STUDENT HEALTH & SCHOOL FORMS BOOKLET

2020-2021

PARENT CHECKLIST

ALL PARENTS MUST COMPLETE

- ☐ Student Medical Information 2020-2021 ..... Page 5
- ☐ Request for Emergency and Health Information ..... Page 25
- ☐ School Messaging Consent Form (Robo Call) ..... Page 27
- ☐ Media Consent Form and Release ..... Page 29
- ☐ Family Income Information Forms ..... Page 31

PARENTS MUST COMPLETE IF YOU WANT DENTAL AND/OR VISION SERVICES FOR STUDENTS

- ☐ Dental Consent Form ..... Page 9
- ☐ Vision Consent Form ..... Page 13

DOCTOR MUST COMPLETE THE FORMS AND PARENT MUST RETURN TO SCHOOL CLERK

- ☐ Proof of Dental Examination Form - For students that have private dentist ..... Page 15
- ☐ Vision Examination Report - For students that have a private eye doctor ..... Page 16
- ☐ Asthma Action Plan - For students with asthma, see school clerk or nurse ..... Page 19
- ☐ Healthcare Provider Statement for Food Substitution
  For students with food allergies, see the school clerk or nurse ..... Page 21

Chicago Public Schools

HEALTHY CPS
— OFFICE OF STUDENT HEALTH & WELLNESS —

Table of Contents

Office of Student Health and Wellness
42 W. Madison St., Chicago, IL 60602

Dear CPS Parents and Families,

The health and safety of your children is always our top priority, especially during a public health emergency. Every child has a fundamental right to high-quality healthcare. We want our students to have access to healthcare providers who specialize in preventative care and can address chronic conditions and health issues that are unique to children.

At CPS, we are committed to providing access to medical and dental services for all students who need them. Our district also collects key medical information annually to ensure that we can meet the unique health and safety needs of every child. This information is kept on file at your child's school and will remain confidential.

Please read through this packet carefully for information about CPS health requirements and services. All parents and guardians are required to submit the following forms to their school clerk as soon as possible.

- Student Medical Information 2020–2021 (page 5)
- Request for Emergency and Health Information (page 25)
- School Messaging Consent Form (page 27)
- Media Consent Form and Release (page 29)
- Family Income Information Forms (page 31)

Information about our dental and vision services, which are available to all students, can be found on pages 8 and 12, and the consent forms to enroll in these services are on pages 9 and 13. If you take your child to a private dentist or eye doctor, please ask those doctors to complete pages 15 and 16.

If any of the following pertains to your child, additional action is required:

- **Chronic health condition:** Consult with your child's school nurse, who will provide forms for you to take to your doctor to complete.
- **Food allergy:** Ask your doctor to complete the Healthcare Provider Statement for Food Substitution Form on page 21 and then submit the completed form to your child's school.
- **Asthma:** Ask your doctor to complete the Asthma Action Plan on page 19 and then submit the completed form to your child's school.

We are here to support you in ensuring that your children remain healthy and safe this school year. For assistance with signing up for health insurance and SNAP benefits, please call our hotline at (773) 553-KIDS (5437) or go to www.cps.edu/health for more information. If you have any questions or concerns, please contact Project Manager Katheryn Stafford-Hudson at (773) 535-8675 or kgstafford-h@cps.edu.

Sincerely,

Dr. Kenneth L Fox
Chief Health Officer
Chicago Public Schools

Minimum Health Requirements 2020-2021

Evidence shows that healthy students have better attendance patterns and perform better academically. The following health requirements apply to all children enrolled in a Chicago Public School. **Children must provide proof of required immunizations and health exams before October 15, 2020, or they will face exclusion from school.**

Health insurance can provide children and their families with comprehensive health care coverage that can be used for doctor's visits, immunizations, prescription medications, dental care, eye exams, glasses and more!

If you would like help enrolling your child in health insurance, call the Healthy CPS Hotline: 773-553-KIDS (5437) or visit www.cps.edu/cfbu

All Kids Health Insurance provides coverage for children in Illinois, regardless of immigration status.

If you need help finding a health center near you please call: 773-553-KIDS (5437) or visit https://findahealthcenter.hrsa.gov

Recommended Vaccine

To prevent HPV cancers HPV (human papillomavirus) vaccination is recommended for preteen girls and boys at age 11 to 12 years. Preteens need HPV vaccinations for protection from HPV infections that cause cancer. CDC recommends that 11 to 12 year olds receive two doses of HPV vaccine at least six months apart. Teens and young adults who start the series later, at ages 15 through 26 years, need three doses of HPV vaccine to protect against cancer-causing HPV infection. For more information: www.cdc.gov/vaccines/vpd/hpv/public/index.html

For more information about CPS health requirements, contact your School Nurse.

EXAMINATION REQUIREMENTS

Physical Examination requirements due upon enrollment, or by **10/15/20**

Physical Examination must be completed within one year prior to entry to:

- Preschool and kindergarten (physical exam and lead screening through age 6)
- 6th grade and 9th grade (ages 5, 11, 15 for un-graded programs)
- Any student entering CPS for the first time

Vision Examination requirements due upon enrollment, **no later than 10/15/20**

- Entering the State of Illinois for the first time at any grade level.
- Entering kindergarten

Dental Examination requirements due **5/15/21** for kindergarten, 2nd , 6th grade and **9th** grade.

IMMUNIZATION REQUIREMENTS

Diphtheria, Pertussis (Whooping Cough), Tetanus (DTP, DTaP & Tdap)

- Four (4) or more doses. The first 3 doses with intervals of 4 weeks apart. The interval between the 3rd and 4th dose is at least 6 months.
- The last dose qualifying as a booster and received on or after the 4th birthday
- One (1) dose of the Tdap vaccine for 6th to 12th grades.

Polio

- Four (4) or more doses. The first 3 doses with intervals of 4 weeks apart. The interval between the 3rd and 4th dose is at least 6 months.
- The last dose qualifying as a booster and received on or after the 4th birthday.
- A 4th dose is not needed if the 3rd dose was administered at age 4 or older and 6 months after the previous dose.

Measles, Mumps, and Rubella (MMR)

- One (1) dose required for preschool, & a second dose required for all students kindergarten to 12th grade.
- 1st dose received at 12 months or later
- 2nd dose must be administered at least four weeks (28 days) after 1st dose

Hepatitis B

- Three (3) doses required for all students.
- 1st dose at birth.
- 2nd dose received no less than 28 days or 4 weeks after 1st dose.
- 3rd dose received no less than 2 months after the 2nd dose and 4 months after the 1st dose.

Varicella (Chicken Pox)

- Two (2) doses of varicella are required for kindergarten, 1st, 2nd, 3rd, 6th, 7th, 8th, 9th, 10th,11h, & 12th grades. The first dose on or after the first birthday and the second dose no less than four weeks (28 days) after the first dose.
- One (1) dose required on or after the first birthday for Prek, 3rd, 4th, 5th, grades.

Haemophilus Influenzae, Type B (HIB)

- Three (3) doses required for primary series.
- If none received before age 15 months, only one (1) dose required from age 15 months to 59 months of age. Not required age 5 years or older.

Pneumococcal Conjugate (PCV)

- Four (4) doses required for primary series.
- If none received before age 24 months, only one (1) dose required from age 24 to 59 months of age. Not required age 5 years or older.

Meningitis Conjugate (MCV4)

- One (1) dose of the meningitis vaccine for 6th, 7th and 8th grades
- Two (2) doses of the meningitis vaccine for 12th grade.
- 2nd dose must be administered at least 8 weeks after 1st dose
- If the 1st dose was given at age 16 or older; only one (1) dose will be required for 12th grade.

Chicago Public Schools

Office of Student Health and Wellness
42 West Madison • Chicago, Illinois 60602
Telephone: 773-553-3560 • Fax: 773-553-1883

Student Medical Information 2020 – 2021

This form must be updated and returned to school each school year.

Please let your school know about your child's health and health care. This is a good way to keep your child safe. The information is **CONFIDENTIAL** and will be shared only with CPS staff who need to know (Nurse, Principal, Designee, or Clerk).

