

“EARLY” REGISTRATION FOR RETURNING STUDENTS

We will be having early registration this year for a select group of students.

**Thursday, May 26th from 4pm to 8pm
At Joseph Arthur Middle School**

The following requirements must be met in order to qualify for early registration.

- 1. You must be currently enrolled at Central Elementary School or Joseph Arthur Middle School.**
- 2. You MUST bring COMPLETED FORMS and THREE proofs of residency with you at the time of registration.**

**Fees for 2011—2012:
REGISTRATION FEES: \$10 PER STUDENT!
\$5 for Bus Passes
\$20 for MAC Ins. (6th - 8th grade students only)**

A late fee of \$10 will be assessed if returning students are not registered on one of the scheduled registration days.

All paperwork required will be provided to you prior to this date for you to complete, please bring it with you to registration along with your proofs of residency and any Immunization or Physical information.

2011—2012

Important Dates:

Summer School: July 11th—28th

**“EARLY” REGISTRATION FOR
RETURNING STUDENTS ONLY**

**Thursday, May 26th from 4pm to 8pm
At Joseph Arthur Middle School**

Summer Registration:

Tuesday, July 12th from 9:00 am to 3:00 pm

Wednesday, July 13th from 9:00 am to 3:00pm

Thursday, July 14th from 12:00 pm—8:00 pm

Wednesday, July 20th & 27th from 9:00 am—3:00 pm

First Day of School:

Thursday, August 18th

EARLY DISMISSAL

Late Registration:

Thursday, August 18th from 1:00 to 3:00pm

**A \$10 late registration fee will be charged and these students will
not be able to start until Monday, Aug 30th.**

Open House: August 16th

Dear Resident:

Welcome to Central School District #104! As we prepare for a great school year here are some things you can do to support our efforts. Remember, **ALL RETURNING AND NEW STUDENTS MUST REGISTER EACH SCHOOL YEAR AND PROVE RESIDENCY EACH YEAR.**

If you are unable to make it to these registration dates, there will be a \$10 late registration fee charged per student, in addition to the \$10 registration fee per student. Students who have not registered at one of the dates above **WILL NOT** be permitted to attend class the first day of school.

*****IMPORTANT NOTICE*****

The first day of school is Thursday, August 18, 2011. The first day of school will be an **EARLY DISMISSAL DAY**. Your child must be registered before attending the first day of school.

PAPERWORK: All registration forms must be completed in full and signed where needed.

(Forms may also be found on the School Website – www.central104.org)

ITEMS YOU MUST BRING WITH YOU:

RESIDENCY

School districts are concerned about registering or enrolling pupils that cannot produce documented proof of residency in the school district. To help combat some confusion at registration, we have some guidance that explains all the areas of residency for non-special education pupils. [Residency for special education pupils is generally based on guardianship. See 105 ILCS 5/14-1.11 and 5/14-1.11a; see also 23 Ill. Admin. Code 226.]

All students must prove residency this year. One item from each category **must** be received in order to register your child.

Category A:

- Home Ownership Title, Deed or Mortgage Statement
- **Current** Lease Agreement or Current Receipt of Monthly rent
- **Current** Real Estate Tax Bill

Category B:

- **Current** Utility Bill (water, electric, etc.)
- Occupancy Permit
- Homeowner or Renter Insurance Bill

Category C:

- **Current** paycheck stub with address in the District
- Documentation of TANF or Approval Letter from Nutrition Program and Support Services
- Driver's license with address in the District

Students **MUST** reside within the boundaries of Central School District #104. Guardianship for the sole purpose of education will not be accepted. Any person who knowingly or willfully presents to any school district false information regarding residency of a pupil for the sole purpose of enabling that pupil to attend any school in that district without the payment on a non-resident tuition charge shall be guilty of a Class C misdemeanor, punishable by up to 30 days incarceration and/or a fine up to \$1500. (730 ILC85/5-9-1)

STUDENT REQUIREMENTS

- Certified birth certificate must be on file for students
- Illinois Transfer Form is required for all new students transferring within the state of Illinois

