



## **SY25 New Student Enrollment Checklist**

All school forms and enrollment documents **MUST** be turned in to secure spot.

### **School Forms**

- School Enrollment Form
- Home Language Survey
- Federal Ethnic Survey
- Media Consent Form
- Emergency and Health Information Form
- School Messaging Consent Form
- Directory and Recruiter Opt-Out Form
- Family Income Verification Form (one per family)

### **Enrollment Documents**

- Proof of Age (Birth Certificate)
- Proof of Address, 2 forms: Utility Bill, Driver's License

### **Medical Forms Due by August 15th, 2024**

- Student Medical Information Form
- Illinois Medical Form (Not older than 1 year)
- Dental Form (Not older than 1 year)
- Eye Examination Report (Not older than 1 year)

### **School Use**

Student Name: \_\_\_\_\_

Received By: \_\_\_\_\_



# School Enrollment Form



Please print or type:

## Student Information

SCHOOL NAME

STUDENT ID#

**School Use Only:** Prevent duplicate student records. Search in Student Information System (SIS) for an existing Student ID before creating a new one.

REGISTRATION GRADE LEVEL  
*(when first entering CPS)*

LEGAL LAST NAME

LEGAL FIRST NAME

LEGAL MIDDLE NAME

GENERATION  
(Jr., etc)

BIRTH DATE  
*(mm/dd/yyyy)*

LEGAL SEX  
(F/M/N)

\*AFFIRMED GENDER  
(F/M/N/U)

\*AFFIRMED FIRST NAME

STUDENT'S SIBLINGS' NAMES IF CURRENTLY ENROLLED IN CPS:

\*Optional. For more information regarding affirmed gender and affirmed name, please visit: [Supporting Gender Diversity Toolkit](#)

\*AFFIRMED MIDDLE NAME

\*AFFIRMED LAST NAME

## Personal Information

BIRTH CERTIFICATE ON FILE  YES  NO

BIRTH VERIFICATION TYPE (BIRTH CERTIFICATE, PASSPORT, MEDICAL CARD ETC.)

\*BIRTH COUNTRY

BIRTH STATE

BIRTH CITY

\*Complete if student was not born in the United States (US) or one of its Territories:

DATE OF FIRST ENROLLMENT  
IN ANY US SCHOOL:

FULL YEARS COMPLETED  
SCHOOL IN US:

**School Use Only:** Note that "Date of first enrollment in any US School" becomes a required field in SIS if "Birth Country" is not the US or one of its Territories.

## Student Address/Phone

PHYSICAL (HOME) ADDRESS (include unit number if applicable)

City

State

Zip

HOME PHONE #

MAILING ADDRESS (include unit number if applicable) (if different than Home)

City

State

Zip

HOMELESS/TEMPORARY  
LIVING CONDITIONS

## Enrollment

LAST CHICAGO PUBLIC, OPTIONS, CHARTER, OR CONTRACT SCHOOL ATTENDED

\*SCHOOL TRANSFERRING FROM (if not a Chicago Public, Options, Charter, or Contract School)

CITY, STATE, ZIP

\*IS THE STUDENT IN GOOD STANDING?  YES  NO

*(Instructions to school: for out-of-state public school or any private school students, a certification of "good standing" should be received from the Parent/Guardian. Refer to CPS Policy 702.1 for more information.)*

IS THE STUDENT RECEIVING ANY TYPE OF SPECIAL EDUCATION SERVICES?  YES  NO IF YES, PROVIDE DETAILS

*(Instructions to school: if yes, please notify the Case Manager.)*

STUDENT ENROLLED BY (Print Last Name, First Name and Middle Name and Relationship)

## Included Information

FEDERAL ETHNIC AND RACE CATEGORIES: *(Enter information into SIS from the current Race and Ethnicity Survey form)*

HOME LANGUAGE SURVEY: *(Enter information into SIS from the current Home Language Survey form)*

PARENT/GUARDIAN CONTACTS: *(Enter information into SIS from the current Request for Emergency and Health Information form)*

EMERGENCY/HEALTH INFORMATION: *(Enter information into SIS from the current Request for Emergency and Health Information form)*

### Enrollment Status Codes:

- 01 – No Former School
- 02 – Chicago Public School (to incl. Options/Charter/Contract)
- 03 – Chicago Private School
- 04 – IL Public Schl, not Chicago
- 05 – IL Private Schl, not Chicago
- 06 – US Public Schl, not Illinois
- 07 – US Private Schl, not Illinois
- 08 – Not in USA

[CPS Enrollment and Leave Code User Guide](#)

Signature of Parent/Guardian

Date of Enrollment

*Must have an original signature; an electronic signature is not acceptable*

School Use Only:	ENROLLMENT STATUS CODE (insert a # from the left)	GRADE LEVEL	HOMEROOM/DIVISION #
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CUMULATIVE FOLDER



# Home Language Survey 2024-2025

Office of Language and Cultural Education



Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.