_____ _____ _____
Student Name Date of Birth Student ID Number

_____ _____
School Grade

1. Please indicate your child's health status below

☐ *My child has no known health conditions*

My Child has a known condition(s). Please check all that apply*:*

☐ *Allergies (food or other) – please specify:* _____
☐ *Asthma* *Year Diagnosed* _____
☐ *Diabetes – please circle one: Type 1 Type 2* *Year Diagnosed* _____
☐ *Seizures/Epilepsy* *Year Diagnosed* _____
☐ *Sickle Cell Disease* *Year Diagnosed* _____
☐ *Other:* _____ *Year Diagnosed* _____

2. My child has a primary doctor.	YES	NO

If yes, please provide the healthcare provider's name and phone number:

*Name:*_____ *Phone number:* _____

☐ *I give permission for my child's school nurse or designee to talk to the doctor about my child's health.*

3. My child is covered by health insurance.	YES	NO

If your child needs health insurance call Healthy CPS 773-553-KIDS (5437)

This Form is **NOT** the same as a "**Plan of Care**" (detailed medical care instructions to keep your child safe). If your child has a health condition that may require action at school, please provide school with documentation from your physician and schedule an appointment with your school nurse. Complete a "Medical Plan of Care Form" at: www.cps.edu/oshw (or get it from the school nurse), and return it to school. **If your child has a health condition, please schedule an appointment with the school nurse.**

Parent Name: _____ Date: _____

Parent Signature: _____

Phone Number: _____ Email: _____

Must have the original signature, an electronic signature is not acceptable

PLEASE RETURN THE FORM TO THE SCHOOL NURSE

IF THE STUDENT HAS A HEALTH CONDITION PARENTS MUST SCHEDULE A MEETING WITH THE SCHOOL NURSE

Nurses Use Only
Reviewed by:
Date and Initial

HEALTHY CPS
— OFFICE OF STUDENT HEALTH & WELLNESS —

HEALTHY IS...
regular check-ups!

Regular check-ups are important and so is connecting your family to a medical home where you can establish relationships with trusted doctors and nurses that know your child's story and can help with their health care needs.

HAVING A MEDICAL HOME ALLOWS A DOCTOR TO »

Make sure that your child is meeting their **height** and **weight targets.**

Check their vision and hearing to make sure that they will be successful in the classroom.

Screen for diseases such as diabetes, asthma, heart disease and developmental issues.

The Office of Student Health and Wellness (OSHW) can help you apply for low-cost or free health insurance (Medicaid) and SNAP. We will:

- » Walk you step-by-step through the Health Insurance (Medicaid) and SNAP application.
- » Help you understand your eligibility and the documents needed to apply.
- » Assist you with renewing your Health Insurance or SNAP benefits.
- » Help you connect to a health plan, primary health physician, and a medical home.

GOOD HEALTH CAN'T WAIT! MAKE AN APPOINTMENT TODAY! »

① Call **773-553-KIDS** (5437)

② Visit **CPS.EDU/HEALTH**

NOTE: In Illinois, children may qualify for low-cost/free health insurance regardless of Immigration Status.

The Children and Families Benefits Unit (CFBU) of the Chicago Public Schools (CPS) is funded by the Supplemental Nutrition Assistance Program (SNAP) of the United States Department of Agriculture. This institution is an equal opportunity provider.

HEALTHY CPS
— OFFICE OF STUDENT HEALTH & WELLNESS —

Chicago Public Schools

Office of Student Health and Wellness
42 W. Madison St., Chicago, IL 60602

Dear Parent/Guardian,

Healthy teeth are important for your child's overall health and wellbeing, and one way to help your child maintain healthy teeth is to ensure he or she receives a dental cleaning every six months. Illinois law requires every child in Kindergarten, 2nd, 6th, and 9th grade to have a dental exam by May 15 of each year, and to help families meet this requirement, CPS and the Chicago Department of Public Health have partnered to provide high-quality dental services to students who do not have access to a dentist. It is recommended that students see the dentist every six months.

The CPS Dental Program provides the following services:

- Dental Examination
- Dental Cleaning, if needed
- Fluoride Treatment, if needed
- Dental Sealants, if needed
- Referral for other treatment, if needed

If the student has received a dental exam within the past six months, the child will only receive a dental examination and dental sealants as needed in the CPS Dental Program at their school. The student will not receive a dental cleaning.

If your child does not have a private dentist and has not received dental care in the last 6 months, he or she is eligible to participate in the CPS Dental Program at their school. Dental services are available to your child at no cost, however, if you have public health insurance (Medicaid), your benefits will be used. The dentist will come to your child's school once during the school year.

To enroll your child in the CPS Dental Program, please complete and sign both sides of the following two forms in this packet and return them to school as soon as possible.

1. *School-Based Oral Health Program, Dental Consent, Release of Liability and Authorization Form*
2. *School-Based Oral Health Program Authorization Form- HIPAA*

If your child has a private dentist and will not need to participate in the CPS Dental Program, please have your dentist complete the *Illinois Dental Examination Report Form* and return it to your child's school. This form is on the back of this letter and can also be found at http://cps.edu/OSHW/Documents/ProofDentalExam.pdf.

If you have any questions, please contact Katheryn Stafford-Hudson, Project Manager (773) 535-8675, kgstafford-h@cps.edu.

Sincerely,

Dr. Kenneth L Fox
Chief Health Officer

School Based Oral Health Program
Dental Consent, Release of Liability and Authorization Form

Student Name:_____Student's Date of Birth_____ ☐ Male ☐ Female

School Name:_____Student ID#_____Grade:_____Room# _____

Parent/Guardian Name:_____Home Address: _____

Phone Number:_____Zip Code:_____Medicaid/ALL KIDS - 9 Digit Recipient #_____

As the parent/guardian of the above named student, I understand that through the City of Chicago Department of Public Health and the Chicago Public School's **SCHOOL-BASED ORAL HEALTH PROGRAM** (the "**PROGRAM**"), licensed dentists will be coming to my child's/ward's school in the near future to provide a **DENTAL EXAM/SCREENING and as needed a DENTAL CLEANING, FLUORIDE TREATMENT** and **DENTAL SEALANT(S)** at **NO COST** to students or their families in the school. Dental sealants, in addition to regular brushing and flossing, protect your child's/ward's teeth from **DECAY**. Dental Sealants are thin, plastic coatings put on the tops of the back-teeth to SEAL OUT food and germs. Sealants are applied on teeth that appear not decayed, and they don't hurt. **PROGRAM SERVICES DO NOT INCLUDE DRILLING OR SHOTS.**

I understand that in consideration for my child's/ward's participation in the **PROGRAM**, and as evidenced by my signature below, I hereby release and hold harmless the **CITY OF CHICAGO**, its departments, including the Department of Public Health, and its employees, officers, volunteers, agents and representatives, and **THE BOARD OF EDUCATION OF THE CITY OF CHICAGO**, its members, trustees, agents, officers, contractors, volunteers and employees from any liability which may accrue to me or to my child/ward, for any and all losses, injuries, damages to me or my child/ward, both known and unknown, foreseen and unforeseen, arising in connection with my child's/ward's participation in the **PROGRAM** whether or not said losses, injuries, damages, or liabilities result in whole or part from the negligence of the **CITY OF CHICAGO**, its departments, including the Department of Public Health, its employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives.

I further understand that as evidenced by my signature below, I acknowledge that a licensed dentist providing medical or dental care, treatment, diagnosis, or advice without charge on behalf of the City of Chicago Department of Public Health is not liable for civil damages resulting from his or her acts or omissions in providing such medical or dental care, treatment, diagnosis, or advice under the Program except for willful or wanton misconduct. To authorize dental providers and the Chicago Department of Public Health to share information relating to PROGRAM dental services provided to your child/ward, please sign the Authorization Form that is on the other side of this page. This signed consent form is valid for **365** days from the date that it is signed by the child's/ward's parent or guardian.

