

Union Ridge School District 86  
4600 N. Oak Park Ave. Harwood Heights, IL 60706  
708-867-5822

## General Registration



When registering bring the following:

- Student's birth certificate
- Parent/Guardian Picture ID
- Custody documents(if applicable): court order agreement, judgment or decree that gives custody of the child to any person, including divorce decrees to one or both parents
- Illinois State "Good Standing" Transfer Form (Students transferring from Illinois public schools, grades 1-8)
- Current physical/immunization record on the Illinois Department of Human Services (DHS) form.
- **EC NEW STUDENTS ONLY : *Proof of income is required. Examples include, Pay stubs, CCAP, WIC, SNAP, TANF, Medicaid benefits. Most recent tax return or letter from employer. Signed written statement from the family, only if you have no income source.***

### One of the following:

- Current mortgage/current closing papers
- Property tax bill
- A signed and dated lease with proof of most recent rent payment (cancelled check/receipt). If you do not have a current lease, please contact the office or go on line for a "Letter of Residence from Landlord in Lieu of Lease" form.
- A letter of residency is to be used when the person seeking to enroll a student is living with a district resident. An affidavit of residency must be completed by the guardian of the student and the district resident

### And any three of the following:

- Illinois vehicle registration
- Harwood Heights / Norridge vehicle sticker receipt
- Voter registration
- Current cable or credit card bill
- Current public aid card
- Current homeowners/renters' insurance and premium payment receipt
- Utility bill (gas, electric, or water)
- Bank statement
- Illinois driver's license/Illinois State ID.
- U.S. mail received at residence

# Union Ridge School Dist. 86, Harwood Heights, IL

## Early Bird Special

Kindergarten to 8<sup>th</sup> Grade - \$230.00 per student  
includes the \$50.00 technology fee per student and  
\$30.00 device insurance fee per student

**After June 30, 2024** - \$230.00 per student  
includes the \$50.00 technology fee per student  
\$30.00 device insurance fee per student  
and a \$25.00 fee per **family**

**No Registration Fee for Early Childhood**

☐ **Please check if New Student**

FAMILY NAME: \_\_\_\_\_  
Single Parent Household ☐ Yes ☐ No

Is mother an active member of the military? ☐ Yes ☐ No

Is father an active member of the military? ☐ Yes ☐ No

STUDENT NAMES	GRADE	FEE	Technology Fee
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Make checks or money orders payable to **Union Ridge School Dist. 86**

Total Fee Due \$

Office Use Only:

Check/Money Order # \_\_\_\_\_ Cash \$ \_\_\_\_\_ Date \_\_\_\_\_

Online \$ \_\_\_\_\_

## **FEES**

A nominal fee is charged for educational purposes each year.

### **Waiver of Fees for In-District Students**

Book and fee costs may be waived when requested by the parent or guardian, if the family qualifies financially under the guidelines established for free lunch under the National School Lunch program. Fees may also be waived where there is a very significant loss of income due to severe illness or injury in the family or unusual expenses such as fire, flood, or storm damage.

School fees may include:

1. All charges for required textbooks and instructional materials.
2. All charges and deposits collected by a school for use of school property.
3. Charges for field trips made during school hours, or made after school hours if the field trip is a required or customary part of a class or extra-curricular activity.
4. Charges for supplies required for a particular class.
5. Graduation fees.
6. School records fees.

School fees *do not* include:

1. Library fines and other charges made for the loss, misuse, or destruction of school property.
2. Charges for the purchase of yearbooks, pictures, diploma covers or similar items.
3. Charges for optional travel undertaken by a school club or group of students outside of school hours.
4. Charges for admission to school dances, athletic events or other social events.
5. Optional community service programs for which fees are charged such as preschool, before-and after-school child care, recreation programs.

If an application for assistance is denied, the family may appeal to the Superintendent of the District.

# UNION RIDGE SCHOOL STUDENT ENROLLMENT FORM

[Print Form](#)

**DETERMINING RESIDENCY:** Pupil residency is generally to be determined by the residence of the person who has legal custody of the student. Legal custody means that exercised by a natural parent, an adoptive parent, or a foster parent when the youth has been placed by a court or the Department of Children and Family Services (DCFS).  
**CRIMINAL SANCTIONS:** A person who knowingly enrolls an non-resident student on a tuition-free basis or presents a school district with false information on a non-resident student is guilty of a Class C misdemeanor.