STUDENT HEALTH REQUIREMENTS

- Physical (PreK, Kindergarten, 6th, and all new students)
- Immunization record (PreK, Kindergarten, 6th, and all new students)
- Dental record (Kindergarten, 2nd, and 6th): HB 752- Public Act 93-946
- Eye exam (Kindergarten): SB0641 – Public Act 095-0671. An eye exam is required for students in Kindergarten and ALL students new to Illinois Public Schools. This exam must be conducted by a licensed optometrist or a physician licensed to practice medicine in all of its branches.
- Sports physicals (6th, 7th, 8th for students wanting to participate in sports; must be on file before sports tryouts and be valid through the entire season).

REGISTRATION FEES: There will be a \$10 registration fee per student and a \$5 bus fee if your student needs to ride the bus. There is also a \$20 laptop insurance fee for 6th-8th grade students. **A \$10 late fee will apply to any returning student who is registered after the July 27st deadline in addition to the \$10 registration fee per student.**

BUS: The fee for the bus pass covers the entire school year. These passes are to be used for the bus driver to identify the students riding the bus. Bus routes may not be available until open house. Bus passes will be given the first full week of school.

FOOD SERVICE PROGRAM: There may be a representative from the Cafeteria to answer any questions and to take deposits on your child's breakfast/lunch account. Please make all checks payable to: **Central School District #104**, this applies to Joseph Arthur Middle School, as well as Central Elementary School.

The first day of student attendance for the 2011 – 2012 school year is August 18th; this is an EARLY DISMISSAL day. Hours for the 1st day of school are:

Central School: 7:50am – 11:00am

Joseph Arthur: 8:30am – 12:00pm

Sincerely,

Dawn Elser, Central Elementary School, Principal
Jered Weh, Joseph Arthur Middle School, Principal

- Central Elementary (EC/PK-4)
- Joseph Arthur M.S. (5-8)

Central School District #104
Registration for School Year 2011-2012

2011-2012
 Grade _____

Student Last Name _____ First Name _____ Middle Name _____ Date of Birth (MM-DD-YYYY) _____ Male Female

Is student hispanic? Yes No

Birth Place (City, State, Country) _____

Race: White African American Am. Indian/Alaskan Native Asian Pacific Islander Hispanic Multiracial

Other languages spoken at home _____ New to district Yes No

Family 1 (where student resides):

Parent/Guardian 1 Full Name _____ Primary Contact Number _____ Work Number _____ Cell Number _____

Relationship to Student _____ Email Address _____

Address (where student resides) _____ City, State, ZIP _____

Parent/Guardian 2 Full Name _____ Primary Contact Number _____ Work Number _____ Cell Number _____

Relationship to Student _____ Email Address _____

Family 2 (if applicable):

Parent/Guardian 1 Full Name _____ Primary Contact Number _____ Work Number _____ Cell Number _____

Relationship to Student _____ Email Address _____

Address _____ City, State, ZIP _____

Parent/Guardian 2 Full Name _____ Primary Contact Number _____ Work Number _____ Cell Number _____

Relationship to Student _____ Email Address _____

Emergency Contacts (please list in preferred order):

Name _____ Phone Numbers _____ Relationship to Student _____

Name _____ Phone Numbers _____ Relationship to Student _____

Name _____ Phone Numbers _____ Relationship to Student _____

Name _____ Phone Numbers _____ Relationship to Student _____

Central Elementary (EC/PK-4)

Central School District #104
Registration for School Year 2011-2012

2011-2012

Joseph Arthur M.S. (6-8)

Grade _____

Physician: _____

Phone Number: _____

Dentist: _____

Phone Number: _____

Hospital: _____

Phone Number: _____

Before/after school care and phone number: _____

Please circle the special services your child receives: _____ Date of last IEP Meeting: _____

None Speech OT PT Special Education Rtl/Title Other _____

Other useful information:

By signing below, I state that the above student resides within the boundaries of Central School District #104. Guardianship for the sole purpose of education will not be accepted. Any person who knowingly or willfully presents to any school district false information regarding residency of a pupil for the sole purpose of enabling that pupil to attend any school in that district without the payment on a non-resident tuition charge shall be guilty of a Class C misdemeanor, punishable by up to 30 days incarceration and/or a fine up to \$1500. (730 ILC05/5-9-1).