Race: (Please check one) White Black Asian / Pacific Islander American Indian/ Native Alaskan **Hispanic** (Please check one) Yes No

MEDICAL INFORMATION: Has your child/ward ever had any of the following: **YES or NO** If YES: Please check the appropriate condition below:

Asthma Diabetes Currently has Heart Murmur Rheumatic Fever or Rheumatic Heart Disease Epilepsy Blood Disorder / Disease Hepatitis

Is your child/ward taking any medication? If YES, Please list medication: _____

Does your child/ward have any Allergies? If YES, Please list Allergies: _____

Any other medical related conditions? If YES, Please list the conditions: _____

As the parent or guardian of the above - named child or ward, I consent for my child or ward to participate in the SCHOOL-BASED ORAL HEALTH PROGRAM, which includes a dental exam/screening and as needed a dental cleaning, fluoride treatment and dental sealant(s) and the receiving of Quality Assurance exams. I authorize the dental provider to use my child's or ward's Medicaid, ALL KIDS number for billing purposes only. **I understand that if I fail to sign this Dental Consent Form and Release of Liability, my child or ward will not receive any services under this program.**

Please sign both sides:

Must have the original signature, an electronic signature is not acceptable

Parent/Guardian **Date:**

School - Based Oral Health Program Authorization Form – HIPAA

Student Name:_____ Student Date of Birth: _____

School Name:_____Parent/Guardian Name: _____

By signing below, I understand that I am giving my authorization to the dental provider and the City of Chicago Department of Public Health to use and/or disclose my child's/ward's protected health information, to the following person(s) or organization(s) for the purposes of reports, documentation of oral health trends, and Medicaid and grant billing: City of Chicago, Department of Public Health, 333 S. State Street, 2nd Floor, Chicago, Il 60604; Individual School Principal; Illinois Department of Healthcare and Family Services, 201 So. Grand Avenue East, Springfield, Il, 62763; Illinois Department of Public Health - Oral Health Division, 535 W. Jefferson Street, 2nd Floor, Springfield, Il, 62761, Chicago Public Schools, Office of Student Health and Wellness, 42 West Madison, Garden Level, Chicago Illinois 60602. Federally Qualified Health Centers (FQHC), Oral Health Forum (OHF), 1100 West Cermak Road, Suite 518, Chicago, Il 60608. Infant Welfare Society of Chicago (IWS), 3600 W Fullerton Ave, Chicago, Oak Park-River Forest Infant Welfare Clinic, 320 Lake Street, Oak Park, Il 60302 and Chicago Public School approved Dental Vans.

CDPH and dental providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization. This Authorization is voluntary, and I may refuse to sign it. I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re- disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA) and federal privacy regulations. I may revoke this Authorization in writing by sending notice to the HIPAA Privacy Officer, City of Chicago, Department of Public Health, 333 S. State Street, 2nd Floor, Chicago, Il 60604. Revocation is not effective with respect to actions taken prior to the revocation. This authorization is valid for **365** days from the date that it is signed by the child's/ward's parent or guardian.

Please sign both sides

Must have the original signature, an electronic signature is not acceptable

Parent/Guardian | | Date | |

HEALTHY CPS
OFFICE OF STUDENT HEALTH & WELLNESS

CPS VISION SERVICE LOCATIONS

Chicago Public Schools has partnered with Illinois Eye Institute and Tropical Optical to provide vision exams for CPS students. Seven locations throughout the city have been provided for your convenience. Please review the list of vision service locations listed below. If insurance is available it will be billed. If uninsured, vision services will be provided at no charge.

Princeton Vision Clinic
5125 S. Princeton Ave.
Chicago, IL 60609

Call for an appontment
773-535-8675

Students Pre-K - High School

Illinois Eye Institute
Lewenson Center
3241 S. Michigan
Chicago, IL 60616

Call for an appointment
312-949-7990

Students Pre-K - High School

Tropical Optical
Call Elizabeth Ramos
for an appointment
at
(773) 762-5662
Must have the student's ID number (school can provide)

For children 5 yr and above

If you need additional information about the CPS Vision Program, please contact the Student Health Staff at

(773) 535-8675 or
(773) 535-1968

TROPICAL OPTICAL LOCATIONS

6141 West Cermak Rd | Cicero, IL 60804	**3213 West 47th Place | Chicago, IL 60632**
3624 West 26th Street | Chicago, IL 60623	**2767 North Milwaukee Ave | Chicago, IL 60647**
2250 South 49th Avenue | Cicero, IL 60804	**9137 South Commercial Ave | Chicago, IL 60617**

Office of Student Health and Wellness
42 W. Madison St., Chicago, IL 60602

Dear Parent/Guardian,

Did you know one in four children have an undiagnosed vision problem that may affect their ability to learn? Every child needs an annual vision exam, especially if any of the following apply to your child:

- My child is entering kindergarten
- My child has never received a vision exam
- My child is entering Illinois schools for the first time at any grade level
- My child failed the school vision screening
- My child has an IEP
- My child's teacher recommended they receive an eye exam
- My child is performing below grade level
- My child experiences any of the following:
  - Squinting
  - Blurred or double vision
  - Tilting of the head
  - Holding reading materials close to face
  - Losing place while reading
  - Rubbing eyes
  - Excessive tearing or headaches

All kindergarten students and any child entering the State of Illinois for the first time must have a vision exam per state law by October 15.

- **If your child has a private eye doctor,** please have your child's eye doctor complete the State of Illinois Eye Examination Report on page 16. The form can also be found online at: http://cps.edu/OSHW/Documents/VisionExaminationForm.pdf.

- **If your child does not have a private eye doctor,** your child is eligible to participate in the CPS Vision Program. Through this program, your child will receive eye exams. If your child requires glasses, an optician will help your child select the frame, and glasses will be delivered to your child's school within four weeks. Students who receive glasses are eligible for replacement glasses due to loss or damage for up to 12 months from the initial eye exam. Private vision insurance or government insurance such as Medicaid, Medicare or any Managed Care Organization will be billed, if available. If a student does not have vision insurance, services are provided at no cost to the family.

  To enroll your child in the CPS Vision Exam Program, please complete the Vision Services Consent Form on page 13 and the Student Medical History Form on page 14.

If you have any questions please contact Katheryn Stafford-Hudson, Project Manager, at (773) 535-8675 or kgstafford-h@cps.edu, or the CPS Vision Team at Princeton (773) 535-8674.

Sincerely,

Dr. Kenneth L Fox
Chief Health Officer

Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible

Vision Services Consent, Release of Liability, and Authorization Form

Please Print: Parent Email Address _____

Student Name: _____ Student's Date of Birth_____ ☐ Male ☐ Female

School Name: _____Student ID# _____Grade: _____Room# _____

Parent/Guardian Name: _____Home Address: _____Phone: _____

Medicaid/Medical Card/ALLKids recipient #_____ Race/Ethnicity_____

Private Vision Insurance: _____Group ID_____ ID#_____ Cardholder Name:_____ Birth Date_____

Private Medical Insurance: _____ Group ID _____ ID# _____ Cardholder Name: _____

As the parent/guardian of the above name student, I understand that my child will receive a comprehensive eye exam to determine if he/she needs prescription glasses or other treatment by a vision care professional (Provider)

I further understand that this eye exam may be performed by an Optometrist; an Ophthalmologist; qualified specialist; or an intern, a resident, or a student clinician or technician under the supervision of an Optometrist, Ophthalmologist, or another qualified specialist, and I consent to have my child receive a vision exam and/or treatment.

I further understand that neither the school nor the Board of Education of the City of Chicago (Board) are supervising or overseeing any services (such as an eye exam) or materials (such as eye glasses) that may be furnished to my child and that the Board and the school will have no responsibility for the quality of any such services or materials.

In consideration for the services and materials that my child will receive, I hereby agree to indemnify, release and hold harmless, and defend the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers, representatives, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuries, damages to me or my child, both known and unknown, foreseen and unforeseen, arising in connection with my child's receipt of services and materials, whether or not said claims, losses, injuries, damages, or liabilities result in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives. I further agree to release and hold harmless the Providers and Co-Sponsors, their employees, officers, volunteers, agents and representatives from and against any and all claims, demands, actions, complaints, suits or other forms of liability that will arise out of or by reason of, or be caused by any performance of services provided by such Providers or the quality of the eyeglasses or any other materials furnished by them under the Program, unless attributed to their willful or wanton misconduct. In the event that one provision of this form is held unenforceable, that provision shall be severed and the remainder of the form shall remain in effect.

