MANH Health, Physical Exam & Immunization Requirements 2022-2023

Infant / Toddler / Primary Students (ages 0-6)

Physical Examination (performed within 1 year of the date of the first day of school) including all **required immunizations**. Documentation of the physical exam and Immunizations must be submitted on the State of Illinois ***Certificate of Child Health Examination Form*** before the first day of school in August of 2022.

Kindergarten Students

1. **Physical Examination** (performed within 1 year of the date of the first day of school)including all **required immunizations**. Documentation of the physical exam and Immunizations must be submitted on the State of Illinois ***Certificate of Child Health Examination Form*** before the first day of school in August of 2021.
2. **Dental Examination (performed within 18 months of the May 15th deadline). Documentation of the dental exam must be submitted on the State of Illinois *Proof of School Dental Examination Form* by May 15th, 2022.**
3. ***Vision Examination (performed within 1 year of the date of the first day of school). Documentation of the eye exam must be submitted on the State of Illinois Eye Examination Report by October 15th, 2022.***

2nd Grade Students

Dental Examination (performed within 18 months of the May 15th deadline). Documentation of the dental exam must be submitted on the State of Illinois ***Proof of School Dental Examination Form*** by **May 15th, 2023.**

6th Grade Students

1. **Physical Examination** (performed within 1 year of the date of the first day of school) including all **required immunizations**. Documentation of the physical exam and Immunizations must be submitted on the State of Illinois ***Certificate of Child Health Examination Form*** before the first day of school in August of 2022.
   IMPORTANT– Immunizations must include **one dose of Meningococcal Conjugate Vaccine** before entry into 6th Grade.
2. **Dental Examination (performed within 18 months of the May 15th deadline). Documentation of the dental exam must be submitted on the State of Illinois *Proof of School Dental Examination Form* by May 15th, 2023.**

9th Grade Students

Physical Examination (performed within 1 year of the date of the first day of school) including all **required immunizations**. Documentation of the physical exam and Immunizations must be submitted on the State of Illinois ***Certificate of Child Health Examination Form*** before the first day of school in August of 2022.

Dental Examination (performed within 18 months of the May 15th deadline). Documentation of the dental exam must be submitted on the State of Illinois Proof of School Dental Examination Form by May 15th, 2023.

12th Grade Parents

IMPORTANT– Students must present proof of **two doses of Meningococcal Conjugate Vaccine** for entry into 12th grade unless the first dose was administered at 16 years of or older, in which case documentation of only one dose is required. Documentation can be provided on the *Certificate of Child Health Examination Form* or other written form or letter from the health care provider's office and turned in before the start of school in August, 2022.

Parents of Students Requesting Exemptions from Required Immunizations and/0r Physical Examinations

IMPORTANT! - The Illinois State Board of Education requires all parents who are requesting religious exemption to immunizations and/or physicals to file with the school before October 15th on Illinois ***Certificate of Religious Exemption to Required Immunizations and/or Examinations Form***. In addition to a statement detailing the religious beliefs that prevent the child from receiving each vaccination exemption requested, this form must also be signed by the parent and by the doctor or health care provider.

Please note that in a disease outbreak, or after exposure to any of the diseases for which immunization is required, schools may exclude children who are not vaccinated from attending school in order to protect all students.

Students New to the Montessori Academy of North Hoffman

1. **Physical Examination** (either performed within one year of the date of the first day of school or, minimally, a copy of the student's most recent required physical from K, 6th, or 9th Grade.) including proof of all **required immunizations**. Documentation of the physical exam and Immunizations must be submitted on the State of Illinois ***Certificate of Child Health Examination Form*** before the first day of school in August of 2022.
2. If your child is enrolling in an Illinois school for the first time, a **Vision Examination** (performed within 1 year of the date of the first day of school) is required. Documentation of the eye exam must be submitted on the State of Illinois ***Eye Examination Report*** by October 15th, 2022.

*****IMPORTANT - Any student not in compliance with physical and immunization requirements may be excluded from school beginning October 15th until the correct documentation is submitted to the office.***

State of Illinois
Certificate of Child Health Examination

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

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

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				**Comments:** * indicates invalid dose		
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. **Parent/Guardian Signature**		**Date**	
Bone/Joint problem/injury/scoliosis?	Yes No						

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

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **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**