Parent/Guardian Signature

Date

Dear Parents/Guardians:

Central School District #104 is pleased to announce that we are implementing a new product called Family Access by Skyward, Inc. Family Access is a secure internet based website that will allow you to easily keep track of nearly everything your student(s) does while at school. Among other things, this new service will allow you to view your student's attendance, grades, schedule, progress, assignments, and emergency information. Family Access is a free service and will be available to all parents with children enrolled in the district.

In order for you to begin using Family Access, you will need to register for a login and password. By signing and returning the form below, you are authorizing Central School District #104 to provide you with your unique login and password.

We are very excited about how Family Access will help you stay informed about your student's progress and hope that we can use this tool to create a stronger relationship between parents and our school community.

If you need technical assistance, please contact Jermaine Gayle at jgayle@central104.org.

Sincerely,

Central School District #104 Technology Department

Please fill in the appropriate information below for each parent and/or guardian that would like to have a login and password assigned to them so they can view their student's information, grades and progress in Family Access. Parents and/or guardians of the same student(s) can share the same login and password if that would be easier for them. If the spaces below are insufficient to accommodate your family, please e-mail all of the below information to Gloria Meyer at gmeyer@central104.org for Central Elementary students or Denyse Anderson at danderson@central104.org for Joseph Arthur students.

Name _____

Phone # _____ E-mail _____

Name _____

Phone # _____ E-mail _____

Please check all that are appropriate

_____ Please send my password(s) via email

_____ Please call me with my password(s)

_____ Please mail my password(s) to _____

_____ No password is required – I waive this service at this time

Signature _____ Date _____

Please return with registration information

Central School District #104 Authorization Form

Student's Name _____ Date _____ Grade _____

Student Handbook

Central School District #104 students will receive a copy of the Central School District #104 Parent-Student Handbook. The handbook is also available online. The handbook will be included in the student agenda book. I understand the handbook outlines the policies and procedures used to govern Central School and that my student and I are responsible for reading and understanding this material.

X _____
Parent/Guardian Signature

Bus Rules and Guidelines

I have received a copy of the Central School District #104's Bus Rules and Guidelines. I will discuss these rules with my son/daughter. I understand the Bus Rules and Guidelines apply to daily transportation and all school related trips. Students are expected to sit down in their seats and use a reasonable voice tone. The majority of bus write-ups deals with students yelling, being disrespectful, or out of their seat. Excessive and/or severe write-ups will result in suspension from the bus.

X _____
Parent/Guardian Signature

Acceptable Use Policy for Electronic Networks – AUP

Central School District #104 offers its students access to technology and the Internet. Access is a privilege that entails responsibility on the student's part to refrain from accessing content that includes obscene language or content that is not educationally sound. All users of the District's electronic networks must agree to follow the Central School District's Acceptable Use Policy.

X _____
Parent/Guardian Signature

Photographic Permission

Students will be photographed for various reasons in educational settings at Central School. Newspapers may run feature articles on students' activities. Students will be pictured in our annual yearbook and monthly and district newsletter. Your permission is necessary to include your child's name and photograph.

Central School District #104 has permission to use my child's name and photograph in school related media.

X _____
Parent/Guardian Signature

Central School District #104 Field Trip Permission

Throughout the school year your child may be on several field trips, all of which will have educational value. We are asking you to fill out this permission form that is good for all trips throughout the 2011 - 2012 school year. The teacher will send a note home with your child prior to any field trip his/her class takes.

