Palos School District 118
8800 W. 119th St. | Palos Park, IL 60464 | 708-448-4800 | www.palos118.org

IMPORTANT NOTICE OF HEALTH REQUIREMENTS FOR PRESCHOOLERS

ALL PHYSICAL EXAMS DUE JULY 1st

(No admittance on the first day of school without physical exam on file in health office)

The State of Illinois and Palos Consolidated School District 118 **require** that each student **provide proof** of having met the following health requirements for school:

1. **EVIDENCE OF A PHYSICAL EXAMINATION** by a State Licensed Health Care Provider (using the "Certificate of Child Health Examination" form) within one year of entering school.

2. **MEDICAL VERIFICATION OF COMPLETE IMMUNIZATION HISTORY,** which states month, day, year, and signature of the doctor or nurse for each immunization below.
   a. DTP/DTaP: At least 4 doses
   b. POLIO: At least 3 doses
   c. HEPATITIS B: A series of three doses
   d. VARICELLA: One dose on or after 12 months of age (may have laboratory proof or verification of disease by Health Care Provider)
   e. MEASLES: The first dose after 12 months of age and the second dose no sooner than one month later (may have laboratory proof or verification of disease by Health Care Provider)
   f. MUMPS: One dose on or after 12 months of age (may have laboratory proof or verification of disease by Health Care Provider)
   g. RUBELLA: One dose on or after 12 months of age (may have laboratory proof)
   h. HAEMOPHILUS INFLUENZA TYPE B
      Those who have not received the primary series of Hib vaccine according to the Hib vaccine schedule must show proof of receiving one dose of Hib vaccine at 15 months of age or older.
   i. INVASIVE PNEUMOCOCCAL DISEASE: One dose of pneumococcal vaccine, if the primary series of pneumococcal vaccine has not been received

3. **MEDICAL VERIFICATION OF DIABETES SCREENING IS REQUIRED.**
4. **MEDICAL VERIFICATION OF LEAD SCREENING IS REQUIRED.** If screening determines the student is at risk, proof of blood testing, according to the Illinois Department of Public Health, is also required.
5. **APPROVAL OF PARTICIPATION IN PHYSICAL EDUCATION AND INTERSCHOLASTIC SPORTS** near the bottom of the page must be checked by the health care provider with modifications, if needed.
6. **HEALTH HISTORY** to be completed and signed by a parent/guardian and verified by the health care provider.

Please be sure that the physical form is completed entirely BEFORE you leave the doctor's office.

State of Illinois
Certificate of Child Health Examination

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

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

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or **DTaP**						
Tdap; Td or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.
If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR** ****MUMPS MO DA YR** **HEPATITIS B MO DA YR** **VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐Measles* ☐Mumps ☐Rubella ☐Varicella Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)	Yes / No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	List:
Diagnosis of asthma?	Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	Yes No				
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	Yes No		**Parent/Guardian Signature**		**Date**

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

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

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**_____
Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears		Screening Result:	**Gastrointestinal**		
Eyes		Screening Result:	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

INSTRUCTIONS FOR COMPLETING

ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM

Who may use the *Certificate of Religious Exemption to Required Immunizations and/or Examinations Form:*

- Parents or legal guardians who are requesting a religious exemption to immunizations or examinations **must** use this form for students entering kindergarten, sixth, or ninth grades.
- A separate form must be used for **each child** with a religious exemption enrolled to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school.
- This form may not be used for exemptions from immunizations and/or examination for personal or philosophical reasons. Illinois law does not allow for such exemptions. (See excerpts below from Public Act 099-0249 enacted August 3, 2015 at page bottom.)

When use of this form becomes required: October 16, 2015

How to complete the *Certificate of Religious Exemption to Required Immunizations and/or Examinations Form*:

- Complete the Parent/Guardian sections, which include key information about the student and the school the student will be entering, and the immunizations or examinations for which religious exemption is being requested. Provide a statement of religious belief(s) **for each vaccination/examination requested**.
- The form must be signed by the child's parent or legal guardian **AND** the child's health care provider* responsible for performing the child's health examination.
- Submit the completed form to local school authority on or before October 15th of the school year, or by an earlier enrollment date established by a school district.

