

MEDICAL UPDATES AND INFORMATION 2011-2012

Grade	Certificate of Child Health Examination Form	Vision Examination Form	Dental Examination Form	2011-2012 Emergency Form One form for each student	*District 29 Medication Authorization Form	Sports Physical (Certificate of Child Health Examination Form)
K	Due Oct. 15, 2011	***Due Oct. 15, 2011	Due May 15, 2012	Due Aug. 29, 2011	Due Aug. 29, 2011	N/A
1	N/A	N/A	N/A	Due Aug. 29, 2011	Due Aug. 29, 2011	N/A
2	N/A	N/A	Due May 15, 2012	Due Aug. 29, 2011	Due Aug. 29, 2011	N/A
3	N/A	N/A	N/A	Due Aug. 29, 2011	Due Aug. 29, 2011	N/A
4	N/A	N/A	N/A	Due Aug. 29, 2011	Due Aug. 29, 2011	N/A
5	N/A	N/A	N/A	Due Aug. 29, 2011	Due Aug. 29, 2011	* If doing spring sport only Good for 1 year
6	Due Oct. 15, 2011	N/A	Due May 15, 2012	Due Aug. 29, 2011	Due Aug. 29, 2011	Good for 1 year
7	N/A	N/A	N/A	Due Aug. 29, 2011	Due Aug. 29, 2011	Good for 1 year
8	N/A	N/A	N/A	Due Aug. 29, 2011	Due Aug. 29, 2011	Good for 1 year

***District 29 Medication Authorization forms are required for all students receiving daily medications and "as needed" meds such as Tylenol, Advil, Benadryl. Food Allergy Action Plan is to be completed per MD for any child with a severe food and/or bee sting allergy requiring emergency m , epi pen etc. Inhalers must have RX label and parental signature-student may self carry.**

All students must receive physical exams prior to entering Illinois schools for the first time. The exam must have been completed within 1 year prior to the date of entry. Please contact the nurse if you have questions regarding out of state physical exam forms.

Health exams must be dated after Aug. 29, 2010 for Kindergarten, 2nd and 6th grade.

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



State of Illinois Certificate of Child Health Examination

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



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

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA YR		
	DTP or DTaP																	
Tdap; Td or Pediatric DT (Check specific type)	<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		
Polio (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		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										COMMENTS:								
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps											
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

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

Signature	Title	Date
Signature	Title	Date

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease	Signature	Title	Date
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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													
Date