X _____
Parent/Guardian Signature

*****ATTENTION PARENTS*****

Health Requirements for School Year 2011-2012

Kindergarten: All Kindergarten students will need an updated physical examination and updated immunization records. Those exams are due by **September 16th, 2011**. If the physical exam and immunizations are not turned in on time, your child will be excluded from school until the proper forms are received. Students will also need a Dental and an Eye exam. The Eye exam is due by **October 15th, 2011** and must be completed by an eye doctor. The Dental exam is due by **May 15th, 2012**. Please make sure these items are turned in on time to remain in compliance.

2nd Grade: All 2nd grade students will need a Dental exam that will be due by **May 15th, 2012**.

6th Grade: All 6th grade students will need a new physical and updated immunizations. The physical exam and immunization records are due by **September 16th, 2011**. If the physical exam and immunization records are not turned in on time, your child will be excluded from school until the proper forms are received. A dental exam is also required and is due by **May 15th, 2012**.

Sports (for grades 6th-8th): Students who participate in Sports are required to have an updated sports physical **before** trying out for any type of sport. The physical needs to be recent and be able to cover the student for the duration of the sports season.

Physicians are scheduled to administer physicals at Joseph Arthur Middle School on July 14th from 5-7pm, the cost is \$15.00.



PERMISSION FOR TREATMENT

I, _____, parent or legal guardian of _____
(Print Parent/Guardian name) (Print Student Name)

am a resident of the Central School District 104 in O'Fallon and my child is enrolled in District 104. I hereby authorize, and consent to Central School District 104, its employees and agents, and _____; my child's licensed health care provider in his or her group practice, or emergency personnel, in my behalf and in my stead, to administer first aid or emergency medical assistance to my child. This permission and consent extends to the right of Central School District 104, its employees and agents arrange for immediate medical treatment by a licensed or certified physician and/or other medical personnel and for such physician or other medical personnel to apply such emergency techniques which, in their judgment, they deem appropriate to treat any injury sustained by my child.

I do hereby agree to hold harmless and indemnify the school district, its employees and agents, either jointly or severally from and against any and all claims, demands, damages, or causes of action or injuries, resulting from or arising out of the provision of emergency medical treatment by school personnel or by a physician and/or medical personnel.

In case the school officials are unable to contact me (parent/guardian) or any of the designated emergency contacts and my child needs to be transported to a hospital, decisions will be made in the best interest of the child. The law in the State of Illinois states that EMS must transport to the nearest hospital. The person can then be transported to the hospital of my choice.

First Hospital Choice: _____

Second Hospital Choice: _____

Medications: _____

Allergies to Medications: _____

Student Name: _____ School: _____

D.O.B _____ Sex M F Grade: _____ Teacher: _____

Address: _____ Phone Number: _____

Signature of Parent/Guardian: _____ Date: _____

* Please Complete Both Sides *



SCHOOL MEDICATION AUTHORIZATION FORM

Any student who is REQUIRED to take medication of any kind during the school day may be assisted by the school nurse or other designated school personnel if the school district has received the following: (1) a written statement from a licensed health care provider, with prescriptive authority, working within the scope of their practice, detailing the method, amount and time the medication is to be taken, (2) a written statement from the parent/guardian requesting the school district to assist the pupil in the manner set forth by the physician statement and (3) the medication shall be in a properly labeled pharmacy bottle. A new form must be completed for all medication changes and when the medication is discontinued.

NO MEDICATION WILL BE SENT HOME WITH THE STUDENT.
All medication must be kept in and dispensed from the nurses' office.

Physician Statement

_____ is under my professional care and is on the following
(Student Name)

Medication: _____ Dosage: _____
Method of Administration: _____ Time Schedule: _____
Side Effects of particular concern: _____
Start Date: _____ Discontinue Date: _____
Diagnosis: _____

I recommend that the school nurse or other designated school personnel assist in the administering of the medication during school hours. This medication **MUST** be administered during the school day to allow the student to attend school or to address the student's medical condition.