The state requires the district to collect a Home Language Survey for every new student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency and may be eligible for English Learner services.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME
SCHOOL NAME		
STUDENT ID #	NETWORK	ROOM #

## English

If the answer to either question is yes, the law requires the school to assess your child's English language proficiency.

1. Is a language other than English spoken in your home?  Yes  No Which language?

2. Does the student speak a language other than English?  Yes  No Which language?

## Spanish/Español

Si la respuesta a cualquiera de las preguntas es "Sí", la ley requiere que la escuela evalúe la competencia de su niño en inglés.

1. ¿Se habla algún otro idioma que no sea inglés en su hogar?  Sí (yes)  No (no) ¿Cuál idioma?

2. ¿Habla el estudiante algún otro idioma que no sea inglés?  Sí (yes)  No (no) ¿Cuál idioma?

## Chinese / 中文

如果兩個問題中有任何一題的答案為“是”，根據法律要求，學校將評測您子女的英語水平。

英語之外的其他語言?  是的 (yes)  不是 (no) 什麼語言?

女是否說英語之外的其他語言?  是的 (yes)  不是 (no) 什麼語言?

## Arabic / العربية

إذا كانت الإجابة على أي من السؤالين نعم، فإن القانون تطلب من المدرسة تقييم إتقان طفلك للغة الإنجليزية.

هل تُستخدم لغة أخرى غير اللغة الإنجليزية في منزلك؟  لا (no)  نعم (yes) أي لغة؟

هل يتحدث الطالب لغة أخرى غير اللغة الإنجليزية؟  لا (no)  نعم (yes) أي لغة؟

## Polish/Polski

Jeśli udzielił Państwo twierdzącej odpowiedzi na którekolwiek z pytań, przepisy wymagają aby szkoła sprawdziła poziom znajomości języka angielskiego waszego dziecka.

1. Czy mówi się w domu językiem innym niż angielski?  Tak (yes)  Nie (no) Jakim językiem?

2. Czy uczeń mówi innym językiem niż angielski?  Tak (yes)  Nie (no) Jakim językiem?

## Ukrainian / Українська

Якщо ви відповіли «Так» на будь-яке з цих запитань, школа буде зобов'язана за законом оцінити рівень володіння вашою дитиною англійською мовою.

1. Чи розмовляєте Ви вдома іншою мовою окрім англійської?  Так (yes)  Ні (no) Якою мовою?

2. Чи розмовляє Ваша дитина іншою мовою окрім англійської?  Так (yes)  Ні (no) Якою мовою?

Signature of School Official	Date	Parent/Guardian Signature	Date
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Must have an original signature; an electronic signature is not acceptable

### OFFICE USE ONLY

Please make sure both questions are answered completely and that the parents/guardians sign and date the form.

If the language spoken by the parent/guardian is not included on either page of this form, please visit the OLCE Employee Intranet Page, Forms, and click on "Home Language Survey in Additional Languages" which will take you to ISBE's HLS page.

If the parent/guardian does not speak English and the school does not have staff who speaks the parent/guardian's language, identify the language spoken by the parent/guardian through any assistance available in the school, i.e. using interpretation services from a vendor.

### ASPEN REGISTRATION PROCESS

All five fields have to be entered on Aspen: date, answer to question 1, Home language, answer to question 2, and Native language.

When a language other than English is reported for only one of the questions on the form, that Non-English language has to be listed as both Home and Native Language in Aspen.

If there are two different languages other than English listed, enter the language identified in question 2 as both Home and Native language. If there is more than one language listed in question 2, check with the family, since only one of the languages can be entered on Aspen.

English can be entered as the Home language ONLY if both questions are answered No and English is listed for both questions.

If the language is not included on the list of languages available on Aspen, enter "Other" temporarily, but contact OLCE as soon as possible so that the district can ask ISBE to add the new language. An Student Reclassification Recommendation (SRR) will have to be submitted to OLCE to correct the language at a later date.

Maintain Home Language Survey in the Student Cumulative Folder. If the student is an English Learner (EL), maintain the original survey in the Cumulative Folder and also maintain a copy of the survey in the student's English Learner Folder.



# Home Language Survey 2024-2025

Office of Language and Cultural Education



Complete this Home Language Survey at the student's initial enrollment in a Chicago Public School.

