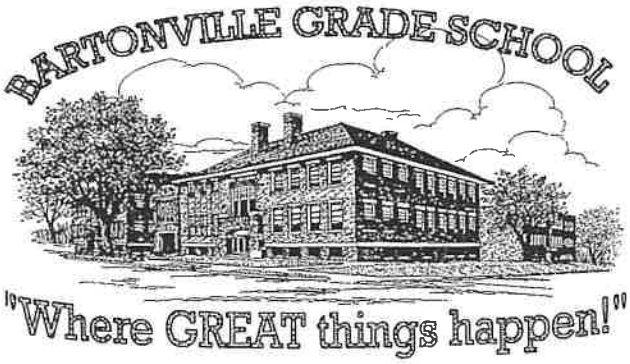


BARTONVILLE SCHOOL DISTRICT #66
6000 South Adams Street
Bartonville, Illinois 61607-2596
www.bgs66.org

Phone: 309-697-3253 Fax: 309-697-3254

Dr. Lan Eberle, Superintendent
Mr. Brad Jockisch, Principal

2020-2021
Student Health Information Sheet

Student's Name: _____ Date of Birth: _____

Gender: Grade:____ Teacher: _____

Visual Aids: glasses/contacts Other required aids: (ie. Hearing aids, walker, etc)

_____

Allergies:
(Drug/Food/Environmental)_____

Reaction(s) seen: _____
Date of Last Reaction: _____
Dietary Restrictions:

_____
(WE MUST HAVE THE "PHYSICIAN STATEMENT FOR FOOD SUBSTITUTION" FORM COMPLETED FOR ANY FOOD SUBSTITUTIONS)

Please check any of the conditions your child may have: ***(If checked a condition, please describe in more detail in space provided below)***

___Asthma	___Bowel Problems	___Nosebleeds
___Heart Problems	___ Skin Problems	___Blood Pressure Problems
___Diabetes	___Ear Infections/Tubes	___Bone Disease/Injury
___Blood Disorder	___Speech Problems	___Hearing Problems
___Vision Problems	___Urinary Problems	___Epilepsy/Seizures
___Emotional/Behavior Problems	___Other_____	

Please list and explain any health issues, serious illnesses, injuries, conditions, past operations, learning or behavioral problems you feel that the school should be aware of:

_____
_____
_____
_____

Asthma:
What triggers an episode?

_____

Medication used (at home or school)?

_____

Circle when medication is needed: Daily Before P.E./Sports Only When Symptoms Occur

Diabetes:
Circle appropriate responses below:
Type:

Type I Type II Diet Controlled

Treatment:

Oral Medication Insulin

Please list times of blood sugar checks if they are required at school:

_____

(CHILDREN WHO ARE DIABETIC REQUIRE A "DIABETES MEDICAL MANAGEMENT PLAN" COMPLETED BY THEIR DOCTOR AND RETURNED TO THE SCHOOL NURSE.)

Seizures:

Type of Seizures: _____ Date of Last Seizure: _____

Triggers Prior to Seizures:

_____

Seizure Medication Needed at School:

_____

Medications: (please list any over-the-counter or prescription medication(s) that your child takes on a regular basis either at home or at school):

_____

_____

***** If medications are to be given at school, a medication permit will need to be completed. Please see the school nurse. *****

I give Bartonville Grade School permission to keep this information sheet on file in the medical files. I realize that this information may be shared with pertinent Bartonville Grade School staff as needed to ensure the best care is given to my child. ***I am aware that the only medicines my child may receive through school without my prior consent are the following: Tums, Hydrocortisone 1% cream, Triple Antibiotic cream, Antifungal cream, Aloe Vera gel, Calamine lotion, and Saline eye drops***. In the event of an emergency where, in the judgment of school authorities, urgent medical care is indicated and I cannot be reached, I also give permission for my child to be transported by ambulance to a hospital and for a doctor of medical personnel to give emergency treatment.

I prefer my child to be treated at _____ Hospital.