Physician Signature Print Name Address and Phone Number Date

If HealthCare Provider is APN or PA, name of Collaborating/Supervising Physician: _____

Parent or Guardian Statement

As the parent/guardian of the above named student, I request that Central School District #104 to assist in carrying out the physician's instructions in the administration of the above named medication during the school day. I further agree that when the medication is so administered, I waive any claims I might have against the school district, its employees and agents arising out of administration of said medication. In addition, I agree to hold harmless and indemnify the school district, 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 of said medication. I have read the policy and procedures for administration of medication in Central School District #104 Handbook and agree to abide by them.

Parent Signature Print Name Date

Please return this form to the school signed by the licensed health care provider, working within their scope of practice, and the parent/ guardian.

NO MEDICATION (PRESCRIPTION OR OVER THE COUNTER) WILL BE ADMINISTERED WITHOUT THE REQUIRED SIGNATURES.

Student Name: _____

Birth Date: _____

MEDICAL HISTORY

ALLERGIES: (Food, Drug, Insect, other)				MEDICATION (List all prescribed or over the counter taken on a regular basis) Home: _____ School: _____			
Diagnosis of Asthma? <input type="checkbox"/> Y <input type="checkbox"/> N		Inhaler use? <input type="checkbox"/> Y <input type="checkbox"/> N		Home <input type="checkbox"/> School <input type="checkbox"/>			
Triggers: _____							
Birth Defects <input type="checkbox"/> Y <input type="checkbox"/> N		Developmental Delay <input type="checkbox"/> Y <input type="checkbox"/> N		Loss of function of one of paired organs (eye; ear; kidney; testicle) <input type="checkbox"/> Y <input type="checkbox"/> N			
Blood Disorders? Hemophilia, Sickle Cell, Other. Explain <input type="checkbox"/> Y <input type="checkbox"/> N		Hospitalizations <input type="checkbox"/> Y <input type="checkbox"/> N please explain					
Diabetes <input type="checkbox"/> Y <input type="checkbox"/> N Type: _____ Blood sugar testing <input type="checkbox"/> Insulin Injection <input type="checkbox"/> Insulin pump <input type="checkbox"/>		Head Injuries <input type="checkbox"/> Y <input type="checkbox"/> N _____ concussion (age & treatment) _____ _____ skull fracture (age & treatment) _____		Surgeries <input type="checkbox"/> Y <input type="checkbox"/> N please explain			
Seizures <input type="checkbox"/> Y <input type="checkbox"/> N Please describe _____		Serious Injury or Illness <input type="checkbox"/> Y <input type="checkbox"/> N please explain					
Heart Problems							
Shortness of Breath <input type="checkbox"/> Y <input type="checkbox"/> N		Heart Murmur <input type="checkbox"/> Y <input type="checkbox"/> N restrictions <input type="checkbox"/> Y <input type="checkbox"/> N		TB skin test positive <input type="checkbox"/> Y <input type="checkbox"/> N year _____ TB disease <input type="checkbox"/> Y <input type="checkbox"/> N year _____ treatment _____			
High blood pressure <input type="checkbox"/> Y <input type="checkbox"/> N		Dizziness or chest pain with exercise <input type="checkbox"/> Y <input type="checkbox"/> N restrictions <input type="checkbox"/> Y <input type="checkbox"/> N					
Eye/Vision Problems <input type="checkbox"/> Y <input type="checkbox"/> N Last exam _____ _____ Glasses _____ Contacts _____ Amblyopia (lazy eye) _____ Loss of Vision right eye _____ left eye _____		Ear/Hearing Problems <input type="checkbox"/> Y <input type="checkbox"/> N hearing loss right ear _____ left ear _____ hearing aids right ear _____ left ear _____		Family tobacco use <input type="checkbox"/> Y <input type="checkbox"/> N Alcohol/Drug use <input type="checkbox"/> Y <input type="checkbox"/> N Family history of sudden death before age 50; explain <input type="checkbox"/> Y <input type="checkbox"/> N			
Bone/Joint problems/injury; scoliosis Please explain _____		Dental: Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> other _____ last exam: _____		Last medical exam _____ Physician: _____			
Childhood Illnesses: _____ Chickenpox (yr) _____		Pertussis or Whooping Cough (yr) _____					
Other Concerns: _____							

Information may be shared with appropriate personnel for health and educational purposes. I further give permission for school medical personnel to contact my medical providers during the school year to clarify appropriate care for my child.

