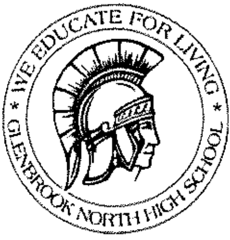

GLENBROOK NORTH HIGH SCHOOL HEALTH OFFICE

Northfield Township High School District 225
2300 SHERMER ROAD
NORTHBROOK, IL 60062
Phone: 847-509-2410
Fax: 847-509-2625

To: Parents/Guardian of Incoming Freshmen
From: Glenbrook North Nurse's Office

This packet contains important medical forms that you will need to complete:

1. **State of Illinois Certificate of Child Health Examination:**
   a. **The physical is required by law for all students to enter high school in Illinois.** This form needs to be returned as soon as possible, and is due no later than the first day of high school. Please make a copy for your records. The completed form should be brought directly to the school and dropped off at either the Main Office or the Health Office. PARENTS: Please complete and sign the Health History section (top section of back page).

2. **Medication Authorization Forms (2 parts):** [1]
   a. **Tylenol/Advil Permission:** The health office keeps a stock of Tylenol/Advil for common aches and pains. If you would like your student to be able to receive these as needed, please have your doctor fill out the Over the Counter Medication Form. Doing this once will cover your student for all 4 years.
   b. **Prescription Medications:** If your student will require any other prescription or scheduled medications to be dispensed during the school day, please have your doctor complete the Prescription Medications Form. This portion of the form must be updated annually. (include inhalers, epi pens, insulin).

*Students are encouraged to carry their own inhalers, epi pens, and diabetic supplies. Please let the health office know if your child will be carrying their rescue medication. We recommend keeping a backup in the health office.

Students entering from out of state or country – Required by the state of Illinois, student's physical and immunizations needs to be completed on the State of Illinois form. Eye exams are also required. All records must be professionally translated to English.

All Health Forms are available to download from the GBN website.

Care Plans (diabetes, asthma, food allergy): The law requires an updated care plan for students with chronic health conditions. Forms can be found on the Nurse section of the GBN website.

Thank you,
The Glenbrook North Nursing Staff

[1] 12/19/2017

State of Illinois
Certificate of Child Health Examination

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

IMMUNIZATIONS: To be completed by health care provider. The mo/da/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.

REQUIRED Vaccine / Dose	DOSE 1 MO	DA	YR	DOSE 2 MO	DA	YR	DOSE 3 MO	DA	YR	DOSE 4 MO	DA	YR	DOSE 5 MO	DA	YR	DOSE 6 MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT			☐Tdap☐Td☐DT		
Polio (Check specific type)	☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										Comments:								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

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

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (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.

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

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

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

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

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

HEAD CIRCUMFERENCE 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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** / / **Result: Positive** ☐ **Negative** ☐ **mm**_________

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value**

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

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

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

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

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

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

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

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

Address **Phone**

Glenbrook High School District 225
Glenbrook North High School
Glenbrook South High School

School Medication Authorization Form
OTC (Over-the-Counter) MEDICATIONS

Illinois State Law requires written permission by a parent/guardian and licensed healthcare provider for administration of any medication at school. Please complete the following information, circle your preference of which over-the-counter medication(s) you would like your child to have permission to take, while at school, and provide the appropriate signatures at the bottom of this form. This form will be kept on file in the Health Office/Nurse's Office and will be valid until graduation.

Student Name:_________________________ **ID#**____________________

Tylenol or Advil Permission

Please **circle** which medication you would like your child to have permission to take during the school day. **The Health Office stocks a generic supply of the medications listed below (acetaminophen and ibuprofen).**

Tylenol 325mg 1-2 tablets (Every 6 hours as needed)

Advil 200mg, 1-2 tablets (Every 6 hours as needed)

Tylenol 500mg (Extra strength) 1 -2 tablets (Every 6 hours as needed)

Parent/Guardian & Physician Authorization

I authorize Glenbrook High School District 225 to administer said medications to my child, on an as needed basis, according to School Board Policy and Medication Administration Procedures and Guidelines.

