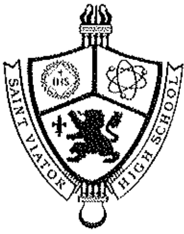

Saint Viator High School

1213 East Oakton Street Arlington Heights IL 60004-5099 (847) 392-4050 Fax (847) 392-4101
www.saintviator.com

February 2016

Dear Parents/Guardians:

Illinois State law requires incoming freshmen have a physical exam before school begins in August. **Physical exams and immunization record forms are due in the Saint Viator office no later than August 1, 2016. Because physicians are booked for freshman physicals months in advance, we suggest that you call for an appointment well before the end of the school year.**

Enclosed is a copy of the Certificate of Health Examination required by the State of Illinois. Please make sure that both the sections required to be completed by parents and your physician are completely filled out, signed and dated. The information in the immunization section is particularly important and must also be signed and dated by your physician or his/her nurse. Please consult the immunization requirement sheet included with this mailing that provides the guidelines for immunizations for your student.

Student Athletes: Students wishing to participate in fall sports must have a physical on file before practices/tryouts begin. Students who anticipate playing any sport should have their physical exam dated after June 1, 2016, so that it will still be valid during the spring sports season. **If your child is asthmatic or has severe allergies, State law permits students to carry their inhaler or epi-pen with parental and physician approval.**

If you choose to take your child to a "walk-in care" clinic or health department clinic, be sure to take a copy of your child's signed, dated immunization records with you. These physicians will probably not administer an immunization or sign the immunization section of the form unless they can review this documentation. If your records are incomplete, contact the nurse at your child's current school as soon as possible to get a copy of the records in your child's file. Health records are generally not accessible during the summer months.

A student entering or enrolling at Saint Viator is required to have proof of appropriate immunizations as required by law and the Illinois Department of Health. Saint Viator will not accept a religious objection to immunizations of a student who wishes to enroll as a sufficient basis for exemption of this statutory requirement. (See Student Handbook p. 47, www.saintviator.com)

Please be sure to return the completed form to the Administration Office either by mail or in person as soon as possible and no later than **August 1, 2016. Please note that your student must have their physical and immunization record on file to begin classes in August.** If you have any questions or concerns, please contact Dr. Deborah Scerbicke at 847-392-4050 x 269 or dscerbicke@saintviator.com.

Thank you,

Deborah Scerbicke

Dr. Deborah A. Scerbicke, Ph.D.
Dean of Students

Minimum Immunization Requirements for Those Entering a Child Care Facility or School in Illinois, Fall-2015