Parent/Guardian Signature _____

Date _____

Phone: _____



**STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

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

Address		City	ZIP code	Parent/Guardian	Telephone # Home	Work
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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			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

Comments

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	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

3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

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
Vision																	
Hearing																	

Printed by Authority of the State of Illinois
(Complete Both Sides)

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	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night coughing	Yes	No				
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No
Developmental delay?	Yes	No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No
Diabetes?	Yes	No		Serious injury or illness?	Yes	No
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No
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 <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Other concerns?		
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	Yes	No		Parent/Guardian Signature _____	Date _____	

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)						
PHYSICAL EXAMINATION REQUIREMENTS		HEIGHT	WEIGHT	BMI	B/P	
DIABETES SCREENING BMD>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. Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (Blood test required in Chicago and other high risk zip codes.)						
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read / / Result mm						
LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES		Date	Results	Date	Results	
Hemoglobin * or Hematocrit *				Sickle Cell * (as indicated)		
Urinalysis				Other		
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs	
Skin				Endocrine		
Ears				Gastrointestinal		
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/>	Result _____	Genito-Urinary	LMP	
		Referred to Ophthalmologist/Optomtrist Yes <input type="checkbox"/> No <input type="checkbox"/>		Neurological		
Nose				Musculoskeletal		
Throat				Spinal examination		
Mouth/Dental				Nutritional status		
Cardiovascular/HTN				Mental Health		
Respiratory						
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>	INTERSCHOLASTIC SPORTS (for one year)		Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>	
Physician/Advanced Practice Nurse/Physician Assistant performing examination						
Print Name _____		Signature _____		Date _____		
Address _____			Phone _____			

(Complete both sides)

**Illinois Department of Public Health
PROOF OF SCHOOL DENTAL EXAMINATION FORM**



To be completed by the parent (please print):

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

To be completed by dentist:

Oral Health Status (check all that apply)

Yes No **Dental Sealants Present**

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

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

Yes No **Soft Tissue Pathology**

Yes No **Malocclusion**

Treatment Needs (check all that apply)

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

Restorative Care — amalgams, composites, crowns, etc.

Preventive Care — sealants, fluoride treatment, prophylaxis

Other — periodontal, orthodontic

Please note _____

Signature of Dentist _____

Date _____

Address _____
Street City ZIP Code

Telephone _____

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



May 13, 2011

Dear Parent or Guardian:

Your student(s) may be eligible to receive free or reduced priced meals. A new application for these benefits is required for each new school year.

Please complete the enclosed application in full, and return it with your students' registration information on any of the dates listed below. If you do not wish to participate or know that you will not qualify, please write "OPT – OUT" across the top of the form and sign it in the required area. This form is a required part of the registration process this year.

If it is determined that your student(s) is/are eligible, you will receive notification of the level of benefit. **All incomplete applications will be denied.** If you are not eligible now but have a decrease in household income, become unemployed, or have an increase in household size, you may fill out an application at that time.

You must notify the school when your household income increases by \$50.00 or more per month (\$600.00 per year), when your household size decreases or when you no longer receive food stamps or TANF for your children.

Please return all completed applications to:

Virginia Shelton
Central school District #104
309 Hartman Lane
O'Fallon, IL 62269

In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, Room 326-W, Whitten Building, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410 or call 202-720-5964 (voice and TDD). USDA is an equal opportunity provider and employer.