I understand that the Provider will bill any government or private insurance Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable private insurance for any reimbursable services and/or materials.

If you DO NOT want your child to receive the following services, please check the appropriate box. Please note services will be performed unless indicated otherwise.

If your child has an allergy, please consult your primary care physician before selecting dilation

I understand that as part of this eye exam, pharmaceutical agents (eye drops) will be used for the purpose of dilating my child's eyes. These drops are an important part of an eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops include blurred vision and sensitivity to light, both of which could restrict my child's mobility making it unsafe for him/her to travel unassisted or to operate a vehicle for the rest of the day.

☐ **At this time I DO NOT consent for my child's eyes to be dilated**

I understand that by refusing dilation I may limit the doctor's ability to detect and treat certain conditions.

I understand that my child may be selected to be photographed, video taped, audio taped or interviewed as part of promotional documentation for the Vision Program. I consent to the use of my child's photograph, voice or likeness by the Board or the Provider or CDPH, but not the use of my child's last name. I understand there is no compensation, monies, or reimbursement for my child's participation.

☐ **At this time I DO NOT consent for my child to be photographed or interviewed**

By signing below, I understand that I am giving my authorization to the City of Chicago Department of Public Health (CDPH) and the Board of Education of the City of Chicago (Board) to release and furnish information regarding past vision screening data in my child's education record to Providers to ensure that the Providers can effectively provide services. I authorize the Providers to release and furnish reports to my child's school, including written and verbal reports concerning the results of any eye exam, for inclusion in my child's education record. I also authorize CDPH to release to the Board, my child's information, the date and type of vision services provided, whether my child was recommend for follow-up services, and other information the State of Illinois requests the Board to report. I understand that such records will be subject to the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinois Department of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization.

This authorization is valid for one year. I may revoke this authorization at any time by sending written notification to CDPH, my child's school, or the Board Office of Student Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

*****Please sign and date both signature lines. Complete the medical history on reverse side of this form.*****

Parent/Guardian Signature:_____**Date:**_____

I hereby give my consent for this child to be examined by a Provider for an eye exam and prescription eyeglasses, if prescribed during the eye exam. This consent does not authorize any treatments or service beyond what is stated. I understand my consent will be valid for one year from the date of signature.

Parent/Guardian Signature: _____ **Date:**_____

Must have the original signature, an electronic signature is not acceptable

Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible

Student Medical History Form

Please Print:
Student's Name:_____ School Name: _____

Student's Date of last Eye Exam: _____ Does your child currently wear glasses or contacts? ☐ Yes ☐ No
How did you find out about the Vision Program? (Check all that apply)
School staff Failed Vision Screening Letter Friend Other_____

Does your child have any of the following conditions: (Check all that apply)

☐ Asthma	☐ Behavioral problems	☐ Attention Deficit Disorder	☐ Glaucoma
☐ Neurological problems	☐ Endocrine problems	☐ High Blood Pressure	☐ Musculoskeletal problems
☐ Heart Disease	☐ Mental Health illness	☐ Gastrointestinal problems	☐ Genitourinary problems
☐ Hearing/Ear problems	☐ Diabetes	☐ Other Condition	_____

Is your child taking any medications? ☐No ☐Yes
List medications:

_____

_____

Does your child have allergies? ☐No ☐Yes
List allergies:

_____

_____

Does your child use eye drops? ☐No ☐Yes
List eye drops:

_____

_____

Has your child ever had eye surgery? ☐No ☐Yes
If yes, please explain:

_____

_____

Has s/he had any of the following?

Vision Therapy	☐ No	☐Yes	Eye Injury	☐ No	☐ Yes	Trouble finishing work	☐ No	☐ Yes
Eye patch	☐ No	☐ Yes	Eye Infection	☐ No	☐ Yes	Lack of confidence	☐ No	☐ Yes
Eye Surgery	☐ No	☐ Yes	Itching/Burning	☐ No	☐ Yes	Difficulty sitting still	☐ No	☐ Yes
Pain in eyes	☐ No	☐ Yes	Eye Discharge	☐ No	☐ Yes	Avoids reading/writing	☐ No	☐ Yes
Difficulty Tracking	☐ No	☐ Yes	Tearing/Watering	☐ No	☐ Yes	Difficulty paying attention	☐ No	☐ Yes
Lazy/Wandering Eye	☐ No	☐ Yes	Light sensitivity	☐No	☐ Yes	Reads below grade level	☐ No	☐ Yes
Blurred/Double Vision	☐ No	☐ Yes	Redness	☐ No	☐ Yes	Poor handwriting	☐ No	☐ Yes
Loses place while reading	☐ No	☐ Yes	Drooping Lid	☐ No	☐ Yes	Frustrates easily	☐ No	☐ Yes

Other_____

Does your child have an IEP (Individualized Education Plan)? ☐ No ☐ Yes

Is the child performing at: ☐ above grade level ☐ grade level ☐ below grade level

If below grade level, please select the class (Check all that apply)
☐ Reading ☐ Writing ☐ Math ☐ Social Studies ☐ Other_____

Is the child currently receiving any of the **services** below? (Check all that apply)
☐ Special Education ☐ Tutoring ☐ Speech Therapy ☐ Occupational Therapy (OT) ☐ Physical Therapy (PT)

List any of your child's Hobbies or Special Interests: _____

Is there anything else you would like us to know about your child? _____

Does your child's immediate family member have any of the following? (Check all that apply and the relationship to child)

☐ Wears glasses	☐ Wandering Eye	☐ Diabetes	☐ Cardiovascular problems
☐ Glaucoma	☐ Blindness	☐ Musculoskeletal problems	☐ Neurological problems
☐ Lazy eye	☐ Macular Degeneration	☐ Heart Disease	☐ Mental Health illness
☐ High Blood Pressure			

State of Illinois
Illinois Department of Public Health

Dentist must complet form, parent please return to your child's school or send to Katheryn Stafford-Hudson, kgstafford-h@cps.edu or fax 773-535-8675 or Princeton Vision Clinic GSR 45

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: ☐ Male ☐ Female
Parent or Guardian: Last Name First Name		

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ 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 Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

Doctor must complete report, parents please return report to your child's school or

send report to Katheryn Stafford-Hudson, kgstafford-h@cps.edu or fax 773-535-8677

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15th 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 child beginning school.

Student Name: _____ Birth Date: _____ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: _____ Phone: _____
(Last) (First) (Area Code)

Address: _____ County: _____
(Number) (Street) (City) (Zip Code)

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

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	❑	❑	❑	_____
Internal Exam (media, lens, fundus, etc.)	❑	❑	❑	_____
Neurological Integrity (pupils)	❑	❑	❑	_____
Binocular Function (stereopsis)	❑	❑	❑	_____
Accommodation and Vergence	❑	❑	❑	_____
Color Vision	❑	❑	❑	_____
IOP (glaucoma)	❑	❑	❑	_____
Oculomotor Assessment	❑	❑	❑	_____
Other: _____	❑	❑	❑	_____

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other: _____

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses 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 Who Provides Eye Examinations

Address: _____

_____

Signature: _____
Optometrist or Physician Who Provides Eye Examinations

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: _____

FOR STUDENTS WITH ASTHMA

Asthma is the most common chronic illness of childhood. Chicago has an especially high number of children with asthma, and children in some Chicago neighborhoods suffer more than others. All students, including those with asthma, should feel safe and supported at school.

Please use the forms in this packet to tell your school about your child's asthma. The school nurse or clerk may have additional forms to complete. Health forms must be updated each school year. They are reviewed by the school nurse and relevant CPS staff, and kept on file for use during the school year.

