)

- ❒ Contact school nurse at _____
- ❒ Call 911 for transport to _____
- ❒ Notify parent or emergency contact
- ❒ Administer emergency medications as indicated below
- ❒ Notify doctor
- ❒ Other _____

A seizure is generally considered an emergency when:

- Convulsive (tonic-clonic) seizure lasts longer than 5 minutes
- Student has repeated seizures without regaining consciousness
- Student is injured or has diabetes
- Student has a first-time seizure
- Student has breathing difficulties
- Student has a seizure in water

Treatment Protocol During School Hours (include daily and emergency medications)

Emerg. Med. ✓	Medication	Dosage & Time of Day Given	Common Side Effects & Special Instructions

Does student have a **Vagus Nerve Stimulator?** ❒ Yes ❒ No If YES, describe magnet use:

Special Considerations and Precautions (regarding school activities, sports, trips, etc.)

Describe any special considerations or precautions:

Physician Signature _____ **Date** _____

Parent/Guardian Signature _____ **Date** _____