2011 – 2012 School Year Registration Dates Are:

Thursday, May 26th:	4:00pm – 8:00pm "EARLY REGISTRATION"
Tuesday, July 12th:	9:00am – 3:00pm
Wednesday, July 13th:	9:00am – 3:00pm
Thursday, July 14th:	12:00pm – 8:00pm "EVENING"
Wednesday, July 20th & 27th:	9:00am – 3:00pm

Sincerely,
Virginia Shelton
Secretary, 618.632.6336 x101

LETTER TO HOUSEHOLDS

Dear Parent or Guardian:

Child(ren) need healthy meals/milk to learn. Central School District #104, offers healthy meals/milk every school day. Breakfast costs .75; Lunch costs 1.75; Milk costs .55. Your child(ren) may qualify for free or reduced-price meals or free milk. Reduced-price is \$0.30 for breakfast and \$0.40 for lunch. To apply for free or reduced-price meals, use the Household Eligibility Application, which is enclosed. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to:

Name: Virginia Shelton
Address: 303 Hartman Lane
Telephone: 618-632-6336

Your child(ren) may qualify for free or reduced-price meals if your household income falls within the Federal Income Guidelines.

For school year 2010-2011 only, the United States Department of Agriculture has provided a waiver from the requirement to include the Federal Income Eligibility Guidelines for reduced price meals on this letter. All households are encouraged to apply for meal or milk benefits. (USDA Authority Section 125(1) of the NSLA)

Here are answers to questions you may have about applying:

- 1. Do I need to fill out an application for each child?** No. Complete the application to apply for free or reduced-price meals. Use one Household Eligibility Application for all students in your household per district. We cannot approve an application that is not complete, so be sure to fill out all required information. Return the completed application to person listed above.
- 2. Who can get free meals/milk?** Children in households receiving Supplemental Nutrition Assistance Program (SNAP) or Temporary Assistance for Needy Families (TANF) and most foster children can get free meals regardless of your income. Also, if your household income is within the limits on the Federal Income Chart, your children can get free meals/milk.
- 3. Can homeless, runaway, migrant or Head Start children get free meals?** Please call (or contact the school) to see if your child(ren) qualifies, if you have not been informed that they will receive free meals.
- 4. Who can get reduced-price meals?** Your children can get low-cost meals if your household income is within the reduced-price limits on the Federal Income Eligibility Guidelines (IEG).
- 5. My child receives SNAP or TANF benefits. The school provided me a letter that stated that my child is eligible for free meals via the Direct Certification Process. Do I need to do anything more to ensure that I receive free meals for my child?** No. You do not need to do anything more to receive the free meals. If you do not wish to receive the free meals, you should follow the steps outlined in the letter from the school to notify school personnel immediately.
- 6. My child's application was approved last year. Do I need to fill out another one?** Yes. Your child's application is only good for that school year and for the first few days of this school year. You must send in a new application unless the school told you that your child is eligible for the new school year.
- 7. I get Women, Infants, and Children (WIC). Can my child(ren) get free meals?** Children in households participating in WIC may be eligible for free or reduced-price meals. Please fill out an application.
- 8. Will the information I give be checked?** Yes. We may ask you to send written proof of the information you give.
- 9. If I do not qualify now, may I apply later?** Yes. You may apply at any time during the school year.
- 10. What if I disagree with the school's decision about my application?** You should talk to school officials. You also may ask for a hearing by calling or writing to the person listed above.
- 11. May I apply if someone in my household is not a U.S. citizen?** Yes. You or your child(ren) do not have to be a U.S. citizen to qualify for free or reduced-price meals.
- 12. Who should I include as members of my household?** You must include all people living in your household, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children who live with you.
- 13. What if my income is not always the same?** List the amount that you normally get. For example, if you normally get \$1000 each month, but you missed some work last month and only got \$900, put down that you get \$1000 per month. If you normally get overtime, include it, but not if you get it only sometimes.
- 14. We are in the military. Do we include our housing allowance as income?** If your housing is part of the Military Housing Privatization Initiative, do not include your housing allowance as income. All other allowances must be included in your gross income.
- 15. My spouse is deployed to a combat zone. Is her combat pay counted as income?** No. If the combat pay is received in addition to her basic pay because of her deployment and it wasn't received before she was deployed, combat pay is not counted as income. Contact your school for more information.
- 16. My family needs more help. Are there other programs we might apply for?** To find out how to apply for SNAP, TANF or other assistance benefits, contact your local Department of Human Services office or call (800) 843-6154 (voice) or (800) 447-6404 (TTY).