I attest that the information below is truthful and accurate and that I am a legal resident of Union Ridge School District. 86.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

## STUDENT INFORMATION

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Race/Ethnicity: Is Student Hispanic/Latino? \_\_\_\_\_

What is Student's Race? Check all that apply

☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White

School(s) attended in the last 3 years

School Name: \_\_\_\_\_ School Location: \_\_\_\_\_ Grade: \_\_\_\_\_

School Name: \_\_\_\_\_ School Location: \_\_\_\_\_ Grade: \_\_\_\_\_

Student Currently lives with: \_\_\_\_\_

Marital Status of Parents? Check all that apply

In the event that the parents are divorced a copy of the custody agreement must be filed with the school office.

☐ Married ☐ Divorced ☐ Unmarried ☐ Father re-married ☐ Mother re-married ☐ Father Deceased ☐ Mother Deceased

Other children in the family:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

For Office Use ONLY

☐ BC ☐ Fee  
☐ TR ☐ RES  
☐ Cust ☐ MED

## FATHER'S INFORMATION

Custodial Parent: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Please provide address if different from above

Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## MOTHER'S INFORMATION

Custodial Parent: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Please provide address if different from above

Maiden Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

## Home Language Survey

**Purpose:** To provide the best possible service for your child.

Student: \_\_\_\_\_ Student Date of Birth: \_\_\_\_\_

Country and City of Birth: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

The State requires the district to collect information on 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.

**Please answer the questions below.**

1. Is a language other than English spoken in your home? YES NO

What language? \_\_\_\_\_

2. Does your child speak a language other than English? YES NO

What language? \_\_\_\_\_

**If the answer to either question is "Yes" the law requires that the school assess your child's English language proficiency.**

**YOUR CHILD WILL BE GIVEN THE STATE 'ACCESS' TEST EVERY YEAR UNTIL HE/SHE MEETS THE STATE REQUIREMENTS.**

3. How many years has your child attended school in the United States? \_\_\_\_\_

4. What year did your child start school in the United States? \_\_\_\_\_

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

**UNION RIDGE SCHOOL STUDENT ENROLLMENT**  
**Acceptable Use Policy**  
**Student Contract**

Rules for using the Internet help everyone. By following the rules (listed on the next page), everyone can use the Internet to learn more about the world and communicate with others. Only students who follow these rules may use the Internet and other telecommunication tools. Using the Internet is a responsibility and a privilege, not a right. Inappropriate use will result in a cancellation of those privileges.

- Teachers may view any student communication at any time in order to support the student's development as a responsible citizen.
- Students are responsible for thoughtful, considerate behavior on computers as they are for their general classroom behavior.
- Students are prohibited from using inappropriate, offensive, pornographic, and/or objectionable language and material. Disciplinary action will be taken against any user found sending or acquiring objectionable material over the Internet or developing material on school equipment.
- Teachers and administrators have the right to decide on the educational value of any electronic material. They will decide on the proper action to take with students who do not follow these rules.

I have read both sides of this contract and I understand it. I agree to follow these rules and to use the Internet and school computers in a responsible way to further my education. This agreement will remain in effect until I transfer or graduate.

Student's Name:

