MEDICAL INFORMATION AND FORMS

Accidents

In the event of an accident, the school nurse will be contacted. If the nurse is not immediately available, the injured student will not be moved until examined by an adult trained in first aid. It will be the school nurse's responsibility to determine, upon consultation with the Superintendent of Schools or the Superintendent's designee, the need for further medical assistance. In the event that additional emergency medical aid is needed, paramedics will be called. If possible, the parent will be consulted prior to this action. A report of accident or injury form will be completed and placed on file with the school nurse. School District 29 has purchased Student Accident Insurance Coverage on each child's behalf.

This program provides student coverage for injuries incurred while participating in school-sponsored and/or supervised activities, including athletics. Aside from the school-sponsored coverage provided by District 29, the program administrator also offers 24-hour unlimited Dental Accident coverage and also 24-hour coverage providing protection during vacations and weekends. Refer to the Student Accident Insurance information located under the "Parent" tab. Click on "Back to School" and the information is located under the "District 29" heading.

Health Records

Under Illinois law, every student entering kindergarten and students who are new to the District, must have a current physical examination on file. All children entering kindergarten are required to have a vision examination. All children in kindergarten and second grade are required to have a dental health examination.

Physical Exams

Students entering kindergarten, as well as students who are new to the District must have a new physical examination on file at the time of enrollment or registration. A physical exam cannot be accepted for school enrollment unless a diabetes screening has been completed. Lead screening is a required part of the health examination for children age 6 years or younger prior to admission to kindergarten.

Immunizations

The State of Illinois requires that each school child show evidence of immunity to several childhood diseases. State law requires the exact month, day and year of the immunization be shown along with doctor and parent signatures. Proof of immunization must be presented at the time of enrollment, registration, or before October 15th of the current school year. The school nurse can assist parents in obtaining immunizations by providing referrals, as necessary.

Exemptions

Objections of Parent or Legal Guardian

Parent or legal guardian of a student may object to health examinations, immunizations, vision and hearing screening tests, and dental health examinations for their children on religious grounds. If a religious objection is made, a written and signed statement from the parent or legal guardian detailing such objections must be presented to the local school authority. The objection must set forth the specific religious belief which conflicts with the examination, immunization or other medical intervention. General philosophical or moral reluctance to allow physical examinations, immunizations, vision and hearing screening, and dental examinations will not provide a sufficient basis for an exception to statutory requirements. The Illinois Department of Public Health is responsible for determining whether the written statement constitutes a valid religious objection.

Medical Objection

Any medical objection to an immunization must be:

1. Made by a physician licensed to practice medicine in all its branches indicating what the medical condition is,
2. Endorsed and signed by the physician on the certificate of child health Medical Objection examination and placed on file in the child's permanent record. Should the condition of the child later permit immunization, this requirement will then have to be met.

Please call or email me if you have any questions or concerns.

Ann Mertes, R.N.
847-881-9503
mertesa@sunsetridge29.org

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. 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 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or **DTaP**						
Tdap; **Td** or Pediatric **DT (**Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis 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 result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																						
Age/ Grade																						
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L		
Vision																						
Hearing																						

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

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

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

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

HEAD CIRCUMFERENCE **HEIGHT** **WEIGHT** **BMI** **B/P**

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

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

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. **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			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g.Short Acting Beta Antagonist) ☐ 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** (for one year) **Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete both sides)

State of Illinois
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: ☐ Male ☐ 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 of Exam _____

Address _____ Telephone _____
Street City ZIP Code

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

IOCI 0600-10 Printed by Authority of the State of Illinois

State of Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 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 first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name _____
(Last) (First) (Middle Initial)

Birth Date _____ Gender _____ Grade _____
(Month/Day/Year)

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

Address _____
(Number) (Street) (City) (ZIP Code)

County _____

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

	Distance			**Near**
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

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

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts 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 _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

Address _____

_____

Phone _____

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)

_____
(Date)

Signature _____ Date _____

(Source: Amended at 32 Ill. Reg. _____, effective _____)

Printed by Authority of the State of Illinois
6/09

IOCI1271-09

District 29 Medication Authorization

HEALTH SERVICES

Sunset Ridge School 847-881-9455 Fax 847-446-6388
Middlefork School 847-881-9503 Fax 847-446-6221

Student Name	**Grade**

Medication Allergies: _____ Food Allergies: _____Other Allergies:_____

NON-PRESCRIPTION MEDICATION

Non- prescription *medications must be brought to Health Services by a parent/guardian in a manufacturer-labeled container.* ***Authorizations are valid for 1 school year.***
Medical provider and parent signature required.