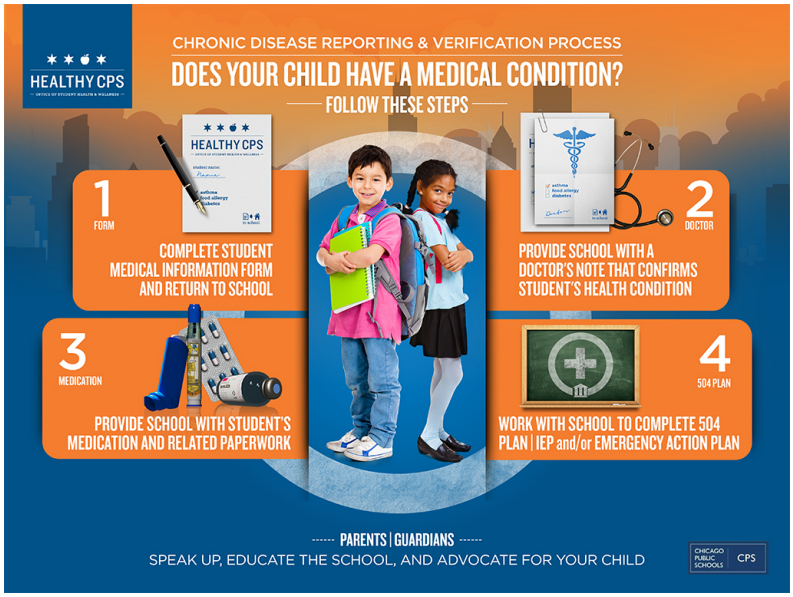
YOU MUST TURN IN THESE FORMS EACH SCHOOL YEAR:

» Asthma Action Plan – **signed and dated by health care provider**

» Request for Administration of Medication – **signed and dated by parent/guardian**

» Original (or clear copy) of asthma medication container or pharmacy label with your child's information

IF YOUR CHILD HAS A CHRONIC HEALTH CONDITION, FOLLOW THESE 4 STEPS:



» Any student with asthma, food allergies, diabetes, or any other chronic condition can have a Section 504 Plan so they are supported during the school day.

» A 504 Plan provides the needed changes the school must make to help your child succeed in school.

» Contact your school nurse to set up a 504 Plan.

QUESTIONS OFTEN ASKED ABOUT ASTHMA CARE AT SCHOOL

Why is it important to tell the school about my child's asthma?

- Your child's asthma may flare up at school. Knowing their medical history helps staff know what to if there is an emergency during the school day.
- The information lets the school know what medicine your child may need, so staff can be ready to help if necessary

Are school staff able to help a student manage their asthma?

Yes. School staff complete a training every year on asthma awareness, including how to recognize and handle asthma emergencies.

Can a student self-manage their asthma?

Yes. CPS students are allowed to carry and use their own "quick-relief" or "rescue" asthma medicine if written parent permission and a prescription label is provided to the school.

What is the school's asthma emergency response?

- Schools will follow the steps outlined in your child's Asthma Action Plan and 504 Plan/IEP.
- If the medication is not working or the student's medicine has not been sent to the school, 911 will be called. Parents will be called after 911.

What if a student has an asthma attack but has no plan on file?

The school will follow an Emergency Asthma Action Plan and call 911. Parents are notified after calling 911.

Does the student need a Section 504 Plan?

- A Section 504 Plan must be offered. Speak to your child's school nurse and doctor to know what is needed.
- A 504 Plan does not mean the student has a disability. The 504 Plan will outline any needed changes a school must make so your student is safe at school.
- If there is no 504 plan, 911 will be called upon recognition of signs and symptoms of an asthma attack

I would like more information about asthma care in school:

- Read the CPS Asthma Policy at http://policy.cps.k12.il.us
- Visit the Office of Student Health and Wellness website at http://cps.edu/oshw
- Talk to your child's school nurse
- Contact the Office of Student Health and Wellness at oshw@cps.edu

Asthma Action Plan

5 years above

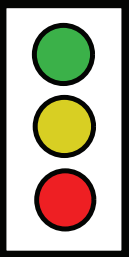
Print Form | Submit by Email

Name	Date of Birth	Effective Date
Doctor		Parent/Guardian
Doctor's Office Phone Number: Day		Parent's Phone
Emergency Contact After Parent		Contact Phone

Student is able to self medicate

☐ Yes ☐ No

The colors of a traffic light will help you use your asthma medicines. Also pay attention to symptoms



Green means GO ZONE
Use preventive medicine

Yellow means CAUTION ZONE! Add prescribed yellow zone medicine

Red means DANGER ZONE!
Get help from a doctor

GO (GREEN)

Use these medicines every day.

You have ALL of these:

- Breathing is good
- No cough or wheeze
- Sleep through the night
- Can work or play

Peak flow above _____

Medicine	How Much to Take	When to Take It

For asthma with exercise, take:

CAUTION (YELLOW)

Continue with green zone medicine and ADD:

You have ANY of these:

- First sign of a cold
- Exposure to known trigger
- Cough
- Mild wheeze
- Tight chest
- Coughing at night

And/or Peak flow from _____ to _____

Medicine	How Much to Take	When to Take It
First	**2 puffs or 1 vial by nebulizer**	**Every 4 hours as needed**
Next **Call Doctor if no improvement**		

IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK, THEN CALL YOUR DOCTOR.

DANGER (RED)

Take these medicines and call your doctor.

Your asthma is getting worse fast:

- Medicine is not helping within 15-20 minutes
- Breathing is hard and fast
- Nose opens wide
- Ribs show
- Lips and/or fingernails blue
- Trouble walking and talking

And/or Peak flow below _____

Medicine	How Much to Take	When to Take It
	2 puffs or 1 vial by nebulizer	**Immediately - Call Doctor**

Get help from a doctor now! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It is IMPORTANT! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Asthma Triggers

Check all items that trigger your asthma and things that could make your asthma worse:

- ☐ Chalk dust
- ☐ Cigarette Smoke and second hand smoke
- ☐ Colds/Flu
- ☐ Dust mites, dust, stuffed animals, carpet
- ☐ Exercise
- ☐ Sudden temperature change
- ☐ Mold
- ☐ Ozone alert days
- ☐ Pests-rodents and cockroaches
- ☐ Pets-animal dander
- ☐ Plants, flowers, cut grass, pollen
- ☐ Strong odors, perfumes, cleaning products
- ☐ Wood Smoke

Foods _____

Other _____

RESPIRATORY HEALTH ASSOCIATION℠ of Metropolitan Chicago

Doctor's Signature/Stamp

Adapted from the original design by the Pediatric Asthma Coalition of New Jersey

HEALTHCARE PROVIDER STATEMENT FOR FOOD SUBSTITUTION

This form must be completed if a parent/student is requesting menu substitutions be made in the dining center for a student's food allergy or intolerance

CHILD'S NAME:	DATE:

Dear Parent/Guardian:

Your child's school participates in a federally-funded School-Based Child Nutrition Program that requires CPS to offer meals and/or milk to students. However, when a disability (for example, a food allergy) or special dietary need or restriction documented by a healthcare provider exists, reasonable menu accommodations must be made. Please provide your contact information and ask your child's healthcare provider to complete this form. **Please return the completed form to your child's School Nurse along with a Food Allergy Action Plan** (found at cps.edu/OSHW). Contact food@cps.edu with any additional questions:

_____ **Parent/Guardian Name**

_____ School Name

_____ **Parent/Guardian Phone Number**

_____ Address (Street)

_____ **Parent/Guardian Email**

_____ Address (City, State, Zip Code)

*Healthcare providers' note: **Food allergies** are a "disability" under the Americans with Disabilities Act. If the child has a food allergy, please check "Yes" for question 1 below.*

PHYSICIAN STATEMENT

1. Does child have a disability that requires food accommodation?
   - ☐ No If **no**, go to item 2 below.
   - ☐ Yes If **yes**, provide the follow information and complete items 3, 4, and 5

   a) What is the disability? _____

   b) What major life activity is affected? _____

   c) What does the disability mean for the child's diet? _____

2. Child has no disability, but requires a special diet. Identify the medical problem that warrants the child's special diet and complete item 3, 4, & 5 below.