STUDENT SIGNATURE: \_\_\_\_\_

Date: \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

Date: \_\_\_\_\_

**UNION RIDGE SCHOOL STUDENT ENROLLMENT**  
**Acceptable Use Policy**  
**Student Contract**

1. Students will respect the computer equipment, computer system, and computer network at Union Ridge School. Intentional damage or misuse will result in loss of computer privileges.
2. Students will adhere to the following: Is this activity safe? Is this activity respectful? Is this activity appropriate?
3. Students will respect the privacy and rights of other network users. Trespassing into files of others is strictly prohibited.
4. Student use of the Internet is restricted to education, research related to school assignments, the exchange of educational information or to the discretion of the Instructor and/or Supervisor.
5. Students are prohibited from using inappropriate, offensive, pornographic and/or objectionable language and material. Disciplinary action will be taken against users found sending or acquiring objectionable material over the Internet or developing material on school equipment.
6. Students are prohibited from violating copyright laws. Students will not download software, shareware or freeware at school.
7. Computer viruses must not be created, introduced, or disseminated by anyone. Intentional damage will result in the student paying the cost to fix the damage, the loss of computer privileges for the remainder of the academic year, and possible expulsion from school.
8. Students are responsible for their passwords: they must guard and protect their passwords as a personal possession. A password must never be shared with anyone. Students will properly log on and log off computers.
9. Students will NEVER give out personal information such as last name, home address, or telephone number for themselves or others over the internet.
10. Students will be mindful of school resources of paper and ink cartridges and use them at the direction of their teachers. All work will be spell checked, proof read and print previewed BEFORE printing.
11. Students are strictly prohibited from attempting to access and/or alter student grades or records, files, or documents. Any such attempt will result in suspension and possible expulsion from school.
12. Students are responsible for equipment borrowed from the school. Parents/Guardians will be responsible for replacement/repair cost should it become damaged, lost or stolen.
13. Students must be familiar with these rules before using the computer equipment. These rules apply at all times and to all computers at Union Ridge School.

## **UNION RIDGE SCHOOL STUDENT ENROLLMENT Internet Publishing Consent and Waiver Form**

**This form is a request for permission to publish your child's work or photograph on the Union Ridge District 86 web site at [www.urs86.org](http://www.urs86.org).**

Student's Name:

I understand that this consent and waiver from give District 86 permission to publish the above named student's work/photograph on the Internet at the District's web site, and/or related web sites, and in various media sources where school business is published. I understand that information and/or videos published on the Internet, or information used in newspapers, magazines, and other media sources, may be viewed by anyone around the world. I understand that the published work/photograph will not be identified by first name and last name. I release District 86 from any liability resulting from or connected with the publication of this information.

Permission to publish this work will stay in effect until cancelled by a parent or guardian.

☐ I give consent

☐ I do not give consent

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

Date: \_\_\_\_\_



## Take Home Device Student and Parent Agreement

Please read the expectations. By signing the agreement, you agree to the following:

- Follow the Union Ridge School District 86 Acceptable Use Policy at home and in school
  - Link to AUP: <https://www.urs86.org/technology/aup-and-guidelines>
- Charge the device each night in a supervised location (kitchen/family room)
- Only use district approved apps, add-ons, extensions, and websites
- To not remove or bypass school security, management, monitoring, and content filtering software
- Keep passwords and accounts private.
- Protect device from extreme temperatures, liquids, pets, and small children
- Do not leave device in an unattended location
- Do not leave device on the floor or places it can be damaged
- Notify the classroom teacher immediately if the device becomes damaged
- Provide a police report to the school within 24 hours if the device is stolen
- If a student fails to return the device and any assigned accessories as directed, the district may seeking reimbursement from the Student's parent(s)/guardian(s).
- Parent(s)/guardian(s) assume complete responsibility for Internet access beyond the network provided by the District. When using the device outside the District, students are bound by the same policies, procedures, and guidelines as in school. Monitor your child's internet activities.
- If the student ceases to be enrolled in District, the student/parents will return the devices in good working order or pay the full replacement cost of the computer.
- Please return this form signed to the school office

As the parent/guardian, my signature indicates I have read and understood all agreements, policies, rules, permissions, responsibilities in the School Acceptable Use Policy, the Network and Internet Safety Policy, COPPA, and expectations for Union Ridge School District 86's Device Take Home Agreement. I agree to the terms, and I give my permission for my child to have access to the described technology resources, and I will monitor my child's device usage at home.

Parent/Guardian Name (please print): \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

As the student, my signature indicates I have read and understand all agreements, policies, rules, and permissions, and responsibilities in the School Acceptable Use Policy, the Network and Internet Safety Policy, COPPA, and all my teacher/classroom technology rules. I agree to abide by the terms and conditions outlined and to use these resources for educational purposes.

