



St. Hubert Catholic School
255 Flagstaff Ln, Hoffman Estates IL 60169
Ph: 847.885.7702 Fax: 847-885-0604
Mrs. Julie Martin, Principal
Mrs. Stephanie Cilek, Assistant Principal



Dear Parents/Guardian,

The State of Illinois **REQUIRES** that all students entering **Preschool, Kindergarten, 6th grade** and **students new to Illinois** have the following immunizations upon entrance to school. The attached Certificate of Child's Health Examination is the only acceptable documentation

Physical Examination: The exam must have been administered within one year prior to the grade level (not before September 2020). All students Preschool through 8th grade must have a physical and immunization record on file. The physician must complete and sign the form and the immunization section must be completed and dates verified by the healthcare provider. **Parents, you must answer the questions located in the box on the top of the 2nd page and sign before you turn the form in to the school office.**

Preschool Immunizations: Specific dates must be provided. (4) DTap, (3) Polio, (4) Hib, (3) Hep B, (1) MMR, (1) Varicella (chicken pox), (4) Pneumococcal and dates for Lead Screening and Diabetes Screening

Kindergarten Immunizations: Specific dates must be provided. (5) DTap, (4) Hib, (3) Hep B, (2) 2 MMR, (2) Varicella, (4) Pneumococcal and dates for Lead Screening and Diabetes Screening

6th Grade Immunizations: Specific dates must be provided. (1) Tdap, (1) Meningitis

Failure to comply with the Illinois School Code will result in your child being excluded from school.

The Health Records are REQUIRED to be completed by the first day of school or your child will not be allowed to attend.

Sincerely,

Julie Martin
Principal

Stephanie Cilek
Assistant Principal

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)	Yes No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes No	List:
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during night coughing?	Yes	No	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	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	*Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Parent/Guardian Signature _____ Date _____				
Ear/Hearing problems?	Yes	No			
Bone/Joint problem/injury/scoliosis?	Yes	No			

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

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

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

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

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

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

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

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

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

NEEDS/MODIFICATIONS required in the school setting **DIETARY** Needs/Restrictions

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

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

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

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

Print Name _____ (MD,DO, APN, PA) Signature _____ Date _____
Address _____ Phone _____