Religious Exemption from Immunizations and/or Examination Form Process:

- The local school authority is responsible for determining whether the information supplied on the Certificate of Religious Exemption to Required Immunizations and/or Examinations Form constitutes a valid religious objection.
- The local school authority shall inform the parent or legal guardian, at the time that the exemption is presented, of exclusion procedures, should there be an outbreak of one or more diseases from which the student is not protected, in accordance with the Illinois Department of Public Health (IDPH) rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690).
- Exempting a child from health, dental, or eye examination does not exempt the child from participation in the program of physical education training provided in Section 27-5 through 27-7 of the Illinois School Code [105 ILCS 5/27-5 through 105 ILCS 5/27-7]. A separate request for exemption from physical education, if desired, would need to be presented.

Excerpt from Public Act 099-0249 enacted August 3, 2015:

Children of parents or legal guardians who object to health, dental, or eye examinations or any part thereof, or to immunizations or to vision and hearing screening tests on religious grounds shall not be required to undergo the examinations or immunizations if the parents or legal guardians present to the appropriate local school authority a signed Certificate of Religious Exemption detailing the grounds for objection and the specific immunizations and/or examinations to which they object. The grounds for objection must set forth the specific religious belief(s) that conflict with the examination, immunization, or other medical intervention. The certificate will be signed by the parent or legal guardian to confirm their awareness of the school's exclusion policies in the case of a vaccine preventable disease outbreak or exposure. The certificate must also be signed by the child's health care provider responsible for performing the child's examination for entry into kindergarten, sixth or ninth grade. This signature affirms that the provider educated the parent or legal guardian about the benefits of immunization and the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.

The religious objection provided need not be directed by the tenets of an established religious organization. However, general philosophical or moral reluctance to allow physical examinations, eye examinations, immunizations, vision and hearing screening or dental examinations will not provide a sufficient basis for an exception to statutory requirements. The local school authority is responsible for determining if the content of the Certificate of Religious Exemption constitutes a valid religious objection.

The local school authority shall inform the parent or legal guardian of exclusion procedures in accordance with IDPH's rules, Control of Communicable Diseases Code (77 Ill. Adm. Code 690) at the time the objection is presented.

ILLINOIS CERTIFICATE OF RELIGIOUS EXEMPTION TO REQUIRED IMMUNIZATIONS AND/OR EXAMINATIONS FORM

PARENT OR LEGAL GUARDIAN - COMPLETE THIS SECTION

Note: *This form is required for all students entering kindergarten, sixth or ninth grades when parent(s) or legal guardian(s) is requesting a religious exemption on or after October 16, 2015. This form also must be submitted to request religious exemption for any student enrolling to enter any public, charter, private or parochial preschool, kindergarten, elementary or secondary school on or after October 16, 2015.*

This form may NOT be used for personal or philosophical reasons. Illinois law does not allow for such exemptions.

Student Name:(last, first, middle) **Parent/Guardian Name**:	**Student Date of Birth**: Month Day Year **Gender**: ☐M ☐F	**School Name:** **City:**	**Grade:**
Address:	**Telephone Number(s)**:	**Exemption requested for** (mark all that apply): ☐ **Hepatitis B** ☐ **DTaP** ☐ **Polio** ☐ **Hib** ☐ **Pneumococcal** ☐ **MMR** ☐ **Varicella** ☐ **Td/Tdap** ☐ **Meningococcal** ☐ **Health Exam** ☐ **Eye Exam** ☐ **Dental Exam** ☐ **Vision/Hearing Tests** ☐ **Other (indicate below)**	

To receive an exemption to vaccination/examination, a parent or legal guardian must provide a statement detailing the religious beliefs that prevent the child from receiving each required school vaccinations/examination being requested.
In the space provided below, state each vaccination or examination exemption requested and state the religious grounds for each request. If additional space is needed, attach additional page(s).

