

Marquette Academy

Academic Excellence in a Catholic Community

May 12, 2025

Dear Parents,

We are preparing for next school year at Marquette Academy. Enclosed in this packet you will find your registration information and all pertinent documents you will need.

We are offering an early registration discount of \$100.00 to families from now until 7:00 pm on Thursday, June 19. We have several opportunities to drop off your completed packets and benefit from the early registration discount. The schedule of dates and times is listed below. **If you complete your packet before this school year is over, you can send it in your student's backpack or return it to the grade school office any time. Please be sure to include the minimum \$400 registration fee. You will receive additional financial information via email from Mary Roberson.**

The FACTS website is now open through August 1st to apply for Grant & Aid. Please note if your family situation is divorced or separated, each parent must sign up for FACTS using ½ of the tuition rate.

Any financial appeals will be forwarded to the review committee on July 17 by 4:00 PM. If we receive requests after this date and time, the funds may be already allocated, resulting in no aid.

Thank you very much for your patience and cooperation.

Respectfully yours,

Brooke Rick
Principal

Drop off dates/times for registration:

***ALL COMPLETED PACKET DROP OFFS ARE AT THE GRADE SCHOOL CAMPUS**

- From June 3 until July 17, every Tuesday & Thursday between the hours of 8:00 am – 4:00 pm at the **Grade School office**.
- Thursday, June 19 will have extended evening hours until 7:00 pm at the Grade School office. **Last day for the \$100 early discount.** In order to receive the \$100 early bird registration discount, you must have all paperwork and registration fees (minimum \$400) turned in by 7:00 pm on this day.
- Thursday, July 17 will have extended evening hours until 7:00 pm at the Grade School office. **This will be our final registration drop off.**

***Any registration received after July 17 will require an appointment with Mary Mann, and will include a \$250 late fee for existing families. All accounts must be current to register for the upcoming school year.**

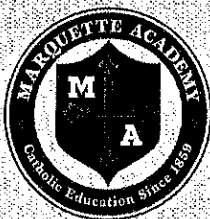
Parents,

All attached financial sheets
need to be signed and
returned with your packet.

Any changes to your
financial sheet (early
discount, scholarships, etc.)
will be added later and sent
to you via email by

Mrs. Mary Roberson.

Thank you.



MARQUETTE ACADEMY

Academic Excellence in a Catholic Community

RE: 25 26 School Year

Marquette Academy Blue/Gold Hours

Dear MA families,

This letter is the agreement for our Blue/Gold hours program. Each MA family is required to work a minimum 5 hours of service to the school. These hours will be mandatory for each MA family. Please note—Financial Aid hours are over and above the required 5 Blue/Gold hours. The first 5 hours completed by each family will be logged as your Blue/Gold hours.

Some examples would be (but not limited to) help at May Merriment for set up, clean up or working the event; working any annual fundraiser, helping with cleaning at the school, etc.

We will send out emails from the offices when there is a need for help and then we can log hours as they are worked. You can work 1 hour for an event or do 5 hours for one event, whatever is easiest for you and your family.

Please let us know if you have any questions.

Thank you in advance for your cooperation in this matter.

Sincerely,
Mrs. Brooke Rick

Parent Signature: _____
(By signing above you are confirming that you are aware of the mandatory program)

Please print family name: _____

Preschool & Elementary Campus
1110 LaSalle St., Ottawa, IL 61350
815.433.1199



High School Campus
1000 Paul St., Ottawa, IL 61350
815.433.0125

www.marquetteacademy.net

Traditions are embraced. Dedication is the norm. Excellence is the expectation.

Parents,

This is for your records.

Please use the attached sheet to set up your FACTS payment plan for tuition. If you already have an account, your information will follow from year to year.

Thank you.



MARQUETTE ACADEMY

Academic Excellence in a Catholic Community

Welcome to Marquette Academy. ALL PAYMENTS ARE REQUIRED TO BE ACH PAYMENTS THROUGH FACTS MANAGEMENT ONLY.