Student Name, ID, & Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Grade & Advisor / Homeroom Teacher: \_\_\_\_\_ Device Info: \_\_\_\_\_

### Insurance Agreement

This insurance is mandatory for K - 8th grade students. Should there be failure to pay the insurance fee, the parent/guardian is fully responsible for the cost of repairs or replacement as determined solely by Union Ridge School office and technology department staff.

#### 2024 - 2025 Accidental Insurance Coverage Cost K - 8th Grade: \$30

The accidental insurance does not cover intentional damages, negligence, theft from unlocked vehicle, mysterious disappearance/lost, cosmetic damage, corrosion & rust, breakdown, and accessories (charger, cable, and case).

#### Office Use Only

Insurance fee received: \_\_\_\_\_ Date: \_\_\_\_\_

Return  
Your Insurance Fee  
With This Form Signed

Link to Acceptable Use Policy: <https://www.urs86.org/technology/aup-and-guidelines>

Please make checks payable to Union Ridge School or bring the exact amount of cash.

**Mandatory parent/guardian School Technology Night will be in August**

Julie Borner  
Principal

## CONSENT FOR RELEASE OF INFORMATION

STUDENT NAMECURRENT GRADE IN SCHOOL

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☐ I hereby authorize School District 86 to **RELEASE** information concerning the above named student(s) to:NAME/AGENCY: 

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ADDRESS: 

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TELEPHONE: 

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FAX: 

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☐ I hereby authorize School District 86 to **OBTAIN** information concerning the above named student(s).**When sending records to District 86, please address to:**Mrs. Julie Borner, Principal  
Union Ridge School District 86  
4600 N. Oak Park Avenue  
Harwood Heights, IL 60706Please check all that apply: ☐ All Student Records ☐ Health 

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☐ IEP ☐ Other 

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☐ Option: Information NOT to be released 

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I understand, upon written request, that I have the right to inspect, copy, and challenge the information contained in the records prior to release. This includes the right to release all or part of my child's record.

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*Parent/Guardian Signature*

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*Date*

## UNION RIDGE SCHOOL DISTRICT 86 - MINIMUM HEALTH REQUIREMENTS

Healthy students perform better in school and have better attendance. They will be better prepared academically and be fit to learn if they maintain good health practices. Having up-to-date physical examinations and immunizations will help assure that our children are ready and physically able to do well in school. Children must have proof of the State-required immunizations and health exams before the school year begins, or they will face exclusion until the requirements are met.

### WHAT DOES YOUR CHILD NEED?

Entering	State-required shots	New Physical Exam	Dental Exam	Eye Exam	Lead Screening/test
Early Childhood	DTaP, Polio, Hib, PCV Hepatitis B, MMR, Varicella	Yes Before starting school	Recommended but not required	No	Yes
Kindergarten	DTaP (with booster after age four), Polio (with booster after age four), MMR #2, Varicella #2	Yes Before starting school	Yes Due by May 15 <sup>th</sup> (End of Kindergarten year)	Yes Due by Oct. 15 <sup>th</sup> (Beginning of Kindergarten year)	Yes, if not done during Early Childhood
1 <sup>st</sup> grade	DTaP, Polio, MMR, Varicella	No	No	No	No
2 <sup>nd</sup> grade	DTaP, Polio, , MMR, Varicella	No	Yes Due by May 15 <sup>th</sup> (end of 2nd grade)	No	No
3 <sup>rd</sup> or 4 <sup>th</sup> grade	DTaP, Polio, , MMR, Varicella	No	No	No	No
5 <sup>th</sup> grade	DTaP, Polio, MMR, Varicella	No	No	No	No
6 <sup>th</sup> grade	DTaP, Tdap booster, Polio, Hepatitis B, MMR, Varicella, Meningococcal	Yes Before starting school	Yes Due by May 15 <sup>th</sup> (end of 6 <sup>th</sup> grade)	No	No
7 <sup>th</sup> or 8 <sup>th</sup> grade	DTaP, Tdap booster, Polio, Hepatitis B, MMR, Varicella	No	No	No	No
Transfer students from another state	According to grade	Exam from previous school must have been done within one year of entering Illinois system and must comply with Illinois code, otherwise a new exam must be submitted	Yes, if entering Kindergarten, 2 <sup>nd</sup> , or 6 <sup>th</sup> grade (Due by May 15 <sup>th</sup> in that grade)	Yes, unless student is already wearing glasses	Yes, if age six or younger
Transfer students from another country	According to grade	Yes All grades – required before student can start school	Yes, if entering Kindergarten, 2 <sup>nd</sup> , or 6 <sup>th</sup> grade (Due by May 15 <sup>th</sup> in that grade)	Yes, unless student is already wearing glasses	Yes, if age six or younger