Religious Exemption Notice:
No student is required to have an immunization/examination that is contrary to the religious beliefs of his/her parent or legal guardian. However, not following vaccination recommendations may endanger the health or life of the unvaccinated student, others with whom they come in contact, and individuals in the community. In a disease outbreak, or after exposure to any of the diseases for which immunization is required, schools may exclude children who are not vaccinated in order to protect all students.
I have read the Religious Exemption Notice (above) and have provided requested information for each vaccination/examination being requested for religious exemption.

Signature of parent or legal guardian (required) Date

HEALTH CARE PROVIDER* – COMPLETE THIS SECTION

Provision of information: I have provided the parent or legal guardian of the student named above, with information regarding ***1) the required examinations, 2) the benefits of immunization, and 3) the health risks to the student and to the community from the communicable diseases for which immunization is required in Illinois.*** *I understand that my signature only reflects that this information was provided; I am not affirming the parent or legal guardian's religious beliefs regarding any examination, immunization or immunizing agent.*

Signature of health care provider*

Date: _____
(Must be within 1 year prior to school entry)

Health Care Provider Name:

Address:

Telephone #: _____

*Health care provider responsible for performing child's health examination includes physicians licensed to practice medicine in all of its branches, advanced practice nurses, or physician assistants.

Colleen Grant Schumann, RN
Supervisor
Palos Township

10802 S. Roberts Road
Palos Hills, Illinois 60465

Office (708) 598-4418
Fax (708) 598-4473
Health Service (708) 598-2441
Fax (708) 598-2717

Health Service

	HEALTH SERVICE HOURS	PHYSICIAN HOURS
MONDAY & FRIDAY	8:00 AM – 3:00 PM	9:00 AM – 3:00 PM
TUESDAY & THURSDAY	12:00 PM – 7:00 PM	2:00 PM – 7:00 PM
WEDNESDAY	2:00 PM – 6:30 PM	2:30 PM – 6:30 PM

Blood Pressure Monitoring: Let us help you keep track of your blood pressure. Come in anytime during Health service hours. **Free of charge.**

Physical Examinations: Our physicians will perform basic school, camp, or employment physicals. Call for an appointment. A complete shot record is necessary for exam. **Resident fee $25.**

Illness: **No sick visit appointments until further notice due to COVID-19.**

Immunizations: Available from infancy through age 18 as recommended by the State of Illinois for those meeting federal program requirements. **$10 administration fee per injection. Residents only.**

Strep Screens: If determined necessary by our physician. **Resident fee $25.**

Diabetes Monitoring: Fasting blood sugars are done Monday and Friday mornings from 8am to 9:30am without appointment. Do NOT eat or drink after midnight. **Resident fee $5 Non-resident fee $10**

Cholesterol Testing: For Total Cholesterol, High Density (HDL), Low Density (LDL), Ratios, Glucose & Triglyceride values. Do NOT eat or drink after midnight. **Resident fee $40. Non-resident fee $50**

Hemoglobin A1C: For diabetics, reflects the average blood sugar level over the previous 2-3 months. No fasting is necessary. **Resident fee $15. Non-resident fee $20**

TB Testing: Mantoux skin test. Must be able to return to the clinic in 48-72 hours for test to be read. Call for an appointment. **Resident fee $20.**

Foot Care: Nail cutting is available to Senior Citizens six days each month. **By Appointment ONLY. Free of charge.**

ALL FEES ARE CASH ONLY. No insurance is accepted or filed.
Our physicians cannot be your primary care provider.
Services by appointment only unless noted.

Services are available to Residents of Palos Township only unless otherwise stated.

