

NEW HORIZON CENTER FOR THE DEVELOPMENTALLY DISABLED

DOCTOR/ MEDICAL FORMS

CHECKLIST AND EXPLANATION

These forms are required for the 2011-2012 school year. They must be returned by the first day of school, **Wednesday, September 7, 2011**. A checklist is provided for your convenience. We have provided this information to assist you in completing the Doctor/ Medical Forms.

The following forms 1-6 in bold type require your doctor or dentist's signature. Please note that those forms identified by a "*" are NOT required by ALL students, only those who receive nursing treatment, tube feeding or have seizures. If it does not apply to your child, leave it blank and return it with the packet.

1. **Certificate of Child Health Examination**
2. **Dental Examination Form (For incoming 2nd and 6th grade only)**
3. **Therapy Order and Permit**
4. ***Permission for Nursing to Administer Treatment**
5. ***Medication Order Form and Permit for Authorized Nursing to Administer Medication**
6. ***Physician's Order Form for Tube Feeding**

Please note that the last three forms should be completed only if applicable. All 6 forms require both doctor and parent/guardian signatures.

These forms are required for the 2011-2012 school year. They must be returned by the first day of school, **Wednesday, September 7, 2011**.



**STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

Student's Name			Birth Date	Sex	School	Grade Level /ID#
Last	First	Middle	Month/Day/Year			

Address		Street	City	ZIP code	Parent/ Guardian	Telephone # Home	Work
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IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

VACCINE/DOSE	1			2			3			4			5			6									
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR							
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																									
Diphtheria and Tetanus (Pediatric DT or Td)																									
Inactivated Polio (IPV)																									
Oral Polio (OPV)																									
Haemophilus influenzae type b (Hib)																									
Hepatitis B (HB)																									
Varicella (Chickenpox)																									
Combined Measles, Mumps and Rubella (MMR)																									
Measles (Rubeola)																									
Rubella (3-day measles)																									
Mumps																									
Pneumococcal (not required for school entry)	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23				<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23				<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23				<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23				<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23			
Check specific type (PCV7, PPV23)																									
Other (Specify hepatitis A, meningococcal, etc.)																									

Comments

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

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

Date of Disease Signature Title Date

3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella
Lab Results Date MO DA YR (Attach copy of lab report, if available)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																			Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade																			
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																			
Hearing																			

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

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	School	Grade Level/ ID #
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

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

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS		HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING BMD-85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/>		Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>			
LEAD RISK QUESTIONNAIRE * Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.					
Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/>		Blood Test Date	Blood Test Result (Blood test required in Chicago and other high risk zip codes.)		
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read / / Result mm					
LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES		Date	Results	Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin				Endocrine	
Ears				Gastrointestinal	
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/>	Result Referred to Ophthalmologist/Optomtrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose				Neurological	
Throat				Musculoskeletal	
Mouth/Dental				Spinal examination	
Cardiovascular/HTN				Nutritional status	
Respiratory				Mental Health	
NEEDS/MODIFICATIONS required in the school setting				DIETARY Needs/Restrictions	
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup					
MENTAL HEALTH/OTHER Is there anything else the school should know about this student? If you would like to discuss this student's health with school or school health personnel, check title: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal					
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe.					
On the basis of the examination on this day, I approve this child's participation in PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>				(If No or Modified, please attach explanation.) INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>	
Physician/Advanced Practice Nurse/Physician Assistant performing examination					
Print Name _____		Signature _____		Date _____	
Address _____			Phone _____		

(Complete both sides)

Illinois Department of Public Health PROOF OF SCHOOL DENTAL EXAMINATION FORM



To be completed by the parent (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:			Address (of parent/guardian):	

To be completed by dentist:

Oral Health Status (check all that apply)

Yes No **Dental Sealants Present**

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 **Soft Tissue Pathology**

Yes No **Malocclusion**

Treatment Needs (check all that apply)

Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

Restorative Care — amalgams, composites, crowns, etc.

Preventive Care — sealants, fluoride treatment, prophylaxis

Other — periodontal, orthodontic

Please note _____

Signature of Dentist _____

Date _____

Address _____
Street City ZIP Code

Telephone _____

Illinois Department of Public Health, Division of Oral Health
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us

NEW HORIZON CENTER FOR THE DEVELOPMENTALLY DISABLED

PHYSICIAN'S THERAPY ORDER

Student's Name: _____

In order to meet the above student's mandated educational program, it is necessary to have a physician's permission for evaluation and treatment by Physical, Occupational and/or Speech, and Social Work Therapies.

The student will not receive therapy without a physician's written permission.

I hereby authorize evaluation, treatment, or consultation regarding the above student by Physical, Occupational or Speech Therapy at New Horizon Center. I understand that all interventions will be in accordance with medical precautions described on this page.