3. List **specific** foods to be omitted:

4. List **specific** acceptable food substitutions. Please attach a menu if applicable:

5. _____ **Signature of Health Care Provider** _____ **Date**

Must have the original signature, an electronic signature is not acceptable

Parent/Guardian: Return this form to your School Nurse

FOR SCHOOL USE ONLY: Please scan and email this form to food@cps.edu.

School Nurse Signature:_____

Date reviewed: _____

Date scanned to food@cps.edu:_____

HEALTH SERVICES

Recommended Vaccines:
HPV and FLU

These vaccines are **safe and effective**.
Make sure your child is protected from these viruses.

HPV Vaccine:

Protect your child now against cancer later in life.

This vaccine series prevents 6 kinds of cancers.

- Safe, like other vaccines
- For both boys and girls
- Recommended at ages 11-12, but can be given later
- This vaccine can be given at the same time as other shots

Protect your child from cancer. Choose to vaccinate against HPV.

FLU Vaccine:

Protect your child from influenza every year.

Getting a flu shot *every year* is the best opportunity to avoid this illness.

Getting the flu isn't just miserable… it can also result in:

- Lost school days
- Lost work days
- Possible hospitalizations
- Sometimes death

Get a flu shot for your child AND the whole family this year.

Both HPV and flu vaccines are recommended by doctors, nurses, and respected medical and public health organizations, such as the American Cancer Society, the Centers for Disease Control and Prevention, and the Chicago Department of Public Health.

For information about these vaccines go to www.CDC.gov/HPV or www.CDC.gov/FLU.
For information about where you can make an appointment or apply for health insurance call our hotline at 773-553-KIDS (5437).
To find a CDPH walk-in clinic go to www.Chicago.gov, and search "find a clinic".

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Chicago Public Schools

Students in Temporary Living Situations (STLS)
Notice of Rights of Homeless Students

The Board of Education of the City of Chicago (Board) shall provide an educational environment that treats all students attending the Chicago Public Schools (CPS) with dignity and respect. Every student in a temporary living situation shall have equal access to the same free and appropriate educational opportunities as students who are permanently housed. This commitment to the educational rights of students in a temporary living situation, youth, and youth not living with a parent or guardian, applies to all services, programs, and activities provided or made available by the Board.

A student is considered to be in a temporary living situation if he or she lacks a fixed, regular, and adequate nighttime residence and includes children and youth who are:

- sharing the housing of other persons due to loss of housing, economic hardship, or similar reason;
- living in a motel/hotel, trailer park or camping ground, due to lack of alternative, adequate housing;
- living in emergency or transitional shelters;
- living in cars, parks, public spaces, abandoned building, substandard housing, bus or train station, or similar setting
- abandoned in hospitals;
- migratory children living in one of the above settings.
- youth not in the custody of a parent/guardian (unaccompanied youth) of any age, in one of the above settings

All STLS Students Have Rights To:

- **Immediate school enrollment.** *A school must immediately enroll students even if they lack health, immunization or school records, proof of guardianship, or proof of residence. "Enrollment" means enrolled into the school, attending classes and participating fully in school activities.*
- **Enroll In:**
  - the school he/she attended when permanently housed or the school in which he/she was last enrolled (school of origin)
  - any school that permanently housed students living in the same attendance area in which the STLS student or youth is actually living are eligible to attend (attendance area school)
- **Remain** enrolled in his/her selected school for as long as he/she remains in a temporary living situation or, if the student becomes permanently housed, until the end of the academic year.
- **Enroll in** preschool
- **Access** to charter schools, selective enrollment schools, magnet schools, and all other CPS programs in the same manner as students who are permanently housed and assistance with application process will be provided upon request
- **Participate** in tutoring services beyond those provided to all students; school-related activities; and/or receive other support services
- **Receive** free school meals, fee waivers, free uniforms, and low-cost or free medical referrals
- **Transportation services**: If parents/caregivers choose to continue their child's education in the school of origin and transportation is requested, CPS will provide transportation to and from the school of origin, and all school-related activities, for as long as the student is in a temporary living situation or, if the student becomes permanently housed, until the end of the academic year.
  - **Eligible students receive CTA transportation cards and adult caregivers of eligible students in grades PK-6 receive CTA transportation cards to accompany the student to/from school. Eligible students in grades PK-6 whose caregiver is unable to accompany them on public transportation due to a hardship may apply for yellow school bus service by submitting documentation or affidavit of their inability to transport the student.** Examples of a "hardship" situation are:
    - Parent/caregiver employment, job training, or education program
    - Parent's/caregiver's mental and/or physical disability
    - Children need to be transported to and from schools at different locations
    - Court order, DCFS, or DCFS contract agent requires activities that do not enable parent/guardian to transport children to and from school
    - Rules of shelter or similar facility will not permit parent/caregiver to leave to transport children to and from school
    - Other good cause why parent/caregiver cannot use public transportation to transport children to and from school

Students who temporarily reside outside of Chicago due to homelessness and attend their CPS school of origin receive transportation assistance as do students experiencing homelessness who live in the City of Chicago but attend a school of origin outside of CPS.

Dispute Resolution: When a school official denies a student in a temporary living situation enrollment, eligibility, school selection and/or transportation, the parent or student may file a complaint with the CPS STLS Department. The STLS Department will attempt to resolve the dispute in a timely manner. The STLS Department will refer you to free and low-cost legal services to help you, if you wish. During the dispute, the student must be immediately enrolled in the school with participation in school activities and/or provided transportation until the dispute is resolved. Every Chicago Public School, including charter schools, has an STLS Liaison who will assist you in making enrollment decisions, provide notice of the dispute resolution process, if needed assist you in completing the dispute resolution forms and refer you to low-cost legal assistance.

For more information about the rights of STLS students in Chicago Public Schools, call the STLS program at (773) 553-2242, fax at (773)553-2182, email at STLSInformation@cps.edu, go to www.cps.edu/STLS, or visit the STLS policy at www.cps.edu/STLSpolicy.

Request for Emergency and Health Information

School Name: _____

PARENTS/GUARDIANS: The school must have on file emergency information that can be used to contact you. Please print clearly. Whenever there is a change in this information, immediately notify the school in writing.

Student ID#	Last Name	First Name	Middle Name	Homeroom #

Birth Date (mm/dd/yyyy)	Student Home Address	Student Home Phone #

Confidential Information Box 1

Complete this box only if (1) it reflects your child's current living situation; OR (2) it reflects your living situation if you are a youth not living with a Parent or Guardian. (Your answer will help school staff with enrollment and may enable the student to receive additional services.) Check one box:

☐ in a car/park/other public place

☐ doubled-up ☐ in a hotel/motel ☐ in a shelter ☐ in transitional housing

School Note: If any box is checked, see the CPS Policy 702.5.

Confidential Information Box 2

Is there a current Order of Protection or No Contact Order which concerns this student? ☐ Yes ☐ No

School Note: If "Yes," follow CPS Policy 704.4 procedures. Enter information in *Legal Alert* field and update contact information, as needed, in SIM.

Parent/Guardian and Emergency Contact Information: Add extra contacts on the back of this form, if needed.

	Parent/Guardian Contact	Parent/Guardian Contact
Contact Name		
Relationship to Student		
Check all that apply:	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pickup	☐ Lives With ☐ Gets Mailings ☐ Emergency ☐ Permission to Pickup
Home Address, *if different from student's*		
Home Phone Number, *if different from student's*		
Cell Phone Number		
Email Address		
Name and Address of Employer		
Work Phone Number		
* Communication Language		

* CPS communicates via phone calls. Select the language that should be used to communicate with you. Languages available for mass communication at this time are English and Spanish (note: other languages upon availability).

List the name of a relative or neighbor who can also be notified in an emergency and has permission to pick up the student:

Name	Home Address	Telephone #	Relationship

Family Doctor's Name, Address, and Phone Number: I authorize you to call my family doctor, if necessary, in an emergency.

