

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 Nam	e: Last	First		Middle		Birth Date: (Month/Day/Year)	
Address:	Street	C	City			ZIP Code	
Name of School	ol:	ZIP Cod	е	Grade Level:		Gender:	
						☐ Male ☐ Female	
Parent or Gua	rdian: Last Name			First Name	е		
Student's Race	e/Ethnicity:						
☐ White	☐ Black/African Americ	can	☐ Hispani	c/Latino	☐ Asiar	1	
☐ Native Ame	rican 🔲 Native Hawaiian/Pa	cific Islander	☐ Multi-ra	cial	☐ Unkn	own	
☐ Other		_					
To be complete	ed by dentist:						
	ecent Examination: Cleaning Sealant		(Check all se	ervices provide		nination date) f teeth due to caries	
_	_		nide liealinen		Nestoration o	r teetii dde to canes	
	atus (check all that apply)						
☐ Yes ☐ No	Dental Sealants Present of	n Permanent IV	lolars				
☐ Yes ☐ No	Caries Experience / Restorextracted as a result of caries O	ration History - R missing perma	— A filling (tempoent 1st molars.	oorary/permanen	t) OR a tooth th	nat is missing because it was	
☐ Yes ☐ No	Untreated Caries — At least walls of the lesion. These criteri root, assume that the whole too considered sound unless a cavi	a apply to pit and th was destroyed	fissure cavitate by caries. Broke	d lesions as well	as those on sn	nooth tooth surfaces. If retained	
☐ Yes ☐ No	Urgent Treatment — absces swelling.	ss, nerve exposure	e, advanced dis	ease state, signs	or symptoms t	hat include pain, infection, or	
Treatment Nee	ds (check all that apply). For	Head Start Agen	icies, please al	so list appointm	ent date or da	te of most recent treatment	
Restorativ	ve Care — amalgams, composites	s, crowns, etc.	Appoir	ntment Date:			
☐ Preventiv	e Care — sealants, fluoride treatm	nent, prophylaxis	Appoir	ntment Date:			
Pediatric	Dentist Referral Recommende	ed	Treatn	nent Completion I	Date:		
Additional cor	nments:						
Signature of D	entist		License :	#:	Date	ə:	

Illinois Department of Public Health, Division of Oral Health 217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov





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(Month/Date	/\(\frac{1}{2}1\)		Gender	Gra	ade		
Parent or Guardian	• /						
Tarchi of Guardian			ast)			(First)	
Phone		`	,			, ,	
(Area Code)			_				
Address							
· ·	(umber)		(Street)			(City)	(ZIP Code)
County							
			To Be Comp	leted By	Examinin	g Doctor	
Case History							
Date of exam							
Ocular history:	Normal	or Positi	ve for				
Drug allergies:							
Other information							
Examination							
	Dista	nce		Near			
	Right	Left	Both	Both	+		
Uncorrected visual acuity	20/	20/	20/	20/			
Best corrected visual acuit	y 20/	20/	20/	20/			
W. 0 0							
Was refraction performed	i with dilati	ion?	Yes No				
			Normal	A	bnormal	Not Able to Assess	Comments
External exam (lids, lash							
Internal exam (vitreous,	lens, fundus	s, etc.)					
Pupillary reflex (pupils)						U	
Binocular function (stere	. ,					u	
Accommodation and ver	gence						
Color vision							
Glaucoma evaluation						U	
Oculomotor assessment							
Other				• .			
NOTE: "Not Able to Asses	s" reters to the	ne inabili	ty of the child to	complete	the test, not	the inability of the doctor	to provide the test.
Diagnosis	D. ***			_			
□ Normal □ Myopia	☐ Hype	ropia	☐ Astigmatism	n 🗀 S	Strabismus	☐ Amblyopia	
Other							

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State of Illinois **Eye Examination Report**

Recommendations

 Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be ☐ Constant wear ☐ Near vision ☐ May be removed for physical educe 	☐ Far vision
2. Preferential seating recommended: ☐ No ☐ Yes	
Comments	
3. Recommend re-examination: □ 3 months □ 6 months □ Other	
4	
5	
Print name Optometrist or physician (such as an ophthalmologist)	License Number
who provided the eye examination \square MD \square OD \square DO Address	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)
Phone	(Date)
Signature	Date
(Source: Amended at 32 Ill. Reg.	, effective)