Sincerely,

Enclosure

LHH (7/10)

INSTRUCTIONS FOR APPLYING

Complete One Application Per Household Per School District

If your household receives SNAP OR TANF, follow these instructions and return this form to your school.

1: List all household members, school and grade for each student, and a SNAP or TANF case number for any household member including adults receiving such benefits. (Attach another sheet of paper if necessary.)

2: Skip

3: Skip

4: Skip

5: Sign the form (A social security number is not necessary.)

6: Contact information (Optional)

7: Children's racial and ethnic identities (Optional)

8: All Kids information (Optional)

If you are applying for a homeless, migrant, runaway, or Head Start child follow these instructions and return this form to your school.

1: List all household members, school and grade for each student. (Attach another sheet of paper if necessary.)

2: Check the appropriate box

If you are applying for a FOSTER CHILD, follow these instructions and return this form to your school.

1: Use a separate application for each foster child. List the foster child's name, school, and grade.

2: Skip

3: Check the box and list the child's personal use monthly income. If none, indicate \$0.00.

4: Skip

5: Sign the form (A social security number is not necessary)

6: Contact information (Optional)

7: Children's racial and ethnic identities (Optional)

8: All Kids information (Optional)

ALL OTHER HOUSEHOLDS, including Women, Infants, and Children (WIC) households, follow these instructions and return this form to your school.

1: List all household members, school and grade for each student, and if the person has no income, check the no income box. (Attach another sheet of paper if necessary.)

2: Skip

3: Skip

4: Follow these instructions to report total household income.

In column A, list the first and last name of each person living in your household with income, related or not (such as grandparents, other relatives, or friends). You must include yourself and all children living with you. Attach another sheet of paper if necessary. **Column B-E lists the current gross income and how often it was received.** Next to each person's name list each type of income received and how often the money is received – weekly, every other week, twice a month or monthly. In column B, list the gross income each person earned from work, not your take-home pay. **Gross income is the amount earned before taxes and other deductions.** The amount should be listed on your pay stub, or your boss can tell you. In column C, list the amount each person received from welfare, child support, or alimony. In column D, list pensions, retirement, social security, and in column E list *All Other Income*, include workers compensation, unemployment, strike benefits, Supplement Security Income (SSI), Veterans Affairs (VA) benefits, disability, regular contributions from people who do not live in your household, and *Any Other Income*. Report net income for self-owned business, farm, or rental income. If you are in the Military Housing Privatization Initiative, do not include this housing allowance.

5: An adult household member must sign the form and list his or her social security number, or mark the box if s/he or she does not have one.

6: Contact information (Optional)

7: Children's racial and ethnic identities (Optional)

8: All Kids information (Optional)

Privacy Act Statement: This explains how we will use the information you give us.

The Richard B. Russell National School Lunch Act requires the information on this application. You do not have to give the information, but if you do not, we cannot approve your child for free or reduced-price meals. You must include the social security number of the adult household member who signs the application. The social security number is not required when you apply on behalf of a foster child or you list a Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) Program, or Food Distribution Program on Indian Reservations (FDPIR) case number or other FDPIR identifier for your child or when you indicate the adult household member signing the application does not have a social security number. We will use your information to determine if your child is eligible for free or reduced-price meals, and for administration and enforcement of the lunch and breakfast programs. We MAY share your eligibility information with education, health, and nutrition programs to help them evaluate, fund, or determine benefits for their programs, auditors for program reviews, and law enforcement officials to help them look into violations of program rules.

Non-Discrimination Statement: this explains what to do if you believe you have been treated unfairly. In accordance with Federal law and U. S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. To file a complaint of discrimination, write USDA, Director, and Office of Civil Rights, 1400 Independence Avenue SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TTY). USDA is an equal opportunity provider and employer.