Please authorize medication administration by checking appropriate boxes or filling in *other medication*:

- ☐ **Ibuprofen 1-2 tablets (200 mg ea.) every 6 hours as needed**
- ☐ **Acetaminophen 1-2 tablets (325 mg ea.) every 4 hours as needed**
- ☐ **Benadryl 1-2 tablets (25 mg. each) for allergy symptoms or allergic reaction**
- ☐ ***Other medication***_____Dose_____Frequency_____

PRESCRIPTION MEDICATIONS-Valid for one school year only

Note- A student may carry a pharmacy labeled inhaler with parent authorization only. Please sign and date at bottom of this page. Name of inhaler medication: _____.

Medications to manage severe allergic reactions and diabetes
A student may carry an Epipen (epinephrine injection), Benadryl, Insulin and diabetic supplies with medical provider and parent authorization.

Epipen with/without Benadryl: _____
Insulin and glucose monitoring: _____

We recommend that *all* emergency medications are stored in the Health Office. It is very important that we have a back–up inhaler that is easily accessible. Please review item #4 on the reverse side regarding self-administration.

Other Prescription Medications: Must be renewed at the beginning of each school year.
All medications must be brought to Nurse's Office by parent/guardian in a prescription-labeled container.
Medication: _____ Dosage: _____

Frequency: _____Duration of order: _____

Medication: _____ Dosage: _____

Frequency: _____Duration of order: _____

Other medications not taken at school that may impact learning: _____

Medical Provider Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Please see reverse side for Administration of Medication Procedure/Guidelines.
05/12

Physician Office Stamp

District 29 Sunset Ridge and Middlefork School
ADMINISTRATION OF MEDICATION TO STUDENTS

Parents/guardians have the primary responsibility for the administration of medication to their children. The administration of medication to students during regular school hours and during school related activities is discouraged unless necessary for the critical health and well being of the student. The administration of medication to students is subject to guidelines established by the Superintendent or designee, in keeping with state agency recommendations (e.g., Illinois Department of Professional Regulation, Illinois Department of Public Health, and Illinois State Board of Education).

PROCEDURES/GUIDELINES:

1. **Medication Authorization Form** - School personnel shall not administer to any student, nor shall any student possess or consume *any prescription or non-prescription medication* unless the student's parent has provided the school with a completed Medication Authorization form. The school nurse reviews the written authorization and may consult with the parent/guardian, licensed prescriber or pharmacist for additional information as necessary. Authorization and any subsequent changes include:
    A. Physician, advanced practice registered nurse, physician's assistant, dentist, or podiatrist-licensed prescriber's written prescription
    B. Student's name, medication name, dosage and date of order
    C. Administration instructions (route, time or intervals, duration of prescription)
    D. Reason/intended effects and possible side effects
    E. Parent/guardian written permission.
2. **Appropriate Containers** - Medication and refills are to be provided in containers, which are:
    A. Prescription labeled by a pharmacy or licensed prescriber displaying Rx number, student name, medication, dosage, and directions for administration, date and refill schedule and pharmacist name.
    B. Manufacturer labeled, **unopened** non-prescription over-the-counter medication.
3. **Administration of Medication** will be by Certificated School Nurse, Registered Nurse, or school administrator. Other school personnel may also volunteer to assist in medication administration and may be given instructions by the nurse. If no volunteer is available, the parent/guardian must make arrangements for administration. The school nurse or administration retains the discretion to deny requests for administration of medication.
4. **Self-Administration -** A student may self-administer medication at school and activities if so ordered by his/her medical provider. Daily documentation will be provided as below (#6) for such health office supervised self-administration. For "as needed" medications such as those taken by students with asthma or allergies, the physician may also order that the student carry the medication on his or her person for his/her own discretionary use according to medical instructions, however no daily documentation will be possible in this case. Students may carry prescription labeled inhalers with parent written permission only. Self-administration privileges may be withdrawn if a student exhibits behavior indicating lack of responsibility toward self or others with regards to medication. Parent signature on this form acknowledges that "the school district is to incur no liability, except for willful and wanton conduct, as a result of any injury arising from the self-administration of medication by the pupil and that the parents/guardians 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 self-administration of medication by the pupil." (Reference IL PA92-0402)
5. **Stock Medications** - Acetaminophen, Ibuprofen and generic Benadryl are kept in stock at school as a courtesy to students in case of an emergency. In an emergency, a one-time dose may be given with phoned parent permission. A Medication Authorization Form will then be sent home for completion and no further doses will be provided without the completed form on file.
6. **Storage and Record Keeping** - Medication will be stored in a locked cabinet. Medication requiring refrigeration will be stored in a secure area. Each dose will be recorded in the student's individual health record. In the event a dose is not administered, the reason shall be entered in the record. Parents may be notified if indicated and it shall be entered in the record. To assist in safe monitoring of side effects and/or intended effects of the treatment with medication, faculty and staff may be informed regarding the medication plan. For long-term medication, written feedback may be provided at appropriate intervals or as requested by the licensed prescriber and/or parent/guardian.
7. **Documentation, Changes, Renewals, and Other Responsibilities** - To facilitate required documentation, medical orders, changes in medical orders, and parent permissions may be faxed to Health Services. It is the responsibility of the parent/guardian to be sure that all medication orders and permissions are brought to school, refills provided when needed, and to inform the nurse of any significant changes in the student's health. Medication remaining at the end of the school year must be released to a parent/guardian or it will be discarded**. Every prescription and over- the-counter medication order must be renewed each school year.**