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME
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SCHOOL NAME
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STUDENT ID #	NETWORK	ROOM #
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**Bosnian/Serbian(Latin) Bosanski/Srpski** Ukoliko ste na bilo koje od ovih pitanja odgovorili sa „Da“, škola će biti zakonski dužna da procijeni nivo znanja engleskog jezika kod vašeg djeteta.

1. Da li se u kući govori na stranom jeziku (različitom od engleskog)?  Da (yes)  Ne (no) Koje jezike?

2. Da li učenik govori neki drugim jezikom (različitim od engleskog)?  Da (yes)  Ne (no) Koje jezike?

**Vietnamese / Tiếng Việt** Nếu câu trả lời cho một trong hai câu hỏi trên là có thì luật pháp yêu cầu trường học phải đánh giá khả năng thông thạo Anh ngữ của con quý vị.

1. Ngôn ngữ khác tiếng Anh có được sử dụng trong nhà quý vị không?  Có (yes)  Không (no) Ngôn ngữ gì?

2. Con quý vị có nói một ngôn ngữ khác ngoài tiếng Anh không?  Có (yes)  Không (no) Ngôn ngữ gì?

**Urdu / اردو** اگر کسی بھی سوال کا جواب ہاں میں ہے تو، قانون کے تحت اسکول سے آپ کے بچے کی انگریزی زبان کی مہارت کا اندازہ لگانا پڑتا ہے۔

کیا آپ کے گھر میں انگریزی کے علاوہ کوئی دوسری زبان بولی جاتی ہے؟  ہاں (yes)  نہیں (no) کون سی زبان؟

کیا طالب علم انگریزی کے علاوہ کوئی دوسری زبان بول سکتا ہے؟  ہاں (yes)  نہیں (no) کون سی زبان؟

**Pashto/انگلیسی** که د هرې پوښتنې ځواب هو وي، قانون له مخې پوښتونځي اړتيا لري چې ستاسو د ماشوم د انگلیسی ژبې مهارت ارزونه وکړي.

آیا ستاسو په کور کېد انگلیسی پرته بله ژبه وپلکیري؟  هو (yes)  نه (no) کومه ژبه؟

آیا ستاسو ماشوم د انگلیسی پرته په بله ژبه خبرې کوي؟  هو (yes)  نه (no) کومه ژبه؟

**Gujarati / ગુજરાતી** તમારા બાળકના અંગ્રેજી ભાષાના કૌશલ્ય માટે આકારણી કરाववा मांगे છે. જો બન્નેમાંથી કોઈ એક પુસ્ત્રનો જવાબ પણ હા માં હોય તો, કાયદો શાળા પાસે

1. શું આપના ઘરમાં અંગ્રેજી સિવાયની ભાષા અન્ય કોઈ ભાષા બોલ આવે છે?  હા (yes)  નહીં (no) કઈ ભાષા?

2. શું વિદ્યાર્થીઓ અંગ્રેજી સિવાયની કોઈ ભાષા બોલે છે?  હા (yes)  નહીં (no) કઈ ભાષા?

**Yoruba / Yorùbá** Tí idáhùn sí ibèèrè nàá bá jẹ̀ Bẹ̀ẹ̀ni, òfin bèèrè pé kí ilé-ẹ̀kọ́ nàá ẹ̀e igbéléwọ̀n bí ọmọ ẹ̀dè Gẹ̀ẹ̀sì sí.

1. Njẹ ẹ n sọ èdè miran yatọ si Èdè-Gẹ̀ẹ̀sì ninu idile yin bí?  Bẹ̀ẹ̀ni (yes)  Bẹ̀ẹ̀kọ (no) Edè wo?

2. Ẹ akẹ̀kọ̀ọ́ nàá n sọ èdè miran yatọ sí èdè-Gẹ̀ẹ̀sì bí?  Bẹ̀ẹ̀ni (yes)  Bẹ̀ẹ̀kọ (no) Edè wo?

**Russian / Русский** Если на любой из этих вопросов дан утвердительный ответ, согласно законодательству школа должна оценить уровень владения английским языком вашего ребёнка.

1. Вы говорите у себя дома на ином языке, нежели на английском?  Да (yes)  Нет (no) На каком языке?

2. Ваш ребёнок говорит на ином языке, нежели на английском?  Да (yes)  Нет (no) На каком языке?

**Tagalog/Tagalog** Ayon sa batas, kung "Oo" ang sagot sa parehong tanong, kailangan suriin ng paaralan ang kakayahan at kaalaman na mag-aaral sa wikang Ingles.

