Chicago Public Schools
School Enrollment Form

School Name______________________________

<table>
<thead>
<tr>
<th>Student Information</th>
<th>School Use Only: Prevent duplicate student records. Search in SIM for an existing Student ID before creating a new one.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student ID#</td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td>First Name</td>
</tr>
<tr>
<td>Middle Name</td>
<td>Generation (Jr., etc.)</td>
</tr>
<tr>
<td>Gender</td>
<td>Birth date (mm/dd/yyyy)</td>
</tr>
<tr>
<td></td>
<td>Registration Grade Level (when first entering CPS)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal, Immigrant, and Refugee Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y / N</td>
</tr>
<tr>
<td>Birth Country</td>
</tr>
<tr>
<td>* Complete if student was not born in the United States (US) or one of its Territories:</td>
</tr>
<tr>
<td>Date of first enrollment in any US School:</td>
</tr>
<tr>
<td>Student has refugee status:</td>
</tr>
</tbody>
</table>

| School Use Only: Note that “Date of first enrollment in any US School” becomes a required field in SIM if “Birth Country” is not the US or one of its Territories. |

<table>
<thead>
<tr>
<th>Student Address/Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical (Home) Address</td>
</tr>
<tr>
<td>Mailing Address (if different than Home)</td>
</tr>
<tr>
<td>Street Number and Name Apt City State Zip Code</td>
</tr>
<tr>
<td>Street Number and Name Apt City State Zip Code</td>
</tr>
<tr>
<td>Home Phone Number</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Demographic, Home Language, Parent/Guardian Contacts, Emergency/Health Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Ethnic and Race Categories: (Enter information into SIM from the Race and Ethnicity Survey form)</td>
</tr>
<tr>
<td>Home Language Survey: (Enter information into SIM from the Home Language Survey form)</td>
</tr>
<tr>
<td>Parent/Guardian Contacts: (Enter information into SIM from the Request for Emergency and Health Information form)</td>
</tr>
<tr>
<td>Emergency/Health Information: (Enter information into SIM from the Request for Emergency and Health Information form)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Status Codes:</td>
</tr>
<tr>
<td>01 – No Former School</td>
</tr>
<tr>
<td>*School Transferring From (if not a Chicago Public, Charter or Contract School)</td>
</tr>
<tr>
<td>*Is the student in good standing? Y / N</td>
</tr>
<tr>
<td>(Instructions to school: for out-of-state public school or any private school students, a certification of “good standing” should be received from the Parent/Guardian. Refer to CPS Policy 10-0623-P01 for more information.)</td>
</tr>
<tr>
<td>Last Chicago Public, Charter, or Contract School Attended</td>
</tr>
<tr>
<td>Is the student receiving any type of Special Education services? Y / N</td>
</tr>
<tr>
<td>(Instructions to school: if yes, please notify the Case Manager.)</td>
</tr>
<tr>
<td>Student Enrolled by (Print Name and Relationship)</td>
</tr>
<tr>
<td>Signature of Parent/Guardian Date of Enrollment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>School Use Only:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enrollment Status Code (insert a 0 from the left) Grade Level Homeroom/Division #</td>
</tr>
</tbody>
</table>
Race and Ethnicity Survey

Student's Name:        School Name:
Gender:        School ID:
Birth Date:

INSTRUCTIONS: Please answer the questions below. Both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

Choose only one.

☐ No, not Hispanic/Latino
☐ Yes, Hispanic/Latino

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

Part B. What is the student's race? Choose one or more.

☐ American Indian or Alaska Native (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)

☐ Asian (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ Black or African American (A person having origins in any of the black racial groups of Africa.)

☐ Native Hawaiian or Other Pacific Islander (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

☐ White (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)
Complete this Home Language Survey at the student’s initial enrollment in a Chicago Public School. This form must be kept in the student’s folder.

