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

IMPORTANT NOTICE OF HEALTH REQUIREMENTS FOR EARLY CHILDHOOD/ PRE-K STUDENTS

ALL PHYSICAL EXAMS MUST BE TURNED IN BY THE FIRST DAY OF SCHOOL OR CHILD WILL BE EXCLUDED FROM SCHOOL ATTENDANCE

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 (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 1 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				Comments:		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
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**

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	
Child wakes during night coughing?	Yes	No	
Birth defects?	Yes	No	
Developmental delay?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	
Diabetes?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No	
Seizures? What are they like?	Yes	No	
Heart problem/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	
Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List all.) When? What for?	Yes	No	
Serious injury or illness?	Yes	No	
TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
TB disease (past or present)?	Yes*	No	
Tobacco use (type, frequency)?	Yes	No	
Alcohol/Drug use?	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

Information may be shared with appropriate personnel for health and educational purposes.

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 | 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.

PALOS COMMUNITY CONSOLIDATED SCHOOLS
DISTRICT 118
PALOS PARK, IL 60464

February, 2018

Dear Parents:

In accordance with state law, effective April 17, 2012, the following policy (7:270) was adopted by the School Board of District 118. A summary of the regulations regarding the Administering of Medication to Students is below.

Should your child require medication (prescription or over the counter) to be administered during school hours or during school activities for maintenance of their critical health and well being, you will need to contact the district nurse or the health clerk at your child's school to obtain the Parent/Physician Authorization form.

Sincerely,

E Deval

Erin Deval
Director of Student Services

Palos Community Consolidated School District 118 7:270

Students

Administering Medicines to Students

Parent(s) or guardian(s) have the primary responsibility for administering medication to their children.

The Superintendent shall establish procedures for the administration of medications to students. The procedures shall be substantially based on the Recommended Guidelines for Medication Administration in the Schools published by the Illinois Department of Public Health and the State Board of Education and shall provide for administration of medication to a student during school hours or during school activities only when necessary to maintain the student in school.

Teachers and other non-administrative school employees except registered nurses shall not be required to administer medication to students.

Nothing in this policy shall prohibit any school employee from providing emergency assistance to students, including administering medication.

Students should not take medication during school hours or during school-related activities unless it is necessary for a student's health and well-being. When a student's licensed health care provider and parent(s)/guardian(s) believe that it is necessary for the student to take a medication during school hours or school-related activities, the parent/guardian must request that the school dispense the medication to the child and otherwise follow the District's procedures on dispensing medication.

No School District employee shall administer to any student, or supervise a student's self-administration of, any prescription or non-prescription medication until a completed and signed "School Medication Authorization Form" is submitted by the student's parent(s)/guardian(s). No student shall possess or consume any prescription or non-prescription medication on school grounds or at a school-related function other than as provided for in this policy and its implementing procedures.

Self-Administration of Medication

A student may possess an epinephrine auto-injector (EpiPen®) and/or asthma medication prescribed for use at the student's discretion, provided the student's parent/guardian has completed and signed a *School Medication*

Authorization Form. The School District shall incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-administration of medication or epinephrine auto-injector or the storage of any medication by school personnel. A student's parent/guardian must indemnify and hold harmless the School District and its employees and agents, against any claims, except a claim based on willful and wanton conduct, arising out of a student's self-administration of an epinephrine auto-injector and/or medication, or the storage of any medication by school personnel.

School District Supply of Undesignated Epinephrine Auto-Injectors

The Superintendent or designee shall implement Section 22-30(f) of the School Code and maintain a supply of undesignated epinephrine auto-injectors in the name of the District and provide or administer them as necessary according to State law. *Undesignated epinephrine auto-injector* means an epinephrine auto-injector prescribed in the name of the District or one of its schools. A school nurse or trained personnel, as defined in State law, may administer an undesignated epinephrine auto-injector to a person when they, in good faith, believe a person is having an anaphylactic reaction. Each building administrator and/or his or her corresponding school nurse shall maintain the names of trained personnel who have received a statement of certification pursuant to State law.

Void Policy; Disclaimer

The **School District Supply of Undesignated Epinephrine Auto-Injectors** section of the policy is void whenever the Superintendent or designee is, for whatever reason, unable to: (1) obtain for the District a prescription for undesignated epinephrine auto-injectors from a physician or advanced practice nurse licensed to practice medicine in all its branches, or (2) fill the District's prescription for undesignated school epinephrine auto-injectors.

Upon any administration of an undesignated epinephrine auto-injector, the Superintendent or designee(s) must ensure all notifications required by State law and administrative procedures occur.

Upon implementation of this policy, the protections from liability and hold harmless provisions as explained in Section 22-30(c) of the School Code apply.

No one, including without limitation parents/guardians of students, should rely on the District for the availability of an epinephrine auto-injector. This policy does not guarantee the availability of an epinephrine auto-injector; students and their parents/guardians should consult their own physician regarding medication.

The Building Principal shall include this policy in the Student Handbook and shall provide a copy to the parent(s)/guardian(s) of students within 15 days after the start of each school term, or within 15 days of starting classes for students transferring to the school district during the school term. Also, within such 15-day period, students shall be informed of the contents of this policy and the rules.

LEGAL REF.: 105 ILCS 5/10-20.14b, 5/10-22.21b, and 5/22-30.
23 Ill.Admin.Code §1.540.