### PLEASE NOTE:

- All students must have a physical exam on file before they will be allowed to participate in physical education classes, whether starting school for the first time, or transferring from another school.
- The physical exam must be documented on the State of Illinois "Certificate of Child Health Examination" form.
- The form must be signed and dated by the doctor.
- The form must include the name, address, and telephone number of the doctor, clearly written or stamped on the form.
- The health history part of the physical form and the enclosed health history sheet must be filled out and dated by the parent.
- Screening for tuberculosis is strongly recommended with each new physical exam.
- Lead assessment/screening is required for students entering pre-school and/or Kindergarten.

### MEDICATION IN SCHOOL

If your child requires any type of medication that absolutely must be given during the school day, a form must be completed and signed by the child's parent and doctor. No medication (prescription or non-prescription) can be given to your child at school without a completed medication form on file. If you need a form, please contact the health office or download it from the URS Website – [www.urs86.org](http://www.urs86.org) – under the "Parent" tab click on "School Nurse Office" - click on "Medication Administration" – click on "School Medication Authorization Form."

If you have any questions regarding the information in this letter, please do not hesitate to contact the health office during regular school hours. The school's phone number is 708-867-5822. The school nurse is in the building from 8:30 AM until 3:45 PM on days when the students are in attendance.





## Certificate of Child Health Examination

<b>Student's Name</b>			<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School/Grade Level/ID#</b>
Last	First	Middle				
<b>Street Address</b>			<b>City</b>	<b>ZIP Code</b>	<b>Parent/Guardian</b>	<b>Telephone (home/work)</b>
<b>HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>						
<b>ALLERGIES</b> (Food, drug, insect, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>List:</b>	<b>MEDICATION</b> (Prescribed or taken on a regular basis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>List:</b>	
Diagnosis of Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Child wakes during night coughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hospitalization? When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Birth Defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Surgery? (List all) When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Developmental delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Serious injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB skin test positive (past/present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No		*If yes, refer to local health department
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB disease (past or present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No		
Head injury/Concussion/Passed out?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tobacco use (type, frequency)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Seizures? What are they like?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alcohol/Drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart problem/Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Family history of sudden death before age 50? (Cause?)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart murmur/High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Dizziness or chest pain with exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Last exam by eye doctor _____			<input type="checkbox"/> Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____			<b>Additional Information:</b>			
Ear/Hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No			Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis? <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Parent/Guardian Signatures:</b> _____ <b>Date:</b> _____			
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.</b>						
<b>REQUIRED Vaccine/Dose</b>	<b>DOSE 1</b> MO DA YR	<b>DOSE 2</b> MO DA YR	<b>DOSE 3</b> MO DA YR	<b>DOSE 4</b> MO DA YR	<b>DOSE 5</b> MO DA YR	<b>DOSE 6</b> 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 Haemophiles Influenza Type B</b>						
<b>Pneumococcal Conjugate</b>						
<b>Hepatitis B</b>						
<b>MMR Measles, Mumps, Rubella</b>						
<b>Varicella</b> (Chickenpox)						
<b>Meningococcal Conjugate</b>						
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose</b>				<b>Comments:</b> * indicates invalid dose		
<b>Hepatitis A</b>						
<b>HPV</b>						
<b>Influenza</b>						
<b>Other: Specify Immunization Administered/Dates</b>						
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.						
Signature _____			Title _____		Date _____	

<b>Student's Name</b>			<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>School</b>	<b>Grade Level/ID#</b>
Last	First	Middle				

**Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.**

**ALTERNATIVE PROOF OF IMMUNITY**

**1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.**  
 \*MEASLES (Rubeola) (MO/DA/YR) \_\_\_\_\_ \*\*MUMPS (MO/DA/YR) \_\_\_\_\_ HEPATITIS B (MO/DA/YR) \_\_\_\_\_ VARICELLA (MO/DA/YR) \_\_\_\_\_

**2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.** Person signing below verifies 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 \_\_\_\_\_

**3. Laboratory Evidence of Immunity (check one)**    ☐ Measles\*    ☐ Mumps\*\*    ☐ Rubella    ☐ Varicella    **Attach copy of lab result.**

\*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.  
 \*\*All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Physician Statements of Immunity **MUST** be submitted to IDPH for review.  
**Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:** \_\_\_\_\_

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

HEAD CIRCUMFERENCE If < 2-3 years old \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BMI \_\_\_\_\_ BMI PERCENTILE \_\_\_\_\_ B/P \_\_\_\_\_

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

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

**TB SKIN OR BLOOD TEST:** Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. [http://www.cdc.gov/tb/publications/factsheets/testing/TB\\_testing.htm](http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm).  
  
☐ No test needed    ☐ Test performed    **Skin Test:** Date Read \_\_\_\_\_ Result: ☐ Positive ☐ Negative    mm \_\_\_\_\_  
**Blood Test:** Date Reported \_\_\_\_\_ Result: ☐ Positive ☐ Negative    Value \_\_\_\_\_

LAB TESTS (Recommended)	Date	Results	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Sickle Cell (when indicated)			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	SYSTEM REVIEW	Normal	Comments/Follow-up/Needs
<b>Skin</b>	<input type="checkbox"/>		<b>Endocrine</b>	<input type="checkbox"/>	
<b>Ears</b>	<input type="checkbox"/>	Screening Result:	<b>Gastrointestinal</b>	<input type="checkbox"/>	
<b>Eyes</b>	<input type="checkbox"/>	Screening Result:	<b>Genito-Urinary</b>	<input type="checkbox"/>	LMP:
<b>Nose</b>	<input type="checkbox"/>		<b>Neurological</b>	<input type="checkbox"/>	
<b>Throat</b>	<input type="checkbox"/>		<b>Musculoskeletal</b>	<input type="checkbox"/>	
<b>Mouth/Dental</b>	<input type="checkbox"/>		<b>Spinal Exam</b>	<input type="checkbox"/>	
<b>Cardiovascular/HTN</b>	<input type="checkbox"/>		<b>Nutritional Status</b>	<input type="checkbox"/>	
<b>Respiratory</b>	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis of Asthma	<b>Mental Health</b>	<input type="checkbox"/>	
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)			<b>Other</b>	<input type="checkbox"/>	
<b>NEEDS/MODIFICATIONS</b> required in the school setting			<b>DIETARY</b> Needs/Restrictions		

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

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

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

On the basis of the examination on this day, I approve this child's participation in \_\_\_\_\_ (If No or Modified please attach explanation.)

**PHYSICAL EDUCATION** ☐ Yes ☐ No ☐ Modified    **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name \_\_\_\_\_ ☐ MD ☐ DO ☐ APN ☐ PA    Signature \_\_\_\_\_ Date \_\_\_\_\_

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



## 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 \_\_\_\_\_

### 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 \_\_\_\_\_  
Optometrist or physician (such as an ophthalmologist)  
who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_

<p><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>_____ (Parent or Guardian's Signature)</p> <p>_____ (Date)</p>
--

Date \_\_\_\_\_

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





## PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the 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 need 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:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian: Last Name		First Name	
Student's Race/Ethnicity: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____			

**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 (check all that apply)**

☐ 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). For Head Start Agencies, please also 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: \_\_\_\_\_

Additional comments: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

**UNION RIDGE SCHOOL STUDENT ENROLLMENT**  
**Student Request for the Loan of Textbooks**

I hereby request the loan of secular textbooks in accordance with Public Act 84-469 of 1981. I understand that this request will remain valid so long as my child is enrolled in Union Ridge School and that I may at any time withdraw the request.