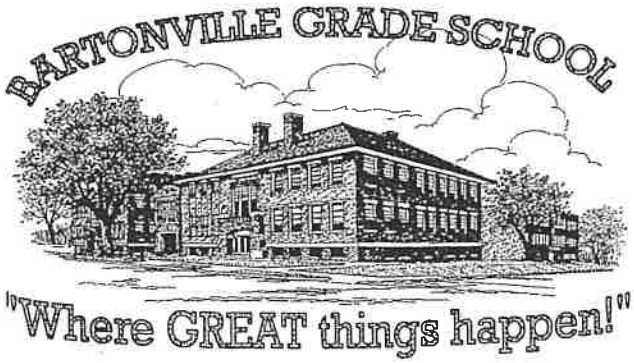
Parent/Guardian Signature: _____

Date: _____

BARTONVILLE GRADE SCHOOL DISTRICT #66
REQUIRED IMMUNIZATIONS FOR SCHOOL YEAR 2020-2021

Updated 1/13/2020	**DTap/Tdap** (Diphtheria, Tetanus, Pertussis)	**Polio***	**MMR** (Measles, Mumps, Rubella)	**Hepatitis B**	**Varicella*** (Chicken Pox)	**Meningococcal** Meningitis (MCV4)	**HIB** (Haemophilus Influenzae , Type B)	**PCV** (Pneumococcal Disease)
Pre-K/ Preschool	**4 doses DTap** (last dose on or after 4th birthday)	**3 doses** (last dose on or after 4th birthday)	**1dose**	**3 doses**	**1 dose**		**3 doses** *see below	**4 doses** *see below
K-2nd grade	**4 doses DTap** (last dose on or after 4th birthday)	**4 doses*** (last dose on or after 4th birthday)	**2 doses**		**2 doses**			
3rd-4th grade	**4 doses DTap** (last dose on or after 4th birthday)	**3 doses** (last dose on or after 4th birthday)	**2 doses**		**2 doses**			
5th grade	**4 doses DTap** (last dose on or after 4th birthday)	**3 doses** (last dose on or after 4th birthday)	**2 doses**		**2 doses**			
6th-11th grade	**4 doses DTap** (last dose on or after 4th birthday) **AND** **1 dose Tdap**	**3 doses** (last dose on or after 4th birthday)	**2 doses**	**3 doses**	**2 doses**	**1 dose** (given on or after 11th birthday)		
12th grade	**4 doses DTap** (last dose on or after 4th birthday) **AND** **1 dose Tdap**	**3 doses** (last dose on or after 4th birthday)	**2 doses**	**3 doses**	**2 doses**	**2 doses** (if 1st dose given at age 16 or older; only 1 dose required)		

*Polio – 4th dose is not needed if the 3rd dose was administered after 4 years of age and at least 6 months after the previous dose.
*Varicella – exempt if healthcare provider verifies child had disease.
*HIB – If none received before age 15 months, only 1 dose required from age 15 months to 59 months of age. **Not required age 5 years or older.**
*PCV – If none received before age 24 months, only 1 dose required from 24 to 59 months of age. **Not required age 5 years of older.**



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2020-2021

School Medication Authorization Form
For Prescription and Over-the-Counter Medicines

This form is required by school law and must be completed by the child's parent(s)/guardian(s)and the students' physician. A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: _____ Birth Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____ Emergency Phone: _____

Grade: _____Homeroom Teacher: _____

To be completed by the student's physician, physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority:

Note: *for asthma inhalers only, use the* ***Asthma Inhalers*** *section below*

Physician's Printed Name: _____

Office Address: _____

Office Phone: _____ Emergency Phone: _____

Medication Name: _____

Purpose: _____

Dosage: _____ Frequency: _____

Time Medication is to be administered or under what circumstances:

_____

Prescription Date: _____ Order Date: _____ Discontinuation Date: _____

Diagnosis Requiring Medication: _____

Is it necessary for this medication to be administered during the school day? Yes ____ No ____

Expected Side Effects, if any: _____

Time Interval for re-evaluation: _____

Other Medications student is receiving: _____

Physician's Signature: _____ Date: _____

BARTONVILLE GRADE SCHOOL DISTRICT #66
REQUIRED EXAMINATIONS FOR SCHOOL YEAR 2020-2021

The following health requirements apply to all children enrolled in an **Illinois public school.** Unless an exemption or extension applies, the failure to comply with the requirements noted below by the first day of school of the current school year will result in the student's exclusion from school until the required health forms are presented to the District.

Physical Examination requirements due upon enrollment. Must be on an **Illinois physical form.**
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**
- **Any student entering State of Illinois Grade School for the first time**

Vision Examination requirements due upon enrollment. Must be on an **Illinois State Eye form**.

- **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** and **6th.** Must be on an **Illinois dental form**.

Asthma Inhalers:

Parent/Guardian please attach prescription label here:

For only parents/guardians of students who need to carry and use their asthma medication or an epinephrine auto-injector:

I authorize the School District and its employees and agents, to allow my child to self-carry and self-administer his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school-sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois law requires the School District to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector. 105 ILCS 5/22-30.

Please initial to indicate (a) receipt of this information, and (b) authorization for your child to carry and use his or her asthma medication or epinephrine auto-injector.

Parent/Guardian Initials: _____

For all parents/guardians:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize the School District and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to *self-administer* pursuant to State law, while under the supervision of the employees and agents of the School District), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors or opioid antagonists to my child when there is a good faith belief that my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not. 105 ILCS 5/22-30, amended by P.A. 99-480. **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices**, and I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration or the child's self-administration of medication.

Parent/Guardian Printed Name: _____

Parent/Guardian Signature: _____ Date: _____

Phone: _____ Emergency Phone: _____

Address (if different than student's above): _____