1. May iba pa bang lengguwahe bukod sa Ingles na ginagamit sa iyong tahanan?  Mayroon (yes)  Wala (no) Anong wika?

2. May ginagamit ba na ibang lengguwahe ang mag-aaral bukod sa Ingles?  Mayroon (yes)  Wala (no) Anong wika?

Signature of School Official	Date	Parent/Guardian Signature	Date
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Maintain Home Language Survey in the Student Cumulative Folder. If the student is an English Learner (EL), maintain the original survey in the Cumulative Folder and also maintain acopy of the survey in the student's English Learner Folder. *Must have an original signature; an electronic signature is not acceptable*



# Race and Ethnicity Survey



please print or type:

STUDENT LAST NAME		FIRST NAME	MIDDLE NAME
GENDER	SCHOOL NAME		
BIRTH DATE	SCHOOL ID (6 digits) to be completed by school staff		

## Instructions

Please answer the questions below. Both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

## PART A

Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) Choose only one.

- No, not Hispanic/Latino**
- Yes, Hispanic/Latino**

*The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to PART B below by marking one or more boxes to indicate what you consider this student's race to be.*

## PART B

What is the student's race? Choose one or more.

- American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- Black or African American** (A person having origins in any of the black racial groups of Africa.)
- Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)



# 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.

Please print or type:

Student Last Name	First Name	Middle Name	Birth Date (mm/dd/yyyy)
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Name of Parent/Guardian/Student if age 18 or older

School Name	Grade	Student ID #
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Signature of Parent/Guardian/Student if age 18 or older	Date
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*Must have an original signature. An electronic signature is not acceptable.*

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.



# Request for Emergency and Health Information



**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.

SCHOOL NAME		STUDENT ID#	
STUDENT LAST NAME	FIRST NAME	MIDDLE NAME	
STUDENT HOME ADDRESS (include unit number if applicable)		City	State Zip
BIRTH DATE (mm/dd/yyyy)	HOMEROOM #	HOME/PRIMARY PHONE #	
<b>CONFIDENTIAL INFORMATION BOX 1</b> 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.) <b>Check one box:</b>		<b>CONFIDENTIAL INFORMATION BOX 2</b> Is there a current Order of Protection or Civil No Contact Order which concerns this student? <b>YES NO</b> Is there a current Temporary Restraining Order or Injunction which concerns this student? <b>YES NO</b>	
in a car/park/other public place/abandoned building/substandard housing doubled-up in a hotel/motel/trailer park/camping ground in a shelter in transitional housing		<b>School Note:</b> If any box is checked, see the CPS Policy 702.5.	
		<b>School Note:</b> If "Yes," follow CPS Policy 704.4 procedures. Enter information in <i>Legal Alert</i> field and update contact information, as needed, in SIS.	

## PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION: Add extra contacts on additional page, if needed.

	PRIMARY PARENT/GUARDIAN CONTACT			PARENT/GUARDIAN CONTACT			PARENT/GUARDIAN CONTACT		
	DCFS Contact			DCFS Contact			DCFS Contact		
Contact First Name, Last Name									
Relationship to Student									
<b>Check all that apply:</b>	Lives With Emergency	Gets Mailings Permission to Pick up		Lives With Emergency	Gets Mailings Permission to Pick up		Lives With Emergency	Gets Mailings Permission to Pick up	
Home Address, if different from student's (include unit number if applicable)									
Primary Phone Number	Cell	Home	Work	Cell	Home	Work	Cell	Home	Work
Secondary Phone Number	Cell	Home	Work	Cell	Home	Work	Cell	Home	Work
Third Phone Number	Cell	Home	Work	Cell	Home	Work	Cell	Home	Work
E-mail Address									
* Communication Language									
Requires Translator	YES	NO		YES	NO		YES	NO	

\* 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, neighbor, family friend, or trusted adult who can also be notified in an emergency and has permission to pick up the student:

NAME	RELATIONSHIP	TELEPHONE #
ADDRESS		

## FAMILY DOCTOR'S NAME, ADDRESS, AND PHONE NUMBER:

I authorize you to call my family doctor, if necessary, in an emergency: **YES NO**

NAME	ADDRESS (include unit number if applicable)	City	State	Zip
TELEPHONE #				

<b>STUDENT HEALTH INSURANCE: (select only one of the three)</b> 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? <b>YES NO</b> Private/Employer Health Insurance: no additional information needed.		<b>CHILDREN OF MILITARY PERSONNEL (optional)</b> As the Parent or Guardian, are you a member of a branch of the armed forces of the United States? <b>YES NO</b> If yes, are you either deployed to active duty or expect to be deployed to active duty during the school year? <b>YES NO</b>	
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Parent/Guardian Signature

Date

Must have an original signature. An electronic signature is not acceptable.