Parent/Guardian Signature ____________________________________ **Date**__________

Physician Signature____ **Date**__________

Physician's Name (Printed)___________________________________ **Date**__________

* fax to GBN Nurses 847-509-2625

Glenbrook High School District 225
Glenbrook North High School
Glenbrook South High School

School Medication Authorization Form
PRESCRIPTION MEDICATIONS

Student Name ID#

Illinois State Law requires written permission by a parent/guardian and licensed healthcare provider for administration of any medication at school. Please complete the following information and have your child's physician provide the appropriate instructions and signatures at the bottom of this form. **Prescription medication orders must be renewed annually.** Parents are responsible for providing the school with all medications in the original prescription-labeled, or manufacturer-labeled bottle.

Asthma/Allergies/Diabetes:
Students with asthma or severe allergies are strongly encouraged to carry their rescue inhalers or Epi-pens on their person. Back-up medications may also be stored in the Health Office/Nurse's Office, and is highly encouraged, so that they are readily available in the event of an emergency. Additionally, a nebulizer is available for use with a valid doctor's order. Diabetic students may keep a supply of insulin, syringes, and a glucometer in the Health Office/Nurse's Office for their use, along with any other needed testing supplies. Most diabetic students keep their supplies in a plastic box labeled with their name and ID number. Diabetic students may store food or snacks in the refrigerator. Please make every effort to supply the Health Office/Nurse's Office with your child's most current Care Plan.

PRESCRIPTION MEDICATIONS

Medication Name and Dosage: ________________

Frequency/Instructions: ____________________

Diagnosis/Indication: ______________________

Possible Side Effects: ______________________

Medication Name and Dosage: ________________

Frequency/Instructions: ____________________

Diagnosis/Indication: ______________________

Possible Side Effects: ______________________

Parent/Guardian & Physician Authorization

I authorize Glenbrook High School District 225 to administer said medications to my child, on an as needed basis, according to School Board Policy and Medication Administration Procedures and Guidelines.

Parent/Guardian Signature ______________________________ **Date**__________

Physician Signature______________________________ **Date**__________

Physician's Name (Printed)______________________________ **Date**__________

* Please complete reverse side of form as well * →

For parents/guardians of students who need to carry and use their asthma medication (rescue inhaler) or epinephrine auto-injector:
I authorize Glenbrook School District 225 and its employees and agents, to allow my child or ward to self-carry and self-administer his or her asthma medication and/or epinephrine auto-injector: (1) while in school, (2) while at a school sponsored activity, (3) while under the supervision of school personnel, or (4) before or after normal school activities, such as while in before-school or after-school care on school-operated property. Illinois Law requires the school district to inform parent(s)/guardian(s) that it, and its employees and agents, incur no liability, except for willful and wanton conduct, as a result of any injury arising from a student's self-carry and self-administration of asthma medication or epinephrine auto-injector (105 ILCS 5/22-30).

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

Parent/Guardian initials ________________

For all parents/guardians:

By signing below, I agree that I am primarily responsible for administering medication to my child. However, in the event that I am unable to do so or in the event of a medical emergency, I hereby authorize School District 225 and its employees and agents, on my behalf, to administer or to attempt to administer to my child (or to allow my child to self-administer pursuant to State Law, while under the supervision of the employees and agents of the school district), lawfully prescribed medication in the manner described above. This includes administration of undesignated epinephrine auto-injectors or opioid antagonists to my child when, in good faith, it is believed my child is having an anaphylactic reaction or opioid overdose, whether such reactions are known to me or not (105 ILCS 5/22-30, amended by P.A. 99-480). **I acknowledge that it may be necessary for the administration of medications to my child to be performed by an individual other than a school nurse and specifically consent to such practices, and**

I agree to indemnify and hold harmless Glenbrook School District 225 and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of said administration, or the child's self-administration of medication.

Parent/Guardian Name (Printed) ____

Parent/Guardian Signature ____

Primary Phone Number: ____

Emergency Phone Number: ____