We've listed below how to sign up on Facts but if you have any questions please let us know. Both Mary Roberson mroberson@marquetteacademy.net and Lisa Tenut ltanut@marquetteacademy.net can help you. They both work at the High School campus and work with all Marquette families. Once we see that you have signed up on the Facts web site your name will be in a pending file and we will finalize it. You can then start paying on the dates you choose. Your monthly payments will not start until August or later if coming to Marquette at a later date. **But please sign up on this site and choose a payment plan as soon as possible.**

*****Starting 2024-25 School Year--If you are an existing MA family you should just roll over to the new year with the same payment plan. Therefore if you want to change the account they are taking out of, you will need to update your account numbers.**

TO SIGN ON TO THE FACTS MANAGEMENT WEBSITE:

Go to our **Marquette Academy website** www.marquetteacademy.net at the top of the page is **ADMISSIONS** click on that and a drop down box will appear. The 7th item under **Admissions** is **FACTS**, click that and the Facts app pops up. On the right side of the page it says **CREATE USERNAME AND PASSWORD** for a **new** account, enter your email address and press enter. Create a new **FACTS** account pops up hit that and then you can begin entering your information.

Here is the **FACTS** phone number for Customer Service in case you need help: [1/866-441-4637](tel:18664414637) you can talk to any Customer Service person. **FACTS Management Website at: <https://online.factsmgt.com>.**

After you have finished setting up your account, we will see your name in **pending** we will finalize it and then we will enter your balance. After that you should see your account by the next day. **Keep track of your Customer number or ID number for future reference.**

Let Mary Roberson – mroberson@marquetteacademy.net or Lisa Tenut – ltanut@marquetteacademy.net know if you have any questions or need help with signing on.

Everyone has to be on Facts Management for our accounting purposes but if you need help with adjusting payment dates or creating a new schedule or maybe just adjusting the date that month we can help you with that. Also, if you want to give us the payment we can enter it for you.

If you don't have access to a computer or having trouble with entering on your phone we can also help you.



Tuition Management

FACTS provides flexible payment plan options to families at private and faith-based schools. Families can budget their tuition, making private school more accessible and affordable. Our process is simple, convenient, and secure.

To set up your FACTS agreement go to <https://online.factsmgmt.com/signin/3FXBJ>

FACTS CONFIRMATION NOTICE

Once your information is received and processed by FACTS, you will receive a confirmation notice. This notice will confirm your payment plan information. Please check this information for accuracy, and contact your school or FACTS with any discrepancies.

Frequently Asked Questions

- **Is my information secure?**
Yes. Your personal information, including payment information, is protected with the highest security standards in the industry. For more information on security, visit [FACTSmgt.com/Security-Compliance](https://factsmgmt.com/Security-Compliance).
- **When will my payments be due?**
Your payment schedule is set by your school, and your financial institution will decide the time of day your payments are processed.
- **What happens when my payment fails on a weekend or a holiday?**
Your payment will be processed on the next business day.
- **What happens if a payment is returned?**
Returned payments may be subject to a FACTS returned payment fee. Watch for a returned payment notice for additional information.
- **How do I make changes once my agreement is on the FACTS system?**
Changes to your address, phone number, email address, or banking information can be made at Online.FACTSmgt.com or by contacting your school or FACTS. Any changes to payment dates or amounts need to be approved by the school and the school will then need to notify FACTS. All changes must be received by FACTS at least two business days prior to the automatic payment date in order to affect the upcoming payment.
- **What is the cost to set up a payment plan?**
If an enrollment fee is due, the amount of the fee is indicated when setting up your agreement. If applicable, the nonrefundable FACTS enrollment fee will be automatically processed within 14 days of the agreement being posted to the FACTS system.

FACTS CUSTOMER SERVICE

We are committed to doing all we can to provide you with the highest quality customer service in the industry. Whether you want to view your account online or speak with one of our highly trained customer service representatives, FACTS is dedicated to serving you. To view your payment plan details, log in to your FACTS account at Online.FACTSmgt.com. Customer Care Representatives are also available to assist you 24/7.

Parents,
All attached
registration forms
need to be
completed and
returned.