# 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 a phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, COVID-19 information and screenings, 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 through 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 phone numbers, including cellular numbers, listed on the student's record. Please make sure these numbers are updated with your school.

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

**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 and texts, 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 and text messages unless or until you revoke your consent. Standard messaging rates and data may apply.**

**I CONSENT as outlined in the above section.**

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

*please print or type:*

_____ Student Last Name				_____ First Name				_____ Middle Name				_____ Birth Date (mm/dd/yyyy)			
_____ Name of Parent/Guardian/Student if age 18 or older															
_____ School Name								_____ Grade				_____ Student ID #			
_____ Signature of Parent/Guardian/Student if age 18 or older												_____ Date			

*Must have an original signature. An electronic signature is not acceptable.*

### PRIORITY #1

_____ Last Name								_____ First Name																					
_____ Primary Phone				Cell	Home	Work				_____ Secondary Phone				Cell	Home	Work				_____ Third Phone				Cell	Home	Work			

### PRIORITY #2

_____ Last Name								_____ First Name																					
_____ Primary Phone				Cell	Home	Work				_____ Secondary Phone				Cell	Home	Work				_____ Third Phone				Cell	Home	Work			

### PRIORITY #3

_____ Last Name								_____ First Name																					
_____ Primary Phone				Cell	Home	Work				_____ Secondary Phone				Cell	Home	Work				_____ Third Phone				Cell	Home	Work			





# Directory and Recruiter Opt-Out Information Sheet

Department of Policy and Procedures



**This Information Sheet for Students and Parents provides instructions on how you can use the “Directory and Recruiter Information Opt-Out Form” to prevent the release of your child’s student directory information. An Opt-Out Form is enclosed for your convenience.**

*The Family Educational Rights and Privacy Act (FERPA), Illinois School Student Records (ISSRA), and Chicago Board of Education Policy 706.3 Parent and Student Rights of Access to and Confidentiality of Student Records* require that Chicago Public Schools (CPS) obtain your written consent before disclosing personally identifiable information from your child’s education records, with certain exceptions. **The Chicago Public Schools may disclose “directory information” without written consent, unless you have advised the District that you do not want the information shared by using the form attached.** This form is to be turned in at time of enrollment and by December 1st.

## Who will have access to this directory information?

CPS may share directory information with third parties (such as city agencies or educational service providers) who have an educational interest in the information and request it. All requests from external parties related to research are reviewed by the CPS School Quality Measurement & Research or the CPS Office of College and Career Success to ensure the request is in the interest of students.

## What is directory information?

Directory information is information that is generally not considered harmful or an invasion of privacy if released. CPS has designated the following as directory information: student’s name; parents’ names; home address; home telephone number; date of birth; grade level; dates of attendance; school photographs; and most recent CPS school attended.

## How do I complete the CPS Directory Information Opt-Out Program Process?

A parent/guardian or student age 18 or older **must complete this form and return it to the school clerk annually at time of enrollment/registration.** The completed opt-out form must be returned to the school no later than December 1 annually. If you have more than one child attending CPS, you must submit a separate request for each child. The Opt-Out Form requires a student identification number. Please make sure you record the 8-digit ID number on the form accurately.

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## For parents/guardians of JUNIORS and SENIORS ONLY:

By law, if military recruiters request contact information (name, address, phone number) for 11th- or 12th-grade students, CPS is required to provide that information unless you choose to block it. Colleges and universities also may request student information. Using the Chicago Public Schools Opt-Out form, you may block the release of your contact information to military recruiters, or to colleges and universities, or to both.

Having your name placed on the Opt-Out list does not in any way limit your ability to request your school to send a transcript or any other material on your behalf to a college or university, a military recruiter, or others, upon request.

## Questions or Concerns?

If you have questions about CPS policy related to the release of student information to third parties, recruiters, or universities please contact [policy@cps.edu](mailto:policy@cps.edu).



# Directory and Recruiter Information Opt-Out Form

Department of Policy and Procedures



Complete this form only if you are opting out of any of the choices provided.

Dear Student, Parent or Guardian:

You have the right to inspect and copy your student's records, challenge the contents of such records, and limit your consent to the designated records or designated portions of information within the records.

If you DO NOT want directory information disclosed, complete this form and return it to the school clerk at time of enrollment/registration. If you do not submit a completed Opt-Out Form, your child's directory information may be provided to recruiters and external parties by CPS upon their request. If you submit this form but do not check at least one box, your child's directory information may be provided to recruiters and external parties upon their request. If you have more than one child attending CPS, you must submit a separate request for each child.