Name of School: **Union Ridge School District 86**

Town/City: **Harwood Heights, Illinois**

County: **Cook**

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_

For Office Use Only

Date of Student Transfer

Date of Student Graduation

# UNION RIDGE SCHOOL District No. 86

4600 North Oak Park Ave.  
Harwood Heights, Illinois 60706  
Phone (708) 867-5822  
Fax (708) 867-5826  
[www.urs86.org](http://www.urs86.org)

Dear Parent/Guardian,

To strengthen our social/emotional outreach efforts, we have implemented universal screening across K-8th grade using the Pediatric Symptoms Checklist-17 (PSC-17). The PSC-17 is a brief questionnaire that helps identify and assess social/emotional changes within children.

It is important to understand that the PSC-17 is not a tool for diagnosing any specific condition.

It includes items that help teachers identify behaviors critical for students' academic engagement. The social workers will analyze the data provided by the checklist to identify students who may potentially require additional support to be successful in the school environment. If you would like to speak with them directly, you have find their contact information below:

EC-3rd Grades	4-8th Grades
Alison Ullmer, MSW School Social Worker Union Ridge School <a href="mailto:aullmer@urs86.org">aullmer@urs86.org</a> (708) 867-5822 ext. 220	Joe Kerke, LCSW ( <i>he, him, his</i> ) Social Worker Union Ridge School <a href="mailto:jkerke@urs86.org">jkerke@urs86.org</a> 708-867-5822 (ext: 200)

Attached to this letter, you will find a copy of the PSC-17.

Thank you for your time.

Joe Kerke and Alison Ullmer

Union Ridge School Social Workers  
[jkerke@urs86.org](mailto:jkerke@urs86.org)  
[aullmer@urs86.org](mailto:aullmer@urs86.org)  
708-867-5822

# Pediatric Symptom Checklist-17 (PSC-17)

Caregiver Completing this Form: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Child: \_\_\_\_\_

		Please mark under the heading that best fits your child			Office Use		
		NEVER	SOME-TIMES	OFTEN	I	A	E
1.	Fidgety, unable to sit still						
2.	Feels sad, unhappy						
3.	Daydreams too much						
4.	Refuses to share						
5.	Does not understand other people's feelings						
6.	Feels hopeless						
7.	Has trouble concentrating						
8.	Fights with other children						
9.	Is down on him or herself						
10.	Blames others for his or her troubles						
11.	Seems to be having less fun						
12.	Does not listen to rules						
13.	Acts as if driven by a motor						
14.	Teases others						
15.	Worries a lot						
16.	Takes things that do not belong to him or her						
17.	Distracted easily						
(scoring totals)							

## Scoring:

- Fill in unshaded box on right with: "Never" = 0, "Sometimes" = 1, "Often" = 2
- Sum the columns.  
PSC17 Internalizing score is sum of column I  
PSC17 Attention score is sum of column A  
PSC17 Externalizing score is sum of column E  
PSC-17 Total Score is sum of I, A, and E columns

## Suggested Screen Cutoff:

PSC-17 - I  $\geq 5$   
PSC-17 - A  $\geq 7$   
PSC-17 - E  $\geq 7$   
Total Score  $\geq 15$

*Higher Scores can indicate an increased likelihood of a behavioral health disorder being present.*



## **Il Kids has changed:**

***Effective 7/1/2022, children enrolled in All Kids Share, Premium Level 1 and Premium Level 2 are now eligible under the All Kids Assist program.***

*Listed below are the changes that will contribute to an easier way of providing healthcare to your children.*

- *These children now have coverage without any premiums or co-payments*
- *These children are now eligible for benefits even with current or recent private insurance (Medicaid as secondary payer)*
- *These children may apply for three months of retroactive coverage, if needed*
- *If eligible These children now have coverage beginning with the month of application*
- *These children now qualify for the comprehensive benefits Medicaid offers, including non-emergency transportation*
- *These children now have access to care coordination under the state's **Medicaid managed care program***
- *These children now have access to vaccines under the **Vaccine for Children's Program (VFC)***

**If you have questions related to your new healthcare coverage, please call the All Kids Hotline at:**

**1-866-ALL-KIDS (1-866-255-5437)**

**TTY: 1-877-204-1012**