Certificate of Child Health Examination

Student's Name					Birth (Mo/D		Sex	Race/Et	hnicity		Scho	ol/Grad	de Level/ID#	
Last	First		Middle											
Street Address		City	Z	IP Code	Parent/0	Guardian					Tele	ohone (ho	ome/work)	
HEALTH HISTORY	: MUS	T BE COMPL	ETED AND	SIGNED	BY PA	RENT/	GUAR	DIAN AND	VERIFIE	D BY	HEALT	H CAR	E PROVIDER	
ALLERGIES	Yes	List:				MEDIC	OITA	V	Yes	List:				
(Food, drug, insect, other)	□ □ No					(Prescrib regular I		aken on a	□ No					
Diagnosis of Asthma?			Yes N	0				f function of c			Yes	No		
Child wakes during night coughin	g?		Yes No					s? (eye/ear/ki talization?	uney/testicie	2)	☐ Yes	¬ No ⊢		
Birth Defects?			☐ Yes ☐ No					? What for?			1es			
Developmental delay?			Yes No					ry? (List all)			Yes	□ No		
Blood disorder? Hemophilia, Sick	le Cell, Ot	ther? Explain.	Yes N	0			-	? What for?			□ voc I	- No -		
Diabetes?			Yes N	0			-	ıs injury or illn		+/2	Yes			
Head injury/Concussion/Passed of	out?		Yes N	0				n test positive		nt)?	Yes*		*If yes, refer to local health department	
Seizures? What are they like?			Yes N	0			-	ease (past or p			Yes*		neath department	
Heart problem/Shortness of brea	ith?		Yes N	0			-	co use (type, f	requency)?		_ :	□ No L		
Heart murmur/High blood pressu	ıre?		Yes N	0			-	ol/Drug use?			Yes	_		
Dizziness or chest pain with exerc	cise?		Yes N	0				y history of sud D? (Cause?)	dden death l	oetore	Yes	No		
Eye/Vision problems?		Glasses Co	ntacts Last exam by eye doctor				+	Dental Braces Bridge Plate Other						
Other concerns? (Crossed eye,	drooping	lids, squinting, o	lifficulty readir	ng)			Additi	ional Informat	ion:					
Ear/Hearing problems?			II I Yes I I No I					formation may be shared with appropriate personnel for health and educational purposes.						
Bone/Joint problem/injury/scolid	sis?						Parent/Guardian Signatures: Date:							
IMMUNIZATIONS: To be c contraindicated, a separa explaining the medical res	te writt	en statement	must be at	er. The m	o/day/y y the he	yr for <i>e</i> alth ca	very d	ose admini vider respo	stered is i	requir comp	ed. If a soleting t	specific he hea	vaccine is medically lth examination	
REQUIRED Vaccine/Dose	М	DOSE 1 D DA YR	DOSE MO DA		1	DOSE 3	/R	DOS MO D		N	DOSE 5		DOSE 6 MO DA YR	
DTP or DTaP														
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap	Td DT	☐ Tdap ☐ 1	ſd □ DT	☐ Tdap	☐ Td	☐ DT	☐ Tdap ☐	Td 🗌 DT	☐ Tda	p 🗌 Td	☐ DT	☐ Tdap ☐ Td ☐ DT	
Polio (Check specific type)	I	PV OPV	☐ IPV [OPV	☐ IF	PV D	PV	☐ IPV	☐ OPV		IPV 🗌	OPV	☐ IPV ☐ OPV	
Hib Haemophiles Influenza Type B														
Pneumococcal Conjugate														
Hepatitis B														
MMR Measles, Mumps, Rubella								Comment	s: * ir	ndicate	s invalid	dose		
Varicella (Chickenpox)														
Meningococcal Conjugate														
RECOMMENDED, BUT NOT REC	QUIRED \	/accine/Dose												
Hepatitis A														
HPV														
Influenza														
Other: Specify Immunization Administered/Dates														
Health care provider (MD, DO								immunizati	on history	must s	ign belov	v.		
If adding dates to the above in	mmuniza	ation history se	ction, put you	r initials b	y date(s)	and sign	here.							
Signature				Title								Date	e	