ADMIN. PROC.: 7:270-AP (Dispensing Medication), 7:270-E (School Medication Authorization Form)

ADOPTED: January 17, 2017

Palos Township Health Service

10802 South Roberts Road • Palos Hills, Illinois 60465 • Phone: 708-598-2441 Fax: 708-598-2717

** APPOINTMENTS are REQUIRED **

CLINIC FEES are CASH ONLY

School and Sport Physicals **	$25
Immunizations **	$10
TB tests	$10
Sick Visits for minor illnesses	$20
Blood Pressure checks	FREE
Podiatry Services	FREE

**A parent must accompany all children under the age of 18. If coming in for an immunization or physical, please bring a record of all previous immunizations and insurance information. Proper identification includes a valid Driver's License or State ID and a utility bill or lease which must be provided at the time of visit.

CLINIC HOURS

Monday & Friday 9am-3pm • Tuesday & Thursday 12pm - 7pm • Wednesday 2pm - 6:30pm

**Any child with a medical condition or medical history such as, but not limited to: ASTHMA, SEIZURES, ADD/ADHD, DIABETES, HEART CONDITIONS, BONE FRACTURES must have written clearance from their own physician prior to examination at Palos Township Health Service. The Health Service does not accept any insurance. Immunizations can only be provided to those meeting eligibility requirements. Proof of insurance must be shown at time of each visit.

2017

Vision and Hearing Screenings

CCDPH offers vision and hearing screening to child care centers, preschools, and elementary schools.

- Please visit our website at www.cookcountypublichealth.org. Click on Clinical Services and look for Vision & Hearing Services for registration details.
- Please fax your registration information to 708.786.4001.
- Appointments for individual (client) screenings are not available.

Dental Services

CCDPH provides dental services on a limited basis. Services may include: examinations, sealants, X-rays, cleanings, fluoride treatments, fillings, and routine extractions.

Who can receive dental services:

Ask about eligibility requirements when making an appointment. In general, they include:

- A parent/guardian should be present during the dental appointment for any student under 18 years of age. If a parent/guardian cannot accompany the child, an authorization form for dental care must be signed and presented to the dental care specialist.

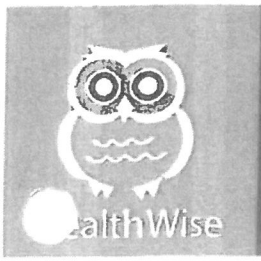
How to make a dental appointment:

To schedule an appointment, call the district office closest to your home Monday thru Friday, 8:30 AM - 4:30 PM.

North	Rolling Meadows	847.818.2860	*TDD: 847.818.2023
Southwest	Bridgeview	708.974.6160	*TDD: 708.974.6043
South	Cottage Grove	708.753.5800	
West	Community Health	773.342.1388	

Reminders:

- Public Aid/AllKids Program Participants: DentaQuest is responsible for assisting clients in locating a participating dental provider in their area of residence. Clients can call toll-free at 1-888-286-2447 (TTY: 1-800-466-7566) for assistance.
- The State of Illinois has mandated dental exams for children in 2nd and 6th grades.



Cook County Department of Public Health Clinics

See page 10 for eligibility requirements.

Cook County Department of Public Health
Promoting health. Preventing disease.
Protecting you.

North	West	Southwest	South
Arlington Heights	Bellwood	Alsip	Burnham
Barrington	Bensenville	Bedford Park	Calumet City
Barrington Hills	Berkeley	Blue Island	Chicago Heights
Bartlett	Berwyn	Bridgeview	Country Club Hills
Buffalo Grove	Broadview	Calumet Park	Dixmoor
Deerfield	Brookfield	Chicago Ridge	East Hazel Crest
Des Plaines	Burr Ridge	Crestwood	Flossmoor
East Dundee	Cicero	Evergreen Park	Ford Heights
Elgin	Countryside	Hickory Hills	Glenwood
Elk Grove Village	Elmwood Park	Hometown	Harvey
Glencoe	Forest Park	Justice	Hazel Crest
Glenview	Franklin Park	Lemont	Homewood
Golf	Harwood Heights	Merrionette Park	Lansing
Hanover Park	Hillside	Oak Lawn	Lynwood
Hoffman Estates	Hinsdale	Orland Hills	Markham
Inverness	Hodgkins	Orland Park	Matteson
Kenilworth	Indian Head Park	Palos Heights	Midlothian
Lincolnwood	La Grange	Palos Hills	Oak Forest
Morton Grove	La Grange Park	Summit	Olympia Fields
Mount Prospect	Lyons	Willow Springs	Park Forest
Niles	Maywood	Worth	Phoenix
Northbrook	McCook		Posen
Northfield	Melrose Park		Richton Park
Palatine	Norridge		Riverdale
Park Ridge	North Riverside		Robbins
Prospect Heights	Northlake		Sauk Village
Rolling Meadows	River Forest		South Chicago Heights
Roselle	River Grove		South Holland
Schaumburg	Riverside		Steger
South Barrington	Rosemont		Thornton
Streamwood	Schiller Park		Tinley Park
Wheeling	Stone Park		
Wilmette	Westchester		
Winnetka	Western Springs		

3rd District Courthouse	*Eisenhower Tower*	*5th District Courthouse*	*6th District Courthouse*
2121 Euclid Ave.	1701 S. First Ave.	10220 S. 76th Ave.	16501 S. Kedzie
Rolling Meadows, IL	First Floor	Bridgeview, IL	Markham, IL
847.818.2860	Maywood, IL	708.974.6160	708.232.4500
847.818.2023*	708.786.4000	708.974.6043*	708.232.4010*
	708.786.4002*		

**TDD/TTY: For people with speech and/or hearing impairments.*