_____

Student Health Insurance: (select only one of the three)

☐ Illinois Medical Card/All Kids: provide student's medical ID # _____*(9-digit number located on back of card)*

☐ No Insurance: are you interested in applying for the Illinois Medical Card/All Kids? ☐ Yes ☐ No

☐ Private/Employer Health Insurance: no additional information needed

Children of Military Personnel *(optional)*

As the Parent or Guardian, are you a member of a branch of the armed forces of the United States? ☐ Yes ☐ No

If yes, are you either deployed to active duty or expect to be deployed to active duty during the school year? ☐ Yes ☐ No

I certify that the information on this form is correct:

_____**(Parent/Guardian Signature)**_____**(Date)**

Must have the original signature, an electronic signature is not acceptable

42 W. Madison Street • Chicago, Illinois 60602
Telephone: 773/553-1600

School Messaging Consent Form

Dear Parent/Guardian/Student if age 18 or older,

Your school and the district will periodically want to send information regarding school or district events, updates or initiatives. We will utilize the phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, and more. To ensure you receive periodic school or district related notifications and reminders, your consent is needed below.

In the event of an emergency, whether or not consent is on file, you will be informed by all contact information provided. Emergency calls include weather closures, health risks, threats, unexcused absences, and other situations affecting the health or safety of students and faculty. Emergency calls will be sent to all the phone numbers, including cellular numbers, listed on the student's record. Please make sure these numbers are updated with the school.

*****Please fill out and return this form to ensure you receive informational calls*****

By signing this form, you are authorizing Chicago Public Schools to use an automated system to periodically deliver automated informational calls or text messages to the phone number(s) provided below. If you change your phone number or no longer wish to receive automated calls, texts or e-mails, you agree to inform Chicago Public Schools immediately. By signing below, you agree that this consent will remain valid and you will continue to receive automated phone calls unless or until you revoke your consent. Standard messaging rates and data may apply.

Instructions: Check Box for Consent or Do Not Consent

☐ I CONSENT as outlined in the above section.
☐ I DO NOT CONSENT as outlined in the above section.

Signature of Parent/Guardian/Student if age 18 or older	Printed Name of Parent/Guardian/Student if age 18 or older
Student's Name	Student ID #
Date	School

Phone Number 1 for Messages: (_____) _____ - _____

Phone Number 2 for Messages: (_____) _____ - _____

E-mail Address: _____

Must have the original signature, an electronic signature is not acceptable

Chicago Public Schools

Media Consent Form and Release

Consent/Release

I hereby consent to have my child photographed, digitally recorded, video taped, audio taped and/or interviewed by the Board of Education of the City of Chicago (the "Board") or the news media when school is in session, either in person or hosted remotely, or when my child is under the supervision of the Board. Further, I consent for these photos, digital recordings, video tapes, audio tapes and/or interviews to be shared with third parties who have received written approval from the Office of Communications. I understand in the course of the above described activities that the Board might like to celebrate my child's accomplishments and work. Therefore, I further consent for the Board's release of information on my child's name, academic/non-academic awards and information concerning my child's participation in school-sponsored activities, organizations and athletics.

I also consent to the Board's use of my child's name, photograph or likeness, voice or creative work(s) on the Internet or on a CD or any other electronic/digital media or print media electronic which may include honorary banners/signs displayed in, near, or around the school building or community.

As the child's parent or legal guardian, I agree to release, indemnify and hold harmless the Board, its members, trustees, agents, officers, contractors, volunteers and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child's name, photograph or likeness, voice or creative work(s), on television, radio or motion pictures, or on the Internet, or on a CD, or any other electronic/digital media or print media or in connection with my child's participation in virtual school events and/or celebratory activities.

It is further understood and I do agree that no monies or other consideration in any form, including reimbursement for any expenses incurred by me or my child, will become due to me, my child, our heirs, agents, or assigns at any time because of my child's participation in any of the above activities or the above-described use of my child's name, photograph or likeness, voice or creative work(s).

I understand that I may cancel this consent by providing written notice to the principal. I also understand that my consent is valid for one school year, including the following summer.

Instructions: Check Box #1 or Box #2

1. ☐ I consent as outlined in the above consent/release section.
2. ☐ I **DO NOT** consent as outlined in the above consent/release section.

Signature of Parent/Guardian/Student if age 18 or older	Printed Name of Parent/Guardian/Student if age 18 or older
Student's Name	Student ID #
Date	School

I understand that I have the right to inspect and copy my student's records, challenge the contents of such records; and limit my consent to the designated records or designated portions of information within the records.

Must have the original signature, an electronic signature is not acceptable

CONFIRMATION *(Only for those applications selected for verification)* ***Signature of Confirming Official :(REQUIRED)*** **Date:**

Part 7- Children's Racial and Ethnic Identities (Optional)

Mark one ethnic identity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Mark one or more racial identities: ☐ Asian ☐ White ☐ Black / African American ☐ American Indian / Alaska Native ☐ Native Hawaiian / Other Pacific Islander

INSTRUCTIONS FOR COMPLETING FAMILY INCOME INFORMATION FORM

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SNAP/TANF, FOLLOW THESE INSTRUCTIONS: Part 1: List all of the household members and date of birth (for students). (Attach another application if necessary.) **Part 2:** List the case number of any household member that corresponds with their name in Part 1. Do not use your Medicare card number. **Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. **Part 6:** Sign the Form. **Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A HOMELESS, MIGRANT, RUNAWAY, OR HEAD START CHILD, FOLLOW THESE INSTRUCTIONS: Part 1: List all of the household members and date of birth (for students). **Skip to Part 3:** Check the appropriate box; obtain date and signature of Homeless, Migrant, or Runaway Liaison/Coordinator. **Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. **Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS: If all children in the household are foster children: Part 1: List Students name, date of birth and check the box for "Foster Child" to the left of your foster child's name. **Skip to Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. **Part 6:** Sign the Form.
If some children in the household are foster children: Part 1: List Students name, date of birth and check the box for "Foster Child" to the left of your foster child's name. **Skip to Part 4:** Follow the instructions under ALL OTHER HOUSEHOLDS INSTRUCTIONS (Part 4) below. **Part 5:** If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. **Part 6:** Sign the Form**. Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS: Part 1: List all of the household members and date of birth (for students). **Skip to Part 4:** Follow these instructions to report total household income:
Column 1 **Name:** List the first and last name of **each** person in your household who receives income, related or not (such as grandparents, other relatives, or friends. Attach another sheet of paper if necessary.). ***Columns 2 & 3*** **Gross Income Amounts and Frequency:** The Gross Income is the amount earned before taxes and other deductions. It should be noted on pay stubs. This is not the same as take-home pay. List the amount each person receives from these sources. Round to the nearest dollar. **All other** sources of income should also be noted on this application. Next to each amount fill in the circle that indicates how often the person receives their stated income (weekly, every other week, twice a month, monthly, or annually). If you do not wish to disclose your income, please note "decline to answer" in this section. Be aware that if you are low-income, failure to share household income information could reduce the funds your school may otherwise receive. **Part 5:** If you are interested in sharing application information with Medicaid or SNAP agencies, check the box and sign. **Part 6:** Sign the Form. **Part 7:** Check the appropriate box to indicate your racial and ethnic identities.

INSTRUCCIONES PARA LLENAR LA SOLICITUD

SI SU HOGAR RECIBE BENEFICIOS DE SNAP/TANF, SIGA ESTAS INSTRUCCIONES: Sección 1: Escriba el nombre de cada persona en su hogar y fecha de nacimiento (de alumnos). (Adjunte otra solicitud, si es necesario.) **Sección 2:** Escriba el número de caso correspondiente a cada persona que recibe SNAP/TANF. No escriba el número de la tarjeta médica. **Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de All Kids (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 6:** Un miembro adulto del hogar **debe** firmar la solicitud. **Sección 7:** Marque los cuadritos que corresponda a su identidad racial y étnica.

SI USTED ESTÁ APLICANDO DE PARTE DE UN NIÑO(A) SIN HOGAR, EMIGRANTE, FUGITIVO(A) o NIÑO EN EL PROGRAMA HEAD START, SIGA ESTAS INSTRUCCIONES: Sección 1: Escriba el nombre de cada persona en su hogar y fecha de nacimiento (de alumnos). **Avance a Sección 3:** Marque el cuadrito que corresponda y obtenga la fecha y firma del coordinador escolar de alumnos sin hogar, emigrantes o fugitivos. **Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de All Kids (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 7:** Marque los cuadritos que corresponda a su identidad racial y étnica.

