



WAUKEGAN HIGH SCHOOL

DONALDO R. BATISTE, Ph.D.
Superintendent
DISTRICT 60

BROOKSIDE CAMPUS • 2325 Brookside Avenue • Waukegan, Illinois 60085
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Dr. Steven P. Hamlin
Principal

YOUR CHILD CAN'T ATTEND 9TH GRADE HIGH SCHOOL WITHOUT COMPLETE HEALTH REQUIREMENTS
SU HIJO NO PUEDE VENIR AL ESCUELA DE NOVENO GRADO SIN LOS REQUISITOS COMPLETOS

Due May 1, 2009
Debido Mayo 1, 2009

Parents of Incoming Freshman:
Padres de Estudiantes de Noveno Grado:

Your child needs the following health requirements in order to be able to attend school:
Su hijo necesita lo siguiente para poder venir al escuela:

Ninth Grade Physical Exam
Examen fisico de Noveno Grado

Diabetes mellitus screening report
Reporte de proposito de el diabetes

Current tetanus-diphtheria booster vaccination
Reciente vacuna de tetanor-diphtheria

Tuberculosis skin test **WITH RESULTS**
*Examen de la piel para tuberculosis **CON EL RESULTADO***

Answer your child's health questions along with signature and date
Contestar preguntas de salud de su hijo con su firma y la fecha

Your child's physical exam for should be completed like the sample in the back of this page.
La forma de el examen fisico de su hijo debe estar completo igual como el ejemplo detras de esta pagina.

Your child's school physical is to be given **ONLY TO THE MIDDLE SCHOOL NURSE.**
*El examen fisico de su hijo debe ser entregado **SOLAMENTE A LA ENFERMERA DE LA ESCUELA SECUNDARIA.***

Sharon Miller,
School Nurse
Enfermera Escolar
(847) 263-4784

Mission Statement

"Educating students for the world of tomorrow is our top priority. Through mobilization of the entire community, we will challenge, teach, and inspire our students. We will provide the resources to serve each of our students, expecting excellence from all involved. We will deliver an exciting education in a safe environment that celebrates our diversity and similarities in a spirit of unity and respect."

MRS. MINERVA CRUZ
Associate Principal

MR. ROMMEL DRAKE
Associate Principal

MRS. MOLLY SCHAEFER
Associate Principal

MR. LUIS CORREA
Assistant Principal



**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 #		Work			
Street	City		ZIP code				Home				

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		
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	R		L
Vision															
Hearing															

Printed by Authority of the State of Illinois
(Complete Both Sides)

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 Yes	No 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
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? _____ 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)