*please print or type:*

_____	_____	_____	_____
<b>Student Last Name</b>	<b>First Name</b>	<b>Middle Name</b>	<b>Student ID Number (8 digits): This is required</b>
_____			_____
<b>School Name</b>			<b>Date</b>

## FOR ALL ELEMENTARY, MIDDLE AND HIGH SCHOOL STUDENTS

**DO NOT disclose my child's directory information to any external party without my prior consent.**

## FOR HIGH SCHOOL JUNIOR AND SENIOR STUDENTS ONLY

You may block the release of your contact information specifically to military recruiters, colleges and universities, or both by checking the boxes below.

**DO NOT disclose my child's directory information to military recruiters without my prior consent.**

**DO NOT disclose my child's directory information to colleges and universities without my prior consent.**

_____	_____	_____	<b>Relationship to Student: Select one</b>	
<b>Last Name</b>	<b>First Name</b>	<b>Middle Name</b>	<b>SELF</b>	<b>PARENT / GUARDIAN</b>

**Signature**

*Must have an original signature. An electronic signature is not acceptable.*



# CPS Family Income Information Form 2024 - 2025



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.

Parents—Please return form to school by **October 30, 2024**.

Schools—Please enter into ODA by **November 20, 2024**.

please print or type:

STUDENT LAST NAME		STUDENT FIRST NAME		STUDENT MIDDLE NAME	
SCHOOL NAME		STUDENT ID		DOES YOUR FAMILY HAVE INTERNET SERVICES AT HOME? YES NO	

**PART 1: Household Information** — List all members of your household living with you.  
*\*Foster Children (legal responsibility of welfare agency or court)*

**PART 2: SNAP/TANF number of any member of your household (go to part 6)**

FOSTER CHILD?	CPS STUDENT?	ALL HOUSEHOLD MEMBER NAMES			DATE OF BIRTH	DHS SNAP OR TANF CASE NUMBER (LAST 9 DIGITS)
		Last	First	M.I.		

### PART 3: Homeless, Runaway Child, or child enrolled in Head Start

HOMELESS RUNAWAY HEAD START	Homeless, Runaway or Head Start Liaison Signature	Date
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### PART 4: List Household Members With Income (SKIP THIS if you answered any of parts 2 or 3)

Enter the amount of income and how often it is received for each household member.

**Frequency:** Weekly, Every 2 Weeks, Twice Monthly, Monthly, Annually

**OTHER INCOME** can be but not limited to Welfare, Child Support, Retirement, Social Security, Worker's Compensation, and Unemployment.

HOUSEHOLD MEMBER NAMES WITH INCOME			GROSS INCOME (before deductions)	OTHER INCOME				
First	Last	M.I.		Weekly	Every 2 Weeks	Twice Monthly	Monthly	Annually
			\$					
			\$					
			\$					
			\$					
			\$					

### PART 5: Opt in for information about other benefits.

YES! I am interested in applying for a waiver of instructional fees.

YES! I am interested in applying for the Supplemental Nutrition Assistance Program (SNAP) and/or the Medicaid Program. Or call 773-553-5437

YES! This student/these students have a parent who is a veteran or active military member. Students with a parent who is a veteran or active military may qualify for a fee waiver.

Signature

### PART 6

**Signature:** 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 and screen CPS students for eligibility for other benefits and that school officials may verify (check) the information as being accurate; and that if I purposely give false information, I may be prosecuted. I consent to the district sharing eligibility status in order to receive benefits based on eligibility status.

Signature of adult household member

Parent / Guardian First Name

Parent / Guardian Last Name

Address

Zip Code

Date

Must have an original signature. An electronic signature is not acceptable.



# CPS Family Income Information Form 2024 - 2025



## 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 | Black / African American        | Native Hawaiian /<br>Other Pacific Islander |
| White | American Indian / Alaska Native |   |

## 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 DHS case number (SNAP or TANF) 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, 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, 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.

## SCHOOL USE ONLY

**Initial Determination:**      ELIGIBLE (Free or Reduced)      INELIGIBLE (Denied, N/A or ?)

### CONFIRMATION (Only for those applications selected for verification)

Signature of Confirming Official (Required) \_\_\_\_\_

Date \_\_\_\_\_



# Student Medical Information 2024 - 2025



**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).

*please print or type:*

STUDENT LAST NAME		FIRST NAME		MIDDLE NAME
GENDER (F / M / X / N)	STUDENT DATE OF BIRTH		SCHOOL NAME	
STUDENT ID #	GRADE		ROOM #	

### 1. DOES YOUR CHILD HAVE ANY KNOWN HEALTH CONDITIONS?

YES      NO

If your child has a health condition, please schedule an appointment with your school nurse. Please check all that apply:

Allergies (food or other)