This consent is valid from September of 2011 through August of 2012.

Dx: _____

*Height/Weight: _____

* Information needed for equipment orders

Precautions (if any): _____

Diet Modifications (if any): _____

Doctor's Signature _____

Date _____

Address _____

Telephone: _____

Fax: _____

I authorize NHC's designated personnel to speak with the physician regarding the above student.

Parent's Signature _____

Date _____

Telephone Number _____

NEW HORIZON CENTER FOR THE DEVELOPMENTALLY DISABLED

**PERMIT FOR AUTHORIZED NURSING PERSONNEL TO ADMINISTER REQUIRED
TREATMENT DURING SCHOOL HOURS
(TO BE COMPLETED BY PHYSICIAN)**

Date _____

This child _____ is under my
medical care for _____ and is required to have the
following treatment administered during school hours: _____

Treatment Order: _____

Equipment Size: _____

Frequency of Treatment: _____

Duration of Treatment: _____

Side Effects/Precautions: _____

To what degree can child participate in treatment procedure?

(Mark with an X)

Independent _____ Needs Assistance _____ Unable to Assist _____

Signature of Physician _____

Printed name of Physician _____

Address _____

Emergency Telephone Number _____

Fax Number _____

(TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

I, _____, give permission for my child to receive the
above treatment(s) as directed by the physician. I will provide all supplies as needed to
do the procedure. I will notify the school in writing if the treatment is discontinued. I
authorize NHC's designated personnel to speak with the physician regarding the above
procedure.

Date _____

Parent's Signature _____

Address _____

Telephone Number _____

Fax Number _____

NEW HORIZON CENTER FOR THE DEVELOPMENTALLY DISABLED

Tel: 773 286-6226 Fax: 773 286-4218 Attn: School Nurse

Medication Order Form

(Permit for Authorized Nursing Personnel to Administer Required Medications During School Hours)

Child's Name _____
(This medication order is valid for one year from the date it was written)

(To Be Completed By Physician)

Date _____

This child _____ is under my medical care for _____
and medication is required during the school day for the
purpose of _____

Name of Drug	Dosage	Frequency	Time to Be Given at School	Duration	Side Effects

Please indicate if the patient is capable of self medication.

Can Self Medicate _____ Cannot Self Medicate _____

Is up to a 2 1/2 hour delay (due to field trips, special events) in administering medication permissible?

Yes _____
No _____

How long a delay _____

Signature of Physician _____

Printed Name of Physician _____

Address _____

Emergency Telephone Number _____

Fax Number _____

(To Be Completed By Legal Guardian)

I, _____, give permission for my child to receive the above medication(s) as directed by the physician. The medication will be sent to New Horizon Center in a container appropriately labeled by the pharmacy. I will notify the New Horizon Center in writing if the medication is discontinued. Also, I will obtain a written doctor's order if the medication dosage is changed. I will bring the medication to the New Horizon Center nurse or send in my child's backpack.

I authorize NHC's designated personnel to speak with the physician regarding the above medication.

I understand that if a field trip/special event is scheduled to take longer than the medication delay time permitted by the physician, my child will not be permitted to participate unless I accompany him/her to administer the medication.

I release NEW HORIZON CENTER, its officers, directors, employees and agents from any and all responsibility or liability in connection with the medication or the administration of the medication as described on this authorization form.

Parent's Signature _____

Address: _____

Date _____

Phone: _____

Email: _____

NEW HORIZON CENTER FOR THE DEVELOPMENTALLY DISABLED

Physician's Order Form for Tube Feeding
(To Be Completed By Physician)

Student: _____ Date: _____

Address: _____

Phone: _____

DOB: _____ Height: _____ Weight: _____

Diagnosis: _____

Name of Tube Feeding Product: _____ Rate _____ Amount _____

Type of administration NG Tube Gastrostomy Jejunostomy

Method of Feeding Gravity Bolus Pump Feeding Time(s)

Flushing Amount NPO ___ Yes ___ No

Method of Flushing Syringe Pump

If G-Tube comes out, should it be replaced by school nurse or is re-insertion by a physician necessary?

School Nurse Physician

Is it necessary to check for tube placement prior to feeding? Yes No

Comments: _____

Physician Signature _____

Phone: _____

Name of Physician (*Print*) _____

Fax: _____

Address: _____

To Be Completed By Parent or Legal Guardian

I give permission for my child to receive the above procedure as directed by physician. I will provide all required supplies. I will notify the school in writing if the procedure is changed or discontinued. I authorize NHC's designated personnel to speak with the physician regarding the above G-Tube feeding.

Parent Signature _____ Date _____

Address _____

Telephone _____ Email _____

Please send in all supplies daily, feeding formula, bags, and pump if indicated. If we do not have the needed supplies, your child cannot be in school.