Thank you.

Early Education & Elementary Campus
1110 LaSalle St., Ottawa, IL
815/433-1199

MARQUETTE ACADEMY

High School Campus
1000 Paul St., Ottawa, IL
815/433-0125

Student Information:

1. Child's Name:

Last First Middle
Social Security No: (HSOnly): Birth Date:

Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐)
(Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
Other Male: ☐ / Female: ☐ Grade entering: _____

2. Child's Name:

Last First Middle
Social Security No: (HSOnly): Birth Date:

Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐)
(Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
Other Male: ☐ / Female: ☐ Grade entering: _____

3. Child's Name:

Last First Middle
Social Security No: (HSOnly): Birth Date:

Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐)
(Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
Other Male: ☐ / Female: ☐ Grade entering: _____

4. Child's Name:

Last First Middle
Social Security No: (HSOnly): Birth Date:

Race or Ethnicity: (Am Indian/Alaskan Native ☐) (Hispanic ☐)
(Asian ☐) (White/ Non-Hisp ☐) (African-Am/Non-Hisp ☐)
Other Male: ☐ / Female: ☐ Grade entering: _____

Parent Information:

Lives with (Circle One): Mother Father Both

Primary Guardian:

Address: City/Zip: _____
Employment: Occupation: _____
Home Phone: Cell Phone: _____
Work Phone: _____
E-Mail: _____

Secondary Guardian:

Address: City/Zip: _____
Employment: Occupation: _____
Home Phone: Cell Phone: _____
Work Phone: _____
E-Mail: _____

Parish or Church You Attend: _____

School District in which you reside: _____

School transferring in from: _____



MEDICAL INFORMATION ONE PER STUDENT

STUDENT/MINOR NAME (first, middle, last): _____

Address: _____ Date of Birth: _____

STUDENT/MINOR'S DOCTOR (first, middle, last): _____ Phone: _____

MEDICAL CONDITIONS: Please list any medical conditions of the student/minor (asthma, diabetes, epilepsy, etc.):

List any allergies or allergic reactions to medications of the student/minor: _____

List any medications the student/minor is presently taking: _____

Other pertinent medical information: _____

Date of student/minor's most recent tetanus shot: _____

MEDICAL INSURANCE INFORMATION: Insurance Company: _____

Plan Number: _____ Employee Identification#: _____

EMERGENCY CONTACTS: Parent or Guardian (first, middle, last name): _____

Cell: _____ Work: _____ Home: _____

Other Contact: Name (first, middle, last): _____

Phone (with area code): _____ Relationship to student/minor: _____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school/parish. A copy may be distributed to the person in charge of each trip or athletic activity in which the student/minor participates. Should the need arise this information will be given to the proper medical authorities.

I, _____, [parent/guardian], understand that in the case of illness or injury to my child, _____ [child's name], the school/parish will try to notify me or the person I have listed as an emergency contact. In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school/parish to 1) arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and 2) sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Signature of Parent/Guardian: _____ Date: _____

Marquette Academy
PERMISSION FORM FOR SCHOOL WALKING TRIPS

I am the custodial and responsible parent/guardian of _____

Name of Student(s)

I request that Marquette Academy allow my school aged child(ren) to participate in walks to various locations around the Marquette Academy Preschool/Elementary/High School campuses neighborhoods. The Marquette Academy teachers and students will take walks to learn about what is currently being studied in class, such as the signs of changes in the seasons and traffic signs.

I request that Marquette Academy allow my preschool, elementary and/or high school aged child(ren) to participate in walks between the Marquette Academy campuses for Masses, plays, retreats, etc. I also request that M.A. allow my student to participate in walks to WCMY Radio Station, 216 Lafayette Street and to area parks.

The activity will be supervised by at least one school employee.

If my child is injured in any way during this trip and if I cannot be immediately contacted at the following phone number _____, I grant full power to the supervising school employee to do as follows:

1. Arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and
2. Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

I understand the risks such trips present to my child, including, but not limited to, serious personal injury or death. Any questions I have concerning these trips have been answered.