SI USTED ESTA APLICANDO DE PARTE DE UN HIJO DE CRIANZA, SIGA LAS SIGUIENTES INSTRUCCIONES: Si todos los niños en el hogar son hijos de crianza: Sección 1: Escriba el nombre, fecha de nacimiento y marque el cuadrito "Hijo de Crianza" al lado del nombre de su(s) hijo/a(s) de crianza. **Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de All Kids (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 6:** Un miembro adulto del hogar **debe** firmar la solicitud. **Si algunos, pero no todos, los niños en el hogar son hijos de crianza: Sección 1** Escriba el nombre, fecha de nacimiento y marque el cuadrito "Hijo de Crianza" al lado del nombre de su(s) hijo/a(s) de crianza. **Avance a Sección 4: Siga las instrucciones bajo TODOS LOS DEMÁS HOGARES (Sección 4) más abajo. Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de All Kids (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 6:** Un miembro adulto del hogar **debe** firmar la solicitud. **Sección 7:** Marque los cuadritos que corresponda a su identidad racial y étnica.

TODOS LOS DEMÁS HOGARES, SIGAN ÉSTAS: Sección 1: Escriba el nombre de cada persona en su hogar y fecha de nacimiento (de alumnos). (Adjunte otra solicitud, si es necesario.). **Avance a Sección 4:** Siga estas instrucciones para reportar el ingreso total de su hogar:
Columna 1 **Nombre:** Escriba nombre y apellido de **cada** persona que vive en su hogar que recibe ingresos, sea pariente o no (tales como abuelos, otros parientes o amigos. Si es necesario, puede adjuntar una hoja adicional.). ***Columnas 2 & 3*** **Ingreso Bruto y cada cuánto es recibido:** El Ingreso Bruto es la cantidad ganada antes de restar impuestos y otras deducciones. Esa suma se encuentra generalmente en el talón del cheque de pago. No es lo mismo que el dinero que se lleva a la casa. Escriba la cantidad que cada persona recibe de estas fuentes de ingreso. No incluyan los centavos. **Todas** las fuentes de ingreso deben ser anotadas en esta solicitud. Al lado de la cantidad, marque el cuadrito que indica la frecuencia con que la persona recibe el ingreso (semanalmente, cada dos semanas, dos veces por mes, mensualmente o anualmente). **Avance a Sección 5:** Si le interesa compartir la información en esta solicitud con agencias de Medicaid (de seguro médico) o de SNAP (anteriormente llamado Cupones para Alimentos), marque el cuadrito y firme. **Sección 6:** Un miembro adulto del hogar **debe** firmar la solicitud. **Sección 7:** Marque los cuadritos que corresponda a su identidad racial y étnica.

CPS FAMILY INCOME INFORMATION FORM 2020-2021

Parents - Please return form to school by September 30, 2020.

Schools – Please enter into ODA by October 18, 2020

School Name *(Nombre de Escuela)*:

The purpose of this form is for CPS to obtain information about families' income to determine school funding. CPS and your school may receive additional funding based on the number of low-income families enrolled. Please complete this form and return it to the school's main office. (El propósito de este formulario de CPS es obtener información sobre el ingreso de las familias para determinar los fondos escolares. CPS y su escuela pueden recibir fondos adicionales basados en la cantidad de familias de bajos recursos matriculadas. Por favor, complete este formulario y entréguelo a la oficina de la Escuela)

Part 1 – HOUSEHOLD INFORMATION (INFORMACIÓN SOBRE EL HOGAR)
List names of all members of your household living with you. *(Escriba los nombres de todas las personas que viven en su hogar.)*
**Foster Children (legal responsibility of welfare agency or court)*

Part 2: SNAP / TANF number of any member of your household *(go to step 6)* ***(N° de SNAP / TANF de cualquier integrante de su hogar (pase al n°6))***

Part 3 – Homeless , Migrant, Runaway Child, or child enrolled in Head Start *(Niño sin Hogar, Emigrante, Fugitivo o Niño en el programa Head Start)*

Foster Child? (*¿Hijo de Crianza?*)	**CPS Student? (*¿Estudiante de CPS?*)**	**All Household Member Names** Last *(Apellido)* First *(Nombre)* MI *(Inicial)*	**Date of Birth** *(Fecha de Nacimiento)*	**DHS Case Number** *(Numero del Caso del DHS)*
☐	☐		/ /	
☐	☐		/ /	
☐	☐		/ /	
☐	☐		/ /	
☐	☐		/ /	
☐	☐		/ /	

☐ **Homeless** ☐ **Migrant** ☐ **Runaway** ☐ **Head Start**

Homeless, Migrant, Runaway or Head Start Liaison Signature

Date (*Fecha*)

Part 4 – List Household Members With Income *(SKIP THIS if you answered any of steps 2 or 3)* Enter the amount of income and how often it is received for each household member. *(Nombres de los integrantes de su hogar que perciben ingresos. Para cada uno, indique sus ingresos y cada cuánto los recibe. DEJE EN BLANCO si ha contestado la Sección 2 o 3 de esta solicitud.)*
Frequency *(Frecuencia)*: Weekly *(Semanalmente)* Every 2 Weeks *(Cada dos semanas)* Twice Monthly *(Dos veces al mes)* Monthly *(Mensualmente)* Annually *(Anualmente)*
OTHER INCOME can be but not limited to Welfare, Child Support, Retirement, Social Security, Worker's Comp. and Unemployment.

Part 5 – *Opt In of information about other benefits.* *(Otros Beneficios)*

Household Member Names With Income First *(Nombre)* MI (Inicial) Last *(Apellido)*	**Gross Income (before deductions)** *(Ingresos Brutos)* Weekly / Every 2 Weeks / Twice Monthly / Monthly / Annually	**Other Income** *(Todos Otros Ingresos)* Weekly / Every 2 Weeks / Twice Monthly / Monthly / Annually
	$ ○ ○ ○ ○ ○	$ ○ ○ ○ ○ ○
	$ ○ ○ ○ ○ ○	$ ○ ○ ○ ○ ○
	$ ○ ○ ○ ○ ○	$ ○ ○ ○ ○ ○
	$ ○ ○ ○ ○ ○	$ ○ ○ ○ ○ ○
	$ ○ ○ ○ ○ ○	$ ○ ○ ○ ○ ○

☐ **YES!** I am interested in applying for a waiver of instructional fees. **SI!** Me interesa aplicar por la exoneración del pago de enseñanza.

☐ **YES!** I am interested in applying for the Supplemental Nutrition Assistance Program (SNAP) and/or the Medicaid Program. ***SI!*** *Me interesa aplicar para el Programa de Asistencia de Nutrición Suplementaria (SNAP) y/o la Medicaid.*
Or call 773-553-5437

Signature (Firma):

Part 6 – Signature *(Firma)*

I certify that all above information is true and all income is reported. I understand that information gathered from this form will be used to calculate Federal funding eligibility for the school and that school officials.may verify (check) the information as being accurate; and that if I purposely give false information, I may be prosecuted. (Certifico que toda la información indicada arriba es verdadera y que he reportado todos nuestros ingresos. Entiendo que la escuela recibirá fondos del gobierno federal basado en la información en este formulario y que los funcionarios escolares puedan verificar la fidelidad de la información; y si doy información falsa intencionalmente, me pueden llevar a juicio).

Signature of adult household member *(Firma del miembro adulto del hogar)*

Address *(Dirección postal o de domicilio)*

Parent / Guardian First Name *(Nombre del adulto del hogar)*

Zip Code *(Código Postal)*

Parent / Guardian Last Name *(Apellido del adulto del hogar)*

Date *(Fecha)*

SCHOOL USE ONLY Initial Determination: ☐ **ELIGIBLE** (FREE OR REDUCED) ☐ **INELIGIBLE** (DENIED, N/A OR ?)