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Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:	Student's Name					Date	Sex	9	Scho	ol	Grade Level/ID#		
Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and Minintrained by the School Authority. Alternative PRODE OF IMMUNITY 1. Cinical diagnosis (measles, mumps, hepatitis is) is allowed when verified by hysician and supported with lab confirmation. Attach copy of lab result. 1. Cinical diagnosis (measles, mumps, hepatitis is) is allowed when verified by hysician and supported with lab confirmation. Attach copy of lab result. 1. MRASIS (Blacobio) (Monta)	Last		First	Middle									
ALTERNATIVE PROOF OF IMMUNITY 1. Clinical diagnosis (measles, mumps, heatitis 8) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. 1. Clinical diagnosis (measles, mumps, heatitis 8) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. 1. WARLES (blaceous) (MODA/WI) 1. PARTIES (BINO) (MODA/WI) 2. History of varicella (chickenpox) disease is acceptable if verified by heatith care provider, school heatith professional or heatith official. Person signing below verifies that the previous of the community (check one) 2. History of varicella (Chickenpox) disease is acceptable if verified by heatith care provider, school heatith professional or heatith official. Person signing below verifies that the previous of the provious of the province of the community (check one) 3. Laboratory Evidence of Immunity (history and the community (check one) 3. Laboratory Evidence of Immunity (MIDE) 3. Laboratory Evidence of Immunity (MIDE) 4. Manuelse cases diagnosed on or after July 1, 2023, must be confirmed by laboratory evidence. 1. Physician Statements of Immunity (MIDE) 1. Martin (MIDE)	Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication												
1. Clinical diagnosis (measles, mumps, hepatitis b); allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. **MIMASSIES (Ruberals) (brothops)** **Jetter of the pure digual districts description of varieties disconservations and susceptite such history as disconservation of discoustive verifies, but the pure digual districts described on the susceptite such history as disconservation of discoustive verifies that the pure digual districts disconservation and susceptite such history as disconservation of discoustive verifies that the pure digual discoustive verifies are disconserved by the pure discoustive verifies and susceptite such history as disconservation of discoustive verifies and pure discoustiv	·												
**MARGELA (MODIOW?) **ARCHELA (MODIOW?) **ARCH				natitis B) is allowed when veri	ified by	, nhysici	an and c	unnorte	d wi	th lah confirmatio	on Attach conv of lah result		
2. History of varicella (chickenpox) disease is a coeptable if verified by health care provider, school health professional or health official. Person signing below retrilled this was perfused and secretified such this yea documentation of disease. Date of Disease		•		•	•			• •			• •		
"All manys cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence." **All manys case diagnosed on or after July 1, 2002, 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: Physician Statements of Immunity MUST be submitted to IDPH for review. Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: Physician Statements of Immunity MUST be submitted to IDPH for review. Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: Physician Statements of Immunity MUST be submitted to IDPH for review. Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: BAD RESCORDING Continued and the Statement of Physician Signature	2. History of varice	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.											
"All manys cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence." **All manys case diagnosed on or after July 1, 2002, 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: Physician Statements of Immunity MUST be submitted to IDPH for review. Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: Physician Statements of Immunity MUST be submitted to IDPH for review. Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: Physician Statements of Immunity MUST be submitted to IDPH for review. Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: BAD RESCORDING Continued and the Statement of Physician Signature	Date of Disease		Signatur	e					_	Title			
**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 CRECUMPERSCRIF (= 2.3 years) BMM PERCINTILE									□ \	/aricella	Attach copy of lab result.		
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:	**All mumps case	s diagno	osed on or afte	r July 1, 2013, must be confire	med b								
Entire section below to be completed by MD/DO/APN/PA HEIGHT WEIGHT WEIGHT BMI BM PERCENTILE BP BAD RECCENTILE SAY years old HEIGHT WEIGHT BMI BM BAD RECCENTILE BP BAD RECCENTILE BP BAD BAD RECCENTILE BP BAD SAY AND BAD BAD BAD BAD BAD BAD BAD BAD BAD BA	Physician Statements of Immunity MUST be submitted to IDPH for review.												
HEAD CIRCUMFERENCE If < 2-3 years old													