05/12

Medical Updates and Information by Grade 2014-15

Grade	Certificate of Child Health Examination Form	Vision Examination Form	Dental Examination Form	2014-2015 Emergency Form One form for each student	*District 29 Medication Authorization Form	Physical Exam- Illinois Certificate of Child Health Examination Form
K	**Due Oct. 15, 2014**	**Due Oct. 15, 2014**	**Due May 15, 2015**	**Due Aug. 27,2014**	**Due Aug. 27 ,2014**	N/A
1	N/A	N/A	N/A	**Due Aug. 27, 2014**	**Due Aug. 27, 2014**	N/A
2	N/A	N/A	**Due May 15, 2015**	**Due Aug. 27, 2014**	**Due Aug. 27, 2014**	N/A
3	N/A	N/A	N/A	**Due Aug. 27, 2014**	**Due Aug. 27, 2014**	N/A
4	N/A	N/A	N/A	**Due Aug. 27, 2014**	**Due Aug. 27, 2014**	N/A
5	N/A	N/A	N/A	**Due Aug. 27, 2014**	**Due Aug. 27, 2014**	**Eligible for spring sport Good for 1 year**
6	**Due Oct. 15, 2014**	N/A	**Due May 15, 2015**	**Due Aug. 27, 2014**	**Due Aug. 27, 2014**	**Good for 1 year**
7	N/A	N/A	N/A	**Due Aug. 27, 2014**	**Due Aug. 27, 2014**	**Good for 1 year**
8	N/A	N/A	N/A	**Due Aug. 27, 2014**	**Due Aug. 27, 2014**	**Good for 1 year**

Concussion information sheet requires parent signature Grades K-8. Students also are required to sign grades 5-8.

***District 29 Medication Authorization forms are required for all students receiving daily medications and "as needed" meds such as Tylenol, Advil, Benadryl. The Allergy Action Plan is to be completed per MD for any child with a severe food and/or bee sting allergy requiring emergency medical care. Please contact your school nurse to review your students Allergy Action Plan.**

****All students must receive physical exams prior to entering Illinois schools for the first time.**
The exam must have been completed within 1 year prior to the date of entry.

*****Health exams must be dated after Aug. 27, 2013 for Kindergarten and 6th grade.**

******Vision Examination: Public Act 95-671, effective January 1, 2008, requires that all children enrolling in kindergarten in a public, private or parochial school and any new student enrolling for the first time shall have an eye examination.**

curryl@sunsetridge29.org Linda Curry Sunset Ridge School
mertesa@sunsetridge29.org Ann Mertes Middlefork School

SUNSET RIDGE SCHOOL DISTRICT 29
Concussion Information and Form

Changes to the Illinois school code recently required districts to adopt a new policy pertaining to concussions and student athletes. The District 29 Board of Education, administration and school nurses felt that the preventative measures outlined in the policy should apply to all District 29 students, not just student athletes. Therefore, all parents are asked to sign the form below to indicate their receipt and review of this important information. Students in grades 5-8 are also asked to sign the form.