In consideration for my child being allowed to make any walking trip, I hereby RELEASE AND AGREE TO INDEMNIFY AND HOLD HARMLESS the Diocese, the parish, the school and their employees and agents, and the volunteers assisting the school, from any and all liability for injuries, damages, medical expenses, or any other loss to my child or family or me (including attorney's fees) arising from or related to my child's participation in an activity.

Signature of Parent/Guardian

Signature of Parent/Guardian

Printed name of Parent/Guardian

Printed name of Parent/Guardian

Date
Edition 2022

Date

Student(s) Name(s): _____

HANDBOOK AGREEMENT

We have read and understand the contents of the parent/student handbook and agree to abide by the rules and expectations stated therein.

Student(s) Signature

Date

Parent(s)/Guardian(s) Signature

Date

PARENT PERMISSION FORM FOR INTERNET ACCESS

Marquette Academy believes that the benefit to students from access to the Internet in the form of information resources and opportunities for collaboration far exceed the disadvantages of access. Should a parent prefer that a student not have Internet access, use of the computers is still possible for more traditional purposes such as word processing.

Terms and Conditions of Internet Agreement

I have read the Marquette Academy Internet policy that is found in the handbook and will review this policy with my child(ren).

I understand that the school does not have control of the Internet content, and I realize that students may be accidentally exposed to material that is controversial or offensive while partaking in an educational lesson.

I release Marquette Academy from any liability or damages that may result from my child's inappropriate or unauthorized use of the Internet.

I release Marquette Academy from any liability related to consequences resulting from my child's unauthorized use of the Internet.

Having carefully read the school's Internet policy, I give permission for my child(ren) to have Internet access at the school. I will support the school's Acceptable Use Policy and reinforce it with my child(ren).

Parent(s)/Guardian(s) Signature

Date

PUBLICITY FORM

On occasion, Marquette Academy takes photographs or makes an audio or video tape recording of children and/or adults involved in school/parish activities. Such photographs or video records may be used by staff and participants to remember the activities or participants. In addition, such photographs and audio/visual recordings may be used in publications or advertising materials to let others know about our school/parish. In addition, local news organizations may hear of our activities or events, and our school/parish may invite or allow them to photograph or record our events to be used, distributed, or displayed as agents of the school/parish see fit. This consent includes but is not limited to: photographs, videotape, and audio recordings.

Parent(s)/Guardian(s) Signature

Date

SERVICE PROJECT (GRADE 8)

I hereby agree that my child _____ may help in the school cafeteria during lunch hour when needed.

Parent(s)/Guardian(s) Signature

Date

Parents,

All attached
medical exams
need to be
completed and
returned at the start
of school.

Thank you.

Dear Parents,

Below are the State medical requirements for the upcoming school year. Please let us know if you have any questions. The appropriate forms for your students are included in the packets and online. All of these forms are **DUE AT THE START OF SCHOOL** with the exception of the dental exam. That can be completed at their first scheduled dental appointment during the school year but has to be turned in by April.

Preschool:

Complete doctor physical with updated immunizations for the first time in preschool.

Kindergarten:

Complete doctor physical with updated immunizations

Complete eye exam

Complete dental examination

Grade 2:

Complete dental examination

Grade 6:

Complete doctor physical with updated immunizations

****IESA sports preparticipation physical evaluation (if playing sports)**

Complete dental exam

Grade 5-12:

****Complete IESA/IHSA preparticipation physical evaluation (if playing sports).**

Concussion Information Acknowledgement and Consent Form (only parent signature required-if playing sports) IESA form is required for grades 5-8. IHSA form is required for grades 9-12.

Grade 9:

Complete doctor physical with updated immunizations

Complete dental examination

****IHSA sports preparticipation physical evaluation (if playing sports)**

Concussion Information Acknowledgement and Consent Form (only parent signature required-if playing sports). IHSA form is required for grades 9-12.