2023

Palos Township Health Service

10802 South Roberts Rd • Palos Hills •IL • 708-598-2441

For the Current Residents of Palos Township • Call for an appointment

CURRENT FEES

- ❖ **PHYSICALS:** fee of $25
- ❖ **SICK VISITS:** Unavailable until further notice.
- ❖ **SHOTS:** administration fee of $10 per shot
  (for those meeting federal program requirements)
- ❖ **VITAMIN B12:(current Dr prescription required)** fee of $10
- ❖ **TB tests:** fee of $20
- ❖ **STREP SCREENS:** fee of $25
- ❖ **DIABETES MONITORING:** fee of $5
- ❖ **CHOLESTECH (including cholesterol values):**
  resident fee of $40 non-resident fee of $50
- ❖ **HEMOGLOBIN A1C:** resident fee of $15
  non-resident fee of $20

ALL FEES ARE CASH ONLY.

NO INSURANCE WILL BE ACCEPTED OR FILED.

*Palos Township Health Service Physicians
CANNOT be your primary care physician.*

PTHS 10/2022

Cook County DEPT of Public Health

Promoting health. Preventing disease. Protecting you.

www.cookcountypublichealth.org

Clinic Appointment Information

All Cook County Department of Public Health clinical services are conducted by appointment only. Eligibility requirements may apply and will be discussed when you call to make your appointment.

To make an appointment at one of our four clinics nearest your home, please call one of the following four numbers and an operator will assist you.

General Clinical Services

847-818-2860

TDD: 847-818-2023

708-786-4000

TDD: 708-786-4002

708-974-6160

TDD: 708-974-6043

708-232-4500

TDD: 708-232-4010

Tuberculosis (TB) Clinics

To make an appointment for at a CCDPH TB clinic or to report a case of Tuberculosis, call the number below. The operator will assist you in making an appointment at one of the four above-listed clinics.

708-836-8600

Additional Services

Breast & Cervical Cancer Screening

Medical/Immunization Records

Prenatal Program

Public Health Nursing

Tuberculosis

Vision and Hearing Screening

WORTH TOWNSHIP CLINIC . . . . . A PREVENTATIVE CLINIC

11601 SOUTH PULASKI ROAD • ALSIP, ILLINOIS 60803 • PHONE: 708-371-3393 FAX: 708-371-2542

SCHOOL, SPORT, and CAMP PHYSICALS *
IMMUNIZATIONS • FLU (When available)
FREE BLOOD PRESSURE CHECKS
PODIATRY SERVICES (preventative)*

*APPOINTMENTS REQUIRE FOR PHYSICALS

A parent must accompany all children under the age of 18. If coming in for an immunization, please bring a record of all previous immunizations or a letter from the school specifying what immunizations need to be given. We now offer services to non-residents of Worth Township at an increased cost. Proper Identification is a Driver's License and/or utility bill which must be provided at the time of visit.

CLINIC RATES • CASH or CHECK ONLY

	Resident	Non-Resident		Resident	Non-Resident
School / Sports Physicals	$25	$40	Children's Immunizations (each)	$10	$20
Work Physicals	$25	$40	TB Skin Test	$20	$20
Camp Physicals	$25	$40	Podiatry (Preventative)	$25	$40
Blood Pressure Check	FREE		Extra Forms	$5	$5

CLINIC HOURS

Monday, Tuesday, & Thursday: 9:00am - 3:30pm
Wednesday: 9:00am - 6:30pm
Friday- Closed*
*(Open Fridays in August for back to school rush: 9:00am-3:30pm)

Any patient with a medical condition or history such as, but not limited to: ASTHMA, SEIZURES, A.D.D., DIABETES, HEART CONDITIONS, OR FRACTURES must have written clearance from their doctor prior to examination at Worth Township Clinic.

The Township Clinic does not accept Public Aid, All Care, or any other type of insurance. Due to recent changes by the State of Illinois, Worth Township can only provide vaccines to children without insurance, anyone receiving MEDICAID (Title 19) or anyone who is a NATIVE AMERICAN or an ALASKAN NATIVE.

Revised March 2018