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, **all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly.** In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:

- Headaches
- "Pressure in head"
- Nausea or vomiting
- Neck pain
- Balance problems or dizziness
- Blurred, double, or fuzzy vision
- Sensitivity to light or noise
- Feeling sluggish or slowed down
- Feeling foggy or groggy
- Drowsiness
- Change in sleep patterns
- Amnesia
- "Don't feel right"
- Fatigue or low energy
- Sadness
- Nervousness or anxiety
- Irritability
- More emotional
- Confusion
- Concentration or memory problems (forgetting game plays)
- Repeating the same question/comment

Signs observed by teammates, parents and coaches include:

- Appears dazed
- Vacant facial expression
- Confused about assignment
- Forgets plays
- Is unsure of game, score, or opponent
- Moves clumsily or displays lack of coordination
- Answers questions slowly
- Slurred speech
- Shows behavior or personality changes
- Can't recall events prior to hit
- Can't recall events after hit
- Seizures or convulsions
- Any change in typical behavior or personality
- Loses consciousness

What can happen if my child keeps on playing with a concussion or returns too soon?

Students with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the student especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the student suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. Because students might not report symptoms of injury, it is critical that administrators, teachers, coaches, parents and students recognize the symptoms of a concussion and respond accordingly.

If you think your child has suffered a concussion

Any student suspected of suffering a concussion should be removed from the game, activity, or practice immediately. No student may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the student should continue for several hours. District 29 Board Policy 720.10 requires students to provide their school with written clearance from a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with Illinois state law, all public schools are required to follow this policy.

You should also inform your child's coach, nurse or classroom teacher if you think that your child may have a concussion. It is better to miss one game than miss the whole season. When in doubt, the student sits out.

Adapted from the CDC and the 3rd International Conference on Concussion in Sports Document created 7/1/2011

For more information on concussions:

http://www.cdc.gov/ConcussionInYouthSports/

www.ihsa.org/resources/sportsmedicine/concussionmanagement.aspx

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All parents are asked to sign and return this form to the school nurse indicating their receipt and review of this information. Students in grades 5-8 will not be allowed to participate in extra-curricular sports without a signed form.

_____	_____	_____
Parent or Legal Guardian Printed	Parent or Legal Guardian Signature	Date
_____	_____	_____
Student Name Printed (Gr. 5-8)	Student Signature (Gr. 5-8)	Date

Asthma Action Plan

AMERICAN LUNG ASSOCIATION®

General Information:

- Name _____
- Emergency contact _____ Phone numbers _____
- Physician/Health Care Provider _____ Phone numbers _____
- Physician Signature _____ Date _____

Severity Classification	Triggers	Exercise
○ Mild Intermittent ○ Moderate Persistent ○ Mild Persistent ○ Severe Persistent	○ Colds ○ Smoke ○ Weather ○ Exercise ○ Dust ○ Air pollution ○ Animals ○ Food ○ Other _____	1. Pre-medication (how much and when) _____ _____ 2. Exercise modifications _____ _____

Green Zone: Doing Well

Peak Flow Meter Personal Best =

Symptoms

- Breathing is good
- No cough or wheeze
- Can work and play
- Sleeps all night

Peak Flow Meter

More than 80% of personal best or _____

Control Medications

Medicine	How Much to Take	When To Take It

Yellow Zone: Getting Worse

Contact Physician if using quick relief more than 2 times per week.

Symptoms

- Some problems breathing
- Cough, wheeze or chest tight
- Problems working or playing
- Wake at night

Peak Flow Meter

Between 50 to 80% of personal best or

_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

IF your symptoms (and peak flow, if used) return to Green Zone after one hour of the quick relief treatment, THEN

- ○ Take quick-relief medication every 4 hours for 1 to 2 days
- ○ Change your long-term control medicines by _____
- ○ Contact your physician for follow-up care

IF your symptoms (and peak flow, if used) DO NOT return to the GREEN ZONE after 1 hour of the quick relief treatment, THEN

- ○ Take quick-relief treatment again
- ○ Change your long-term control medicines by _____
- ○ Call your physician/Health Care Provider within _____ hours of modifying your medication routine

Red Zone: Medical Alert

Ambulance/Emergency Phone Number:

Symptoms

- Lots of problems breathing
- Cannot work or play
- Getting worse instead of better
- Medicine is not helping

Peak Flow Meter

Between 0 to 50% of personal best or

_____ to _____

Continue control medicines and add:

Medicine	How Much to Take	When To Take It

Go to the hospital or call for an ambulance if

- ○ Still in the red zone after 15 minutes
- ○ If you have not been able to reach your physician/health care provider for help
- ○ _____

Call an ambulance immediately if the following danger signs are present

- ○ Trouble walking/talking due to shortness of breath
- ○ Lips or fingernails are blue