Vaccine Requirement	Child Care Facility, Preschool, Early Childhood Pre-Kindergarten Programs	Kindergarten through 12th Grade		Minimum Intervals Allowed Between Doses and *Other Options for Proof of Immunity*
		First Entry into School (Kindergarten or First Grade)	Other Grades	
DTP/DTaP/ or Tdap, Td (Diphtheria, Tetanus, Pertussis)	Three doses by 1 year of age One additional booster dose by 2nd birthday	**Four or more doses of DTP/DTaP** with the last dose qualifying as a booster and received on or after the 4th birthday	**Three or more doses of DTP/DTaP or Td;** with the last dose qualifying as a booster if received on or after the 4th birthday **For Students entering 6th thru 12th grades: 1 dose of Tdap**	Minimum interval between series doses: 4 weeks (28 days) Between series and booster: 6 months *No proof of immunity allowed*
Polio	Two doses by 1 year of age. One additional dose by 2nd birthday	**Three or more doses of the same type of Polio** vaccine with the last dose qualifying as a booster and received on or after the 4th birthday. *If the series is given in any combination of polio vaccine types, 4 or more doses are required with the last being a booster on or after the 4th birthday.	**Three or more doses of Polio** with the last dose qualifying as a booster and received on or after the 4th birthday. *If the series is given in any combination of polio vaccine types, 4 or more doses are required with the last being a booster on or after the 4th birthday.	Minimum interval between series doses: 4 weeks (28 days) *No proof of immunity allowed*
Measles	One dose on or after the 1st birthday but prior to 24 months of age	**Two doses of Measles Vaccine**, the 1st dose must have been received on after the 1st birthday and the second dose no less than 4 weeks (28 days) later.		*Laboratory evidence of measles immunity OR Certified physician verification* of measles disease by date of illness* ***Cases diagnosed after 7/1/2002 must include lab evidence of infection***
Rubella	One dose on or after the 1st birthday but prior to 24 months of age	**Two doses of Rubella Vaccine**, the 1st dose must have been received on after the 1st birthday and the second dose no less than 4 weeks (28 days) later.		*Laboratory evidence of rubella immunity* **History of disease is not acceptable proof of immunity to rubella**
Mumps	One dose on or after the 1st birthday but prior to 24 months of age	**Two doses of Mumps Vaccine**, the 1st dose must have been received on after the 1st birthday and the second dose no less than 4 weeks (28 days) later.		*Laboratory evidence of mumps immunity OR Certified physician verification of mumps disease by date of illness*
Haemophilus influenzae type b	Refer to Hib vaccination schedule for series **Children 24-59 mos. without series must have one dose after 15 mos. of age**	**Not required after the 5th birthday (60 months of age)**		Refer to Hib vaccination schedule *No proof of immunity allowed*
Invasive Pneumococcal Disease	Refer to PCV vaccination schedule for series **Children 24-59 mos. without series must have one dose**	**Not required after the 5th birthday (60 months of age)**		Refer to PCV vaccination schedule *No proof of immunity allowed*
Hepatitis B	**Three doses for all children 2 years of age or older** **Third dose must have been administered on or after 6 months of age (168 days)**	**No Requirements**	**Three doses hepatitis B vaccine administered at recommended intervals for Students entering grades 6 thru 12**	Minimum intervals between doses: 1 & 2- at least 4 weeks (28 days) 2 & 3 - at least 2 months (56 days) 1 & 3 - at least 4 months (112 days) *Laboratory evidence of prior or current infection*
Varicella	**One dose on or after the 1st birthday**	**Two doses of Varicella Vaccine, for Students entering Kindergarten and 1st grades** The 1st dose must have been received on after the 1st birthday and the second dose no less than 4 weeks (28 days) later.	**One dose of Varicella on or after the 1st birthday for Students entering grades 1 thru 12** **Two doses of Varicella Vaccine for Students entering 6th,7th, 9th & 10th grades**	Minimum intervals for administration: The 1st dose must have been received on after the 1st birthday and the second dose no less than 4 weeks (28 days) later. *Statement from physician or health care provider verifying disease history OR Laboratory evidence of varicella immunity*

State of Illinois
Certificate of Child Health Examination

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

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

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

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR

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

Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

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

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

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

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

Address **Phone**

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

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

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

Birth Date ________________ Gender ______ Grade ______
(Month/Day/Year)

Parent or Guardian ____
(Last) (First)

Phone__________________________
(Area Code)

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

County ______________________________________

To Be Completed By Examining Doctor

Case History

Date of exam ________________

Ocular history: ❑ Normal or Positive for ______________________________

Medical history: ❑ Normal or Positive for ______________________________

Drug allergies: ❑ NKDA or Allergic to ______________________________

Other information____

Examination

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

Was refraction performed with dilation? ❑ Yes ❑ No

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

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

Diagnosis

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

Other ____

Continued on back

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Recommendations

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

2. Preferential seating recommended: ❑ No ❑ Yes
   Comments ____
   ____

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

4. ____

5. ____

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

License Number ____________________

Address ____________________
____

Phone ____________________

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

____
(Parent or Guardian's Signature)

____
(Date)

Signature ____________________ Date ____________________

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

Printed by Authority of the State of Illinois

IOCI 15-391