DIABSTES SCREENING: No TEQUINED POR DAY CABO SMIN-BSS Age/See Yes No And any two of the following: Family History Yes No Art Risk Yes No LEAD RISK QUESTIONNAIRE: Required for children aged of months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergraten. (Blood test required if reades in children aged in months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergraten. (Blood test required if reades in children or 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/18/guideliacions/faces/sesting/Tip_lesting.htm. The 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/18/guideliacions/faces/sesting/Tip_lesting.htm. The SKIN OR BLOOD TEST: Recommended Test performed Skin rest. Date Reported Result: Positive Negative Value LAB TESTS (Recommended) Date Results Screening Result: Positive Negative Value LAB TESTS (Recommended) Date Results Screening Result: Developmental Screening Completed N/A Urinalysis Screening Result: Gardorinal Screening Completed N/A Siddle Cell (when indicated N/A Signal Exam Comments/Follow-up/Needs Normal Comments/Follow-up/Needs N/A Siddle Cell (when indicated N/A Signal Exam Comments/Follow-up/Needs N/A Signal Exam Cardiovascular/HTN Comments/Follow-up/Needs N/A Signal Exam Cardiovascular/HTN Comments/Follow-up/Needs N/A Signal Exam Cardiovascular/HTN Comments/Follow-up/Needs Diagnosis of Asthmol			•			-	_						
Ethnic Minority Yes No Signs of Insulin Resistance inyvertendou drafipidemis, policystic ovarian syndrome, acenthose ingressis Yes No At Risk Yes No LEAD RISK QUESTIONNAIRE; Required for children aged is months through 8 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. Illidend test required resides in Chicago high-risk siz occlude in resides in Chicago high-risk siz occlude in Result Yes No Blood Test Indicated? Yes No Blood Test Date Result TS KIN OR BLOOD TEST; Recommended only for children in high-risk groups including children immunosuppressed due to HV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to soldus in high-risk categories. See COC quietienes. https://www.kdc.gov/rby/publications/factsheebs/kes/factsing/Trs_Leshing.htm. No test needed Test performed Sain Test: Date Read Result: Positive Wegative mm					WEIGH	1T	Br	MI		BMI PERCENTILE	B/P		
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 realizes in Chicago or light-risk ap code).	DIABETES SCREENIN	IG: (NOT R		, J		_	,			,			
Questionnaire Administered? Yes No Blood Test Indicated? Yes No Blood Test Date Result TB SKIN DR BLOOD TEST: Recommended only for children in high-risk categories. See CDE guidelines. http://www.dcd.gov/tb/gubilications/facsheets/testing/TB_testing.htm. No test needed Test performed Skin Test: Date Read Result: Positive Negative Walue	LEAD RISK QUESTIO	NNAIRE:	Required for child	ren aged 6 months through 6 years er				-					
TRE SKIN DR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to hill vinection or other conditions, frequent travel to or born in high provisioner countries or chase capacity of the cap				•							.		
prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. https://www.dcd.gov/tb/publications/factsheets/testing/TB_testing.htm. No test needed Test performed Skin Test: Date Read Result: Positive Negative Magative Magative													
Blood Test: Date Reported Result: Positive Negative Value													
LAB TESTS (Recommended) Date Results SCREENINGS Date Results	☐ No test needed	☐ Test	t performed SI	kin Test: Date Read		Result:	Positiv	ve 🗌 N	egati	ve mm			
LAB TESTS (Recommended) Date Results SCREENINGS Date Results			В	lood Test: Date Reported		Res	sult: 🗍 F	Positive	Πи	egative Value			
Hemoglobin or Hematocrit	LAB TESTS (Recommo	ended)								-	Results		
Drinalysis Social and Emotional Screening Completed N/A					Deve	elopment	al Screen	ing					
SYSTEM REVIEW Normal Comments/Follow-up/Needs Skin Endocrine Ears Screening Result: Gastrointestinal Eyes Screening Result: Genito-Urinary LMP: Nose Musculoskeletal Musculoskeletal Musculoskeletal Cardiovascular/HTN Diagnosis of Asthma Medication: Mutritional Status Mutritional Status Mutritional Status Mental Health Mutritions Controller medication (e.g., short Acting Beta Agonist) Mental Health Musculoskeletal Musculoskeletal Mutritional Status Mental Health Mutritional Status Mutritional Status Mental Health Mutritional Status Mutritional Status Mental Health Mutritional Status					_	•					☐ Completed ☐ N/A		
Endocrine Ears Screening Result: Gastrointestinal	· ·	cated											
Endocrine Ears Screening Result: Gastrointestinal			1										
Screening Result: Gastrointestrial	SYSTEM REVIEW		Comments/Follo	ow-up/Needs						Comments/Follow-	up/Needs		
Screening Result: Genito-Urinary LMP:	Skin					Endocrir	ne		1				
Nose	Ears			Screening Result:		Gastroir	testinal]				
Mouth/Dental	Eyes			Screening Result:		Genito-l	Jrinary]	LMP:			
Mouth/Dental	Nose					Neurolo	gical]				
Cardiovascular/HTN	Throat					Musculo	skeletal						
Respiratory	Mouth/Dental					Spinal E	kam]				
Currently Prescribed Asthma Medication: Quick-relief medication (e.g., Short Acting Beta Agonist)	Cardiovascular/HTN					Nutritio	nal Statu	s					
Quick-relief medication (e.g., Short Acting Beta Agonist) Controller medication (e.g., inhaled corticosteroid) DIETARY Needs/Restrictions	Respiratory			Diagnosis of	Asthma	Mental	Health						
Controller medication (e.g., inhaled corticosteroid) DIETARY Needs/Restrictions	,			Poto Agonist\		Other			, T				
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	_			= :					J				
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													
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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 Date													
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PHYSICAL EDUCATION Yes No Modified INTERSCHOLASTIC SPORTS Yes No Modified Print Name Date				o cilila's nealth condition (e.g., seizures,	, astnma,	, insect stin	g, 100d, pe	eanut aller	gy, ble	euing problem, diabet	es, neart problem)?		
Print Name Do DO APN PA Signature Date				this child's participation in			((If No or M	odified	l please attach explana	ation.)		
	PHYSICAL EDUCATIO	N NY	es No M	odified INTERSCHOLASTIC	SPORTS	S Yes	□ No	☐ Mod	lified				
Address Phone	Print Name			MD DO	APN [_ PA Si	gnature				Date		
	Address	·						<u> </u>			Phone		