<table>
<thead>
<tr>
<th>School: ________________________________</th>
<th>Room: _____</th>
<th>School ID #: __________</th>
<th>Network: __________________</th>
</tr>
</thead>
</table>

Student Name: ______________________________________ | Student IS #: ___________________________________ |

English

1. Is a language other than English spoken in your home?
   [ ] No [ ] Yes __________________________ (Language)

2. Does the student speak a language other than English?
   [ ] No [ ] Yes __________________________ (Language)

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

**IMPACT REGISTRATION PROCESS**
(For Office use only)

- The Non-English language identified on either question is the Home Language.
- If two different non-English languages are identified, enter the language identified in question 2 as the Home Language.
- Enter ENGLISH as a Home Language ONLY when both questions are answered no.

### Spanish

1. ¿Se habla algún otro lenguaje que no sea inglés en su hogar?
   [ ] No [ ] Sí __________________________ (Idioma)

2. ¿La escuela evalúa a la fluidez de su niño en el idioma inglés?
   [ ] No [ ] Sí __________________________ (Idioma)

### Polish

1. Czy językem innym niż angielski mówi się w domu?
   [ ] Nie [ ] Tak __________________________ (język)

2. Czy uczeń mówi innym językiem niż angielskim?
   [ ] Nie [ ] Tak __________________________ (język)

### Chinese

1. 在家中是否說英語之外的一種語言?
   [ ] 是 [ ] 否 __________________________ (語言)

2. 該學生是否會說英語之外的一種語言?
   [ ] 是 [ ] 否 __________________________ (語言)

### Arabic

1. هل تتكلم في البيت بلغة أخرى غير اللغة الإنجليزية؟
   [ ] نعم [ ] لا __________________________ (لغة)

2. هل يمكن للطفلة لغة أخرى غير اللغة الإنجليزية؟
   [ ] نعم [ ] لا __________________________ (لغة)

### Bosnian/Croatian/Serbian

1. Da li se u kući govori na stranom jeziku?
   [ ] NE [ ] DA __________________________ (jezik)

2. Da li učenik govori neki strani jezik?
   [ ] NE [ ] DA __________________________ (jezik)

### Urdu

اکیکاگھر بر لکھریتی کی علائم کوڑا یا نیاں بولو جاتی ہے؟

[ ] نہیں [ ] ہے __________________________ (بل) / (ڈی)

اکیکاگھر علم بر لکھریتی کی علائم کوڑا یا نیاں بولو جاتی ہے؟

[ ] نہیں [ ] ہے __________________________ (بل) / (ڈی)

Notes:
- If the parent/guardian does not speak English and the school does not have staff who speaks the parent/guardian’s language, identify the language spoken by the parent/guardian through any assistance available in the school.
- If exact name of the language cannot be determined, enter “Other” as a temporary entry. If you entered “Other,” the exact language must be determined within two weeks after enrollment.
- If the language spoken by the parent is not reflected in this HLS, please visit the OLCE Forms page on the Knowledge Center at [bit.ly/OLCEforms](http://bit.ly/OLCEforms) and click on Home Language Survey in Additional Languages.
School Messaging Consent Form

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

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

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

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

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

Instructions: Check Box for Consent or Do Not Consent

☐ I CONSENT as outlined in the above section.

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

Signature of Parent/Guardian/Student if age 18 or older

Printed Name of Parent/Guardian/Student if age 18 or older

Student’s Name

Student ID #

Date

School

Phone Number 1 for Messages: (____) _____ - _______

Phone Number 2 for Messages: (____) _____ - _______

E-mail Address: _____________________________________________________________
Request for Emergency and Health Information

School Name: ____________________________________________________________

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

Student ID#  Last Name  First Name  Middle Name  Homeroom #

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

**Confidential Information Box 1**
Complete this box only if (1) it reflects your child’s current living situation; OR (2) it reflects your living situation if you are a youth not living with a Parent or Guardian. (Your answer will help school staff with enrollment and may enable the student to receive additional services.) Check one box:

- in a car/park/other public place
- doubled-up  in a hotel/motel  in a shelter  in transitional housing

School Note: If any box is checked, see the CPS Policy 702.5.

