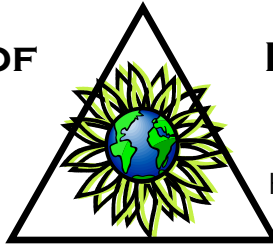


**MONTESSORI SCHOOL OF
NORTH HOFFMAN**

1250 Freeman Road
Hoffman Estates IL 60192-1727
(847) 705-1234



**LOTUS MONTESSORI
SCHOOL**

3805 Huntington Boulevard
Hoffman Estates IL 60192-1607
(847) 705-5678

Dear Parents:

The following is now required by the State of Illinois:

Note: Screenings performed by the doctor's office as part of the school physical do not fulfill the mandate. Vision and hearing screenings are conducted at school by the Hoffman Estates Health & Human Services Department. These will be offered at a low cost to parents.

It is our policy to exclude children from school by October 15 if requirements for health examinations and immunizations are not met.

PHYSICALS

- Prior to initial enrollment
- At two year intervals for children under 5 years old
- Prior to Grades K, 6 & 9

VISION

- Screening beginning at age 3 in all licensed preschool programs
- An eye exam by a qualified eye doctor (optometrist or ophthalmologist) at Kindergarten or when entering an Illinois elementary program
- Screening at Grades 2 & 8
- Screening if new to the school/district
- Screening if referred by teacher

HEARING

- Screening beginning at age 3 in all licensed preschool programs
- Screening at Grades K, 1, 2 & 3
- Screening if new to school/district
- Screening if referred by teacher

DENTAL (Required by May 15)

- Dental exams at Grades K, 2 & 6



**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			Parent/ Guardian	Telephone # Home	Work
Street	City	ZIP code			

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)																		Comments
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.)																		

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	
Vision													
Hearing													

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? Child wakes during the night coughing	Yes No	Indicate Severity	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		Surgery? (List all.) When? What for?	Yes No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Serious injury or illness?	Yes No	
Diabetes?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Head injury/Concussion/Passed out?	Yes No		TB disease (past or present)?	Yes* No	
Seizures? What are they like?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart problem/Shortness of breath?	Yes No		Alcohol/Drug use?	Yes No	
Heart murmur/High blood pressure?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Dizziness or chest pain with exercise?	Yes No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ 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 BMI>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 _____ Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	
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
Childhood Lead Risk Assessment Questionnaire**

**ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING
(410 ILCS 45/6.2)**

Name _____ Today's Date _____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	R E S P O N S E
---	------------------------

- | | |
|---|-------------------|
| 1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? | Yes No Don't Know |
| 2. Does this child have a sibling with a blood lead level of 10 mcg/dL or higher? | Yes No Don't Know |
| 3. Does this child live in or regularly visit a home built before 1978? | Yes No Don't Know |
| 4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978? | Yes No Don't Know |
| 5. Is this child a refugee or an adoptee from any foreign country? | Yes No Don't Know |
| 6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)? | Yes No Don't Know |
| 7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? | Yes No Don't Know |
| 8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)? | Yes No Don't Know |
| 9. Does this child reside in a high-risk ZIP code area? | Yes No Don't Know |

A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result _____ mcg/dL Date _____ Test 2: Blood Lead Result _____ mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

Signature of Doctor/Nurse

Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

**Illinois Department of Public Health
Guidelines for Blood Lead Screening and Lead Risk Assessment**

- **Blood lead screening** is defined as obtaining a blood lead test. **Lead risk assessment** is defined as evaluation of potential for exposures to lead based on questionnaire responses.
- **It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or potential exposure to lead has been identified, regardless of child's age.**
- Illinois has defined ZIP code areas at high risk and low risk for lead exposure based on housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.
- In Illinois, all children from **low-income families** (i.e., Medicaid-eligible children) should receive a blood lead test at ages 12 and 24 months, even if they live in a low-risk ZIP code area. If the child is 3 through 6 years old and has not been tested, a blood lead test is required.

Childhood Lead Risk Assessment Questionnaire

- Complete the Childhood Lead Risk Assessment Questionnaire during a health care visit at ages 12 and 24 months.
 - If responses to all the questions are “NO,” re-evaluate at every well child visit or more often if deemed necessary.
 - If any response is “YES” or “DON'T KNOW,” obtain a blood lead test
- Consider evaluating children before 12 months of age, depending on the area.
- If the child is age 3-6 years **and**
 - 1) there is any “YES” or “DON'T KNOW” **and**
 - 2) has had two successive blood lead test results that were each less than < 10 mcg/dL with one of these tests at age 2 years or older **and**
 - 3) risks of exposure to lead have not changed, **further blood lead tests are not necessary.**
- If the child is 1) 3-6 years, **and** 2) all answers to the Childhood Lead Risk Assessment Questionnaire are “NO,” **and** 3) risks of exposure to lead have not changed, a blood lead test is not necessary.
- If the child is 3-6 years of age and risks of exposures to lead have increased, obtain a blood lead test.
- Continue to use the Childhood Lead Risk Assessment Questionnaire through age 6.

For children living in Chicago:

- A blood lead test for children age 3 and younger should be obtained at 6, 12, 18, 24 and 36 months **OR** at 9, 15, 24 and 36 months.
- Children 4 through 6 years of age with prior blood lead levels <10 mcg/dL should have an annual risk assessment. A blood lead test should be performed if risk increases or if the child exhibits persistent oral behaviors.

**Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466**

High-Risk ZIP Codes for Pediatric Blood Lead Poisoning

Adams	62567	Effingham	62367	Knox	62526	61466	62976	60942
62301	62570	None	62373	61401	62537	61476	62992	60960
62320	Clark	Fayette	62379	61410	62551	61486	Putnam	60963
62324	62420	62458	62380	61414	Macoupin	Monroe	61336	61810
62339	62442	62880	Hardin	61436	62009	None	61340	61831
62346	62474	62885	62919	61439	62033	Montgomery	61363	61832
62348	62477	Ford	62982	61458	62069	62015	Randolph	61833
62349	62478	60919	Henderson	61467	62085	62019	62217	61844
62365	Clay	60933	61418	61474	62088	62032	62242	61848
Alexander	62824	60936	61425	61485	62093	62049	62272	61857
62914	62879	60946	61454	61489	62626	62051	Richland	61865
62988	Clinton	60952	61460	61572	62630	62056	62419	61870
Bond	62219	60957	61469	Lake	62640	62075	62425	61876
62273	Coles	60959	61471	60040	62649	62077	Rock Island	61883
Boone	61931	60962	61480	LaSalle	62672	62089	61201	Wabash
61038	61938	61773	Henry	60470	62674	62091	61236	62410
Brown	61943	Franklin	61234	60518	62685	62094	61239	62852
62353	62469	62812	61235	60531	62686	62538	61259	62863
62375	Cook	62819	61238	61301	62690	Morgan	61265	Warren
62378	All Chicago	62822	61274	61316	Madison	62601	61279	61412
Bureau	ZIP Codes	62825	61413	61321	62002	62628	St. Clair	61417
61312	60043	62874	61419	61325	62048	62631	62201	61423
61314	60104	62884	61434	61332	62058	62692	62203	61435
61315	60153	62891	61443	61334	62060	62695	62204	61447
61322	60201	62896	61468	61342	62084	Moultrie	62205	61453
61323	60202	62983	61490	61348	62090	61937	62220	61462
61328	60301	62999	Iroquois	61354	62095	Ogle	62289	61473
61329	60302	Fulton	60911	61358	Marion	61007	Saline	61478
61330	60304	61415	60912	61364	None	61030	62930	Washington
61337	60305	61427	60924	61370	Marshall	61047	62946	62214
61338	60402	61431	60926	61372	61369	61049	Sangamon	62803
61344	60406	61432	60930	Lawrence	61377	61054	62625	Wayne
61345	60456	61441	60931	62439	61424	61064	62689	62446
61346	60501	61477	60938	62460	61537	61091	62703	62823
61349	60513	61482	60945	62466	61541	Peoria	Schuyler	62843
61359	60534	61484	60951	Lee	Mason	61451	61452	62886
61361	60546	61501	60953	60553	62617	61529	62319	White
61362	60804	61519	60955	61006	62633	61539	62344	62820
61368	Crawford	61520	60966	61031	62644	61552	62624	62821
61374	62433	61524	60967	61042	62655	61602	62639	62835
61376	62449	61531	60968	61310	62664	61603	Scott	62844
61379	62451	61542	60973	61318	62682	61604	62621	62887
Calhoun	Cumberland	61543	Jackson	61324	Massac	61605	62663	Whiteside
62006	62428	61544	62927	61331	62953	61606	62694	61037
62013	DeWitt	61563	62940	61353	McDonough	Perry	Shelby	61243
62036	61727	Gallatin	62950	61378	61411	62832	62438	61251
62070	61735	62934	Jasper	Livingston	61416	62997	62534	61261
Carroll	61749	Greene	62432	60420	61420	Piatt	62553	61270
61014	61750	62016	62434	60460	61422	61813	Stark	61277
61051	61777	62027	62459	60920	61438	61830	61421	61283
61053	61778	62044	62475	60921	61440	61839	61426	Will
61074	61882	62050	62480	60929	61470	61855	61449	60432
61078	DeKalb	62054	Jefferson	60934	61475	61929	61479	60433
Cass	60111	62078	62883	61311	62374	61936	61483	60436
62611	60129	62081	Jersey	61313	McHenry	Pike	61491	Williamson
62618	60146	62082	62030	61333	60034	62312	Stephenson	62921
62627	60550	62092	62063	61740	McLean	62314	61018	62948
62691	Douglas	Grundy	Jo Daviess	61741	61701	62323	61032	62949
Champaign	61930	60437	61028	61743	61720	62340	61039	62951
61815	61941	60474	61075	61769	61722	62343	61044	Winnebago
61816	61942	Hamilton	61085	61775	61724	62345	61050	61077
61845	DuPage	62817	61087	Logan	61728	62352	61060	61101
61849	60519	62828	Johnson	62512	61730	62355	61062	61102
61851	Edgar	62829	62908	62518	61731	62356	61067	61103
61852	61917	62859	62923	62519	61737	62357	61089	61104
61862	61924	Hancock	Kane	62548	61770	62361	Tazewell	Woodford
61872	61932	61450	60120	62543	Menard	62362	61564	61516
Christian	61933	62311	60505	62635	62642	62363	61721	61545
62083	61940	62313	Kankakee	62643	62673	62366	61734	61570
62510	61944	62316	60901	62666	62688	62370	Union	61760
62517	61949	62318	60910	62671	Mercer	Pope	62905	61771
62540	Edwards	62321	60917	Macon	61231	None	62906	
62546	62476	62330	60954	62514	61260	Pulaski	62920	
62555	62806	62334	60969	62521	61263	62956	62926	
62556	62815	62336	Kendall	62522	61276	62963	Vermilion	
62557	62818	62354	None	62523	61465	62964	60932	