List Allergies: \_\_\_\_\_

Asthma

Year Diagnosed \_\_\_\_\_

Seizures/Epilepsy

Year Diagnosed \_\_\_\_\_

Diabetes (please select one)    Type 1    Type 2    Other

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 [cps.edu/oshw](https://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.**

**Please return the form to the school nurse. If the student has a health condition, parents must schedule a meeting with the school nurse.**

Parent/Guardian Name \_\_\_\_\_ Date \_\_\_\_\_ Phone Number \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Email \_\_\_\_\_

**Nurses Use Only**    Reviewed by (Initials) \_\_\_\_\_    Date \_\_\_\_\_

*Must have an original signature.  
An electronic signature is not acceptable.*

Revised February 2024



## State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES  
CFS 600  
Rev 2/2013



<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>
Last	First	Middle	Month/Day/Year			
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		
	<b>DTP or DTaP</b>																	
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>								
<b>MMR</b> Combined Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>											
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> 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.)

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

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

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**

<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (List all prescribed or taken on a regular basis.)		
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)			<b>Parent/Guardian Signature</b>	<b>Date</b>	
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**      **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.      **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 <input type="checkbox"/> No <input type="checkbox"/>	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  Limited

Print Name \_\_\_\_\_ (MD,DO, APN, PA)      Signature \_\_\_\_\_      Date \_\_\_\_\_

Address \_\_\_\_\_      Phone \_\_\_\_\_

(Complete Both Sides)



## PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten, 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 require 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:	
Parent or Guardian: Last Name	First Name		
Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.			
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Two or More Races			

### 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

- 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). Please 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: \_\_\_\_\_

Dental Office Address: \_\_\_\_\_ Office phone number: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_







## 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 \_\_\_\_\_ (Month/Day/Year) Gender \_\_\_\_\_ Grade \_\_\_\_\_

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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

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 \_\_\_\_\_



# 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 \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

<p align="center"><b>Consent of Parent or Guardian</b></p> <p>I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p align="center">_____ (Parent or Guardian's Signature)</p> <p align="center">_____ (Date)</p>
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(Source: Amended at 32 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)



# Minimum Health Requirements 2024 - 2025



Evidence shows that healthy students have better attendance patterns and perform better academically. The State of Illinois requires parents/guardians to provide proof of required immunizations and school physical exams before October 15, 2024, or their child will face exclusion from school. For more information about CPS health requirements, contact your School Nurse.

Health insurance can provide children and their families with health care coverage that can be used for doctor's visits, immunizations, medications, dental care, eye exams, glasses, and more! Medicaid Insurance provides coverage for children in Illinois, regardless of immigration status.

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

If you need help finding a health center near you, visit [findahealthcenter.hrsa.gov](https://findahealthcenter.hrsa.gov).



## Examination Requirements

### Physical Examination

Due upon enrollment or no later than 10/15/24

- Must be completed within 12 months prior to entry to: PE/PK, Kindergarten, 6th Grade, 9th Grade, and any student entering CPS for the first time

### Vision Examination

Due upon enrollment or no later than 10/15/24 for:

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

### Dental Examination

Due 5/15/25 for Kindergarten, 2nd, 6th, and 9th Grade.

## Recommended Vaccines

**CPS recommends that if you have questions about which vaccines are best for you and your child, talk to your doctor or other healthcare professional who knows your health history.**

**HPV:** Recommended to prevent some HPV (human papillomavirus)-related cancers. Recommended at age 11 or 12 years.

**COVID-19:** Helps protect you from severe illness, hospitalization, etc. Recommended for everyone 6 months and older.

**Influenza:** Recommended for all people 6 months and older to get a flu vaccine every year.

These vaccines are recommended by medical providers. They are not required in Illinois for a child to attend school. For more information visit: [cps.edu/vaccine](https://cps.edu/vaccine)



# Minimum Health Requirements 2024 - 2025



## Immunization Requirements

### Due upon Enrollment or No Later Than 10/15/24

Many children missed check-ups and recommended childhood vaccinations over the past few years. CDC and the American Academy of Pediatrics (AAP) recommend children catch up on routine childhood vaccinations and get back on track for school, childcare, and beyond. Getting your child caught up with recommended and school-required vaccinations is the best way to protect them from a variety of vaccine-preventable diseases. The vaccines below are required by the State of Illinois for students attending school unless CPS receives an [Illinois Certificate of Religious Exemption Form](#).