****The IESA/IHSA preparticipation form is new from the State of Illinois. This form needs to be completed and signed by both parents and the physician completing the physical.**

New Student entering from outside Illinois:

Complete doctor physical with updated immunizations

Complete dental examination

Complete eye exam

IESA/IHSA sports preparticipation physical evaluation (if playing sports in grades 5-12)

Concussion Information Acknowledgement and Consent Form (only parent signature required). IESA form is required for grades 5-8 and IHSA form is required for grades 9-12.



Certificate of Child Health Examination

Student's Name Last First Middle			Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Street Address City ZIP Code			Parent/Guardian Telephone (home/work)			
HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER						
ALLERGIES (Food, drug, insect, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:	MEDICATION (Prescribed or taken on a regular basis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	List:	
Diagnosis of Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Child wakes during night coughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hospitalization? When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Birth Defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Surgery? (List all) When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Developmental delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Serious injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB skin test positive (past/present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, refer to local health department	
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB disease (past or present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No		
Head injury/Concussion/Passed out?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tobacco use (type, frequency)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Seizures? What are they like?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alcohol/Drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart problem/Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Family history of sudden death before age 50? (Cause?)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart murmur/High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Dizziness or chest pain with exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Last exam by eye doctor			<input type="checkbox"/> Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading)			Additional Information:			
Ear/Hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No			Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			Parent/Guardian Signatures: _____ Date: _____			
IMMUNIZATIONS: To be completed by health care provider. The mo/day/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)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				Comments: * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal Conjugate						
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 _____	

Student's Name Last First Middle			Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#
Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and <i>Maintained</i> by the School Authority.						
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) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> 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.						
Physician Statements of Immunity MUST be submitted to IDPH for review. Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____						
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 <input type="checkbox"/> Yes <input type="checkbox"/> No		And any two of the following: Family History <input type="checkbox"/> Yes <input type="checkbox"/> No		
Ethnic Minority <input type="checkbox"/> Yes <input type="checkbox"/> No		Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) <input type="checkbox"/> Yes <input type="checkbox"/> No		At Risk <input type="checkbox"/> Yes <input type="checkbox"/> No		
LEAD RISK QUESTIONNAIRE: Required for children aged 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Blood Test Indicated? <input type="checkbox"/> Yes <input type="checkbox"/> 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 .						
<input type="checkbox"/> No test needed <input type="checkbox"/> Test performed		Skin Test: Date Read _____		Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		mm _____
		Blood Test: Date Reported _____		Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative		Value _____
LAB TESTS (Recommended)	Date	Results	SCREENINGS	Date	Results	
Hemoglobin or Hematocrit			Developmental Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A	
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A	
Sickle Cell (when indicated)			Other:			

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	Screening Result:	Gastrointestinal	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	Screening Result:	Genito-Urinary	<input type="checkbox"/>	LMP:
Nose	<input type="checkbox"/>		Neurological	<input type="checkbox"/>	
Throat	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	
Mouth/Dental	<input type="checkbox"/>		Spinal Exam	<input type="checkbox"/>	
Cardiovascular/HTN	<input type="checkbox"/>		Nutritional Status	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis of Asthma	Mental Health	<input type="checkbox"/>	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g., Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g., inhaled corticosteroid)			Other	<input type="checkbox"/>	
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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified	INTERSCHOLASTIC SPORTS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified
Print Name _____ <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APN <input type="checkbox"/> PA Signature _____	Date _____
Address _____	Phone _____



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City	ZIP Code	
Name of School:	ZIP Code		Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Last Name		First Name	
Student's Race/Ethnicity:				
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian				
<input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown				
<input type="checkbox"/> Other _____				

To be completed by dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)
☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Restoration of teeth due to caries

Oral Health Status (check all that apply)

☐ Yes ☐ No Dental Sealants Present on Permanent Molars

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

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

☐ Yes ☐ No Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.

☐ Restorative Care — amalgams, composites, crowns, etc.

Appointment Date: _____

☐ Preventive Care — sealants, fluoride treatment, prophylaxis

Appointment Date: _____

☐ Pediatric Dentist Referral Recommended

Treatment Completion Date: _____

Additional comments: _____

Signature of Dentist _____ License #: _____ Date: _____





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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 _____



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 _____)