**Confidential Information Box 2**
Is there a current Order of Protection or No Contact Order which concerns this student?  Yes  No

School Note: If “Yes,” follow CPS Policy 704.4 procedures. Enter information in Legal Alert field and update contact information, as needed, in SIM.

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

<table>
<thead>
<tr>
<th>Parent/Guardian Contact</th>
<th>Parent/Guardian Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact Name</td>
<td></td>
</tr>
<tr>
<td>Relationship to Student</td>
<td></td>
</tr>
<tr>
<td>Check all that apply:</td>
<td></td>
</tr>
<tr>
<td>☐ Lives With</td>
<td>☐ Gets Mailings</td>
</tr>
<tr>
<td>☐ Emergency</td>
<td>☐ Permission to Pickup</td>
</tr>
<tr>
<td>☐ Emergency</td>
<td>☐ Permission to Pickup</td>
</tr>
</tbody>
</table>

Home Address, if different from student’s

Home Phone Number, if different from student’s

Cell Phone Number

Email Address

Name and Address of Employer

Work Phone Number

* Communication Language

* CPS communicates via phone calls. Select the language that should be used to communicate with you. Languages available for mass communication at this time are English and Spanish (note: other languages upon availability).

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Address</th>
<th>Telephone #</th>
<th>Relationship</th>
</tr>
</thead>
</table>

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

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

- ☐ Illinois Medical Card/All Kids: provide student’s medical ID # ______________________________________ (9-digit number located on back of card)
- ☐ No Insurance: are you interested in applying for the Illinois Medical Card/All Kids?  Yes  No
- ☐ Private/Employer Health Insurance: no additional information needed

Children of Military Personnel (optional)
As the Parent or Guardian, are you a member of a branch of the armed forces of the United States?  Yes  No

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

I certify that the information on this form is correct:

(Parent/Guardian Signature)  (Date)
**State of Illinois**

**Certificate of Child Health Examination**

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>School / Grade Level/ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>Middle</td>
<td>Month/Day/Year</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>Zip Code</th>
<th>Parent/Guardian</th>
<th>Telephone #</th>
<th>Work</th>
</tr>
</thead>
</table>

**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**

<table>
<thead>
<tr>
<th>DOSE 1</th>
<th>DOSE 2</th>
<th>DOSE 3</th>
<th>DOSE 4</th>
<th>DOSE 5</th>
<th>DOSE 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>MO</td>
<td>DA</td>
<td>YR</td>
<td>MO</td>
<td>DA</td>
<td>YR</td>
</tr>
</tbody>
</table>

- **DTP or DTaP**
- **Tdap, Td or Pediatric DT** (Check specific type)
- **Polio** (Check specific type)

**RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose**

- **Hepatitis A**
- **HPV**
- **Influenza**
- **Other: Specify Immunization Administered**

**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**

**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 (Rubella)** 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**

   **Date**

3. **Laboratory Evidence of Immunity (check one)**

   - **Measles**
   - **Mumps**
   - **Rubella**
   - **Varicella**

   Attach copy of lab result.

   **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.
### HEALTH HISTORY

**Allergies**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis of asthma (? Food, drug, insect, other)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child wakes during night coughing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth defects</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Developmental delay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood disorders/Hemophilia, Sickle Cell, Other! Explain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**MEDICATION**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of function of one of paired organs? (eye/ear/kidney/testicle)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hospitalizations?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Surgery? (List all.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Serious injury or illness?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>TB skin test positive (past/present)?</td>
<td>Yes*</td>
<td>No</td>
</tr>
</tbody>
</table>

*If yes, refer to local health department.