To learn more about each vaccine type, talk with your child's healthcare provider or visit: [cdc.gov/vaccines/parents](https://cdc.gov/vaccines/parents)

### Diphtheria, Pertussis, Tetanus

- **Early Childhood (PE/PK):** 3 doses of DTP or DTaP by 1 year of age. One additional booster dose by 2nd birthday.
- **First Entry into School (Kindergarten or 1st Grade):** 4 or more doses of DTP/DTaP with the last dose being a booster and received on or after the 4th birthday.
- **First Entry into School (Other Grades):** 3 or more doses of DTP/DTaP or Td; with the last dose qualifying as a booster if received on or after the 4th birthday
  - Entering 6th grade, for students (under age 11), one dose of Tdap
  - A dose of Tdap or DTaP administered at 10 years of age or later may now be counted as the adolescent Tdap booster
- **Minimum interval between series doses:** 4 weeks (28 days).  
Between series and booster: 6 months

### Polio

- **Early Childhood (PE/PK):** 2 doses by 1 year of age. One additional dose by 2nd birthday. 3 doses for any child 24 months of age or older appropriately spaced.
- **First Entry into School (Kindergarten or 1st Grade):**
  - Any child entering Kindergarten shall show proof of 4 doses with the last dose on or after the 4th birthday.
  - In accordance with the ACIP catch-up series a 4th dose of Polio is not needed if the 3rd dose was administered at age four or older and at least six months after the previous dose was administered.
- **First Entry into School (Other Grades):**
  - 3 or more doses of polio vaccine with the last dose on or after the 4th birthday.
- The 4-dose requirement applies to grades K-6
- **Minimum interval between series doses:** 4 weeks (28 days)
- 4th dose at least 6 months after previous dose

### Measles, Mumps, and Rubella

- **Early Childhood (PE/PK):** 1 dose on or after the 1st birthday.
- **Kindergarten through 12th Grade:** 2 doses of measles/mumps/rubella vaccine, the first dose must have been received on or after the 1st birthday and the second dose no less than 4 weeks (28 days) later.
- Proof of prior **measles** disease shall be verified by a physician and laboratory evidence.
- Proof of prior **mumps** disease shall be verified by a physician or laboratory evidence.
- Laboratory evidence of **rubella** immunity

### Haemophilus influenzae type b (Hib)

- **Early Childhood (PE/PK):** Proof of immunization that complies with the ACIP recommendation for Hib vaccination. Children 24-59 months of age without series shall show proof of 1 dose of Hib vaccine at 15 months or older.
- **Kindergarten through 12th Grade:** Not required for any child 5 years of age or older.

### Invasive Pneumococcal Disease (PCV)

- **Early Childhood (PE/PK):** Proof of immunization that complies with ACIP recommendations for PCV. Children 24 to 59 months of age without a primary series of PCV, shall show proof of receiving 1 dose of PCV after 24 months of age.
- **Kindergarten through 12th Grade:** Not required for any child 5 years of age or older.

### Hepatitis B

- **Early Childhood (PE/PK):** 3 doses appropriately spaced. (see doses under minimum interval). Third dose must have been administered on or after 6 months of age.
- **First Entry into School (Kindergarten or 1st Grade):** Kindergarten through 5th grade is not a requirement.
- **First Entry into School (Other Grades):** Students entering 6th thru 12th grade, three doses of hepatitis B vaccine administered at appropriate intervals.
- **Minimum intervals between doses:** Between 1st and 2nd doses must be at least 4 weeks. Between 2nd and 3rd must be at least 8 weeks. Between 1st and 3rd must be at least 16 weeks.
- Proof of prior or current infection, if verified by laboratory evidence, may be substituted.

### Varicella (Chickenpox Vaccine)

- **Early Childhood (PE/PK):** 1 dose on or after 1st birthday.
- **Kindergarten through 12th Grade:** 2 doses for students entering all grades; The 1st dose must have been on or after the 1st birthday and the 2nd dose no less than 4 weeks (28) days later.
- Proof of prior varicella disease shall be verified by a physician or a healthcare provider or laboratory evidence.

### Meningococcal Disease (MCV4), (MenACWY)

MenACWY vaccines may be administered at same time with Men B vaccines, but at a different anatomic site.

- **First Entry into School (Other Grades):**
  - **Applies to students entering 6th - 11th grades:** 1 dose of meningococcal conjugate vaccine
  - **12th grade entry:** 2 doses of meningococcal conjugate vaccine
- **Minimum intervals for administration:**
  - **For 6th grade entry:** the first dose received on or after the 11th birthday
  - If earlier vaccination (between ages 10 and 11) then follow [Illinois Department of Public Health protocols](#).
  - **For 12th grade entry:** 2nd dose on or after the 16th birthday and an interval of at least 8 weeks after the first dose
  - Only 1 dose is required if the 1st dose was received at 16 years of age or older.