**Other concerns?** (crossed eye, drooping lids, squinting, difficulty reading)

**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**

<table>
<thead>
<tr>
<th>Age/sex</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Ethnic Minority**

**Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans)

**Family History**

<table>
<thead>
<tr>
<th>Topic</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head injury/Concussion/Passed out</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Seizures? What are they like?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart problem/Shortness of breath?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart murmur/High blood pressure?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dizziness or chest pain with exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Eye/Vision problems? Glasses Contacts Last exam by eye doctor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral problems?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dental Braces Bridge Plate Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian**

<table>
<thead>
<tr>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Physical Examination**

- **Hemoglobin or Hematocrit**
- **Urinalysis**
- **Developmental Screening Tool**
- **Endocrine**
- **Gastrointestinal**
- **Genito-Urinary**
- **LMP**
- **Neurological**
- **Musculoskeletal**
- **Spinal Exam**
- **Nutritional status**

**Respiratory**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis of Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quick relief medicine (e.g. Short Acting Beta Agonist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controller medication (e.g. inhaled corticosteroid)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Needs/Modifications**

**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**

**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)?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Physical Education**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Modified</th>
</tr>
</thead>
</table>

**Interscholastic Sports**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Modified</th>
</tr>
</thead>
</table>

**Print Name**

(MD, DO, APN, PA)

**Address**

**Phone**

**Date**
Student Medical Information 2020 – 2021

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

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

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Date of Birth</th>
<th>Student ID Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>School</th>
<th>Grade</th>
</tr>
</thead>
</table>

1. Please indicate your child’s health status below

☐ My child has no known health conditions

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

☐ Allergies (food or other) – please specify: ________________________________

☐ Asthma Year Diagnosed _________

☐ Diabetes – please circle one: Type 1 Type 2 Year Diagnosed _________

☐ Seizures/Epilepsy Year Diagnosed _________

☐ Sickle Cell Disease Year Diagnosed _________

☐ Other: ________________________________ Year Diagnosed _________

2. My child has a primary doctor. YES NO

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

Name: ________________________________ Phone number: ________________________________

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

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

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

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

Parent Name: ___________________________________________ Date: __________

Parent Signature: ___________________________________________

Phone Number: ___________________________ Email: ___________________________

PLEASE RETURN THE FORM TO THE SCHOOL NURSE

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

Nurses Use Only
Reviewed by: ___________________________
Date and Initial: ___________________________
Información Médica del Estudiante 2020 – 2021

Esta información debe ser actualizada y presentada **ANUALMENTE** al comienzo del año escolar.

Comunique con su escuela sobre la salud y cuidado de salud de su hijo. Esto es una buena manera de mantener seguro a su hijo(a). La información es **confidencial** y será compartida sólo con personal de CPS que necesita saber (enfermera, Director o persona designada y Secretaria).

<table>
<thead>
<tr>
<th>Nombre del Estudiante</th>
<th>Fecha de Nacimiento</th>
<th>No. ID del Estudiante</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Escuela</th>
<th>Grado</th>
</tr>
</thead>
</table>

1. Indiqué el estado de salud de su hijo(a)

- [ ] Mi hijo(a) no tiene condiciones de salud.

Mi hijo(a) tiene condición(es) de salud. Por favor marque todo lo que aplique:

- [ ] Alergias (alimentos o otro) – por favor especificar: ____________________________________________________________________________
- [ ] Asma
  - Año diagnosticado: ___________
- [ ] Diabetes – por favor circule tipo: Tipo 1 Tipo 2
  - Tipo ___
  - Año diagnosticado: ___________
- [ ] Convulsiones/Epilepsia
  - Año diagnosticado: ___________
- [ ] Célula falciforme
  - Año diagnosticado: ___________
- [ ] Otro: ______________________
  - Año diagnosticado: ___________

2. Mi hijo(a) tiene un proveedor de atención médica primario.

- [ ] SÍ
- [ ] NO

En caso afirmativo, por favor proporcione el nombre del médico y número de teléfono:

Nombre: ____________________________ Número de teléfono: ____________________________

- [ ] Yo doy permiso a la enfermera de la escuela de mi hijo(a) o persona designada hablar con el proveedor de salud sobre la salud de mi hijo.

3. Mi hijo(a) está cubierto por un seguro de salud.

- [ ] SÍ
- [ ] NO

Si su hijo(a) necesita seguro de salud, llame a Healthy CPS 773-553-KIDS (5437)

Este formulario **NO** es lo mismo que un "Plan de Atención" (atención médica detallada con instrucciones para proteger a su hijo(a)). Si su hijo(a) tiene una condición de salud que puede necesitar una acción en la escuela, por favor háganoslo saber que es lo mejor de hacer. Complete un "Plan de Cuidado Médico" en: www.cps.edu/oshw (o de la enfermera escolar) y regreselo a la escuela. **Si el problema es de alergias o asma, por favor llene el formulario de Plan de Acción para Asma o Plan de Sustitución de Alimentos en este paquete.**

Nombre del Padre (Letra Imprenta): ____________________________ Fecha: ____________________________

Firma del Padre: ____________________________

Número de Teléfono: ____________________________ Correo Electrónico: ____________________________

---

**POR FAVOR DEVUELVA LA FORMA A LA ENFERMERA DE LA ESCUELA.**

**SI EL ESTUDIANTE TIENE UNA CONDICIÓN DE SALUD, LOS PADRES DEBEN DE SER CITA CON LA ENFERMERA DE LA ESCUELA.**

---

**SOLO PARA ENFERMERA**

Reviewed by:

Date and Initial ________
HEALTHCARE PROVIDER STATEMENT
FOR FOOD SUBSTITUTION

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

<table>
<thead>
<tr>
<th>CHILD'S NAME:</th>
<th>DATE:</th>
</tr>
</thead>
</table>

Dear Parent/Guardian:

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

<table>
<thead>
<tr>
<th>Parent/Guardian Name</th>
<th>School Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Phone Number</th>
<th>Address (Street)</th>
</tr>
</thead>
<tbody>
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</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Email</th>
<th>Address (City, State, Zip Code)</th>
</tr>
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</table>

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

---

PHYSICIAN STATEMENT

1. Does child have a disability that requires food accommodation?
   - □ No    If no, go to item 2 below.
   - □ Yes   If yes, provide the follow information and complete items 3, 4, and 5
     a) What is the disability? __________________________
     b) What major life activity is affected? __________________________
     c) What does the disability mean for the child’s diet? __________________________

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

3. List specific foods to be omitted:

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

5. __________________________                      __________________________
     Signature of Health Care Provider                  Date

Parent/Guardian: Return this form to your School Nurse

---

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

<table>
<thead>
<tr>
<th>School Nurse Signature:</th>
<th>Date reviewed:</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

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

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

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

MEDICAL INFORMATION: Has your child/ward ever had any of the following: YES or NO

If YES: Please circle the appropriate condition below:

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

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

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

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

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

Please sign both sides:

Parent/Guardian: __________________________ Date: __________________________
School-Based Oral Health Program Authorization Form – HIPAA

Student Name: ________________________________  Student Date of Birth: ________________________________

School Name: ________________________________  Parent/Guardian Name: ________________________________

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

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

Please sign both sides

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

Vision Services Consent, Release of Liability, and Authorization Form

Please Print:

Student Name: ___________________________ Parent Email Address: ___________________________

School Name: ___________________________ Student’s Date of Birth: ___________ ☐ Male ☐ Female

Parent/Guardian Name: ___________________________ Home Address: ___________________________ Phone: ___________________________

Meadicaid/Medical Card/ALLKids recipient #: ___________________________ Race/Ethnicity: ___________________________

Private Vision Insurance: ___________________________ Group ID: ___________________________ ID#: ___________________________ Cardholder Name: ___________________________ Birth Date: ___________________________

Private Medical Insurance: ___________________________ Group ID: ___________________________ ID#: ___________________________ Cardholder Name: ___________________________

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Parent/Guardian Signature: ___________________________ Date: ___________________________

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

Parent/Guardian Signature: ___________________________ Date: ___________________________
# Student Medical History Form

**Please Print:**
Student’s Name: ___________________________  School Name: ___________________________  

**Does your child currently wear glasses or contacts?**  □ Yes  □ No

**How did you find out about the Vision Program? (Circle all that apply)**
- School staff
- Failed Vision Screening Letter
- Friend
- Other ___________________________

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing/Ear problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endocrine problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention Deficit Disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td></td>
<td></td>
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<tr>
<td>Gastrointestinal problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitourinary problems</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Condition</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Is your child taking any medications?**  □ No  □ Yes

**List medications:**

- _______________________________________________________
- _______________________________________________________

**Does your child use eye drops?**  □ No  □ Yes

**List eye drops:**

- _______________________________________________________
- _______________________________________________________

**Has your child ever had eye surgery?**  □ No  □ Yes

**If yes, please explain:**

- _______________________________________________________

**Has s/he had any of the following?**

<table>
<thead>
<tr>
<th>Condition</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye patch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain in eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Difficulty Tracking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lazy/Wandering Eye</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blurred/Double Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loses place while reading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trouble finishing work**  □ No  □ Yes

**Avoids reading/writing**  □ No  □ Yes

**Frustrates easily**  □ No  □ Yes

**Other**  □ No  □ Yes

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

**Is the child performing at:**

- □ above grade level
- □ grade level
- □ below grade level

**If below grade level, please select the class (Check all that apply)**

- □ Reading
- □ Writing
- □ Math
- □ Social Studies
- □ Other ___________________________

**Is the child currently receiving any of the services below? (Check all that apply)**

- □ Special Education
- □ Tutoring
- □ Speech Therapy
- □ Occupational Therapy (OT)
- □ Physical Therapy (PT)

**List any of your child’s Hobbies or Special Interests:**

- _______________________________________________________

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

- _______________________________________________________

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>□ Wears glasses</th>
<th>□ Wandering Eye</th>
<th>□ Diabetes</th>
<th>□ Cardiovascular problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blindness</td>
<td></td>
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</tr>
<tr>
<td>Musculoskeletal problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurological problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lazy eye</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Macular Degeneration</td>
<td></td>
<td></td>
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<tr>
<td>Heart Disease</td>
<td></td>
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</tr>
<tr>
<td>Mental Health illness</td>
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<td></td>
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</tr>
<tr>
<td>High Blood Pressure</td>
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</tr>
</tbody>
</table>

**Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible**
### Part 6 - Signature (Name)

**Signature (Printed):**

```
[Signature]
```

**Signature (Handwritten):**

```
[Signature]
```

**Address:**

Place your signature here.

---

### Part 7 - Households With Income

#### Other Income

Other income can be from disability, social security, unemployment, employment benefits, etc. Include any changes in the form. The form is applicable to all households. Enter the amount of each other income.

- **Social Security:**
- **Unemployment:**
- **Employment Benefits:**
- **Disability:**
- **Other:**

#### Other Income Details

- **Household Name:**
- **Income Source:**
- **Amount:**
- **Frequency:**

---

### Part 8 - Non-Family Income Information

**School Year:**

[Year]

**School Name:**

[School Name]

**Address:**

[Address]

**Phone Number:**

[Phone Number]

**Email:**

[Email]

---

The purpose of this form is to obtain information about the school district. Please complete this form and return to the school's main office.

[Signature]

[Date]

---

**School Name (Nombre de Escuela):**

CPS FAMILY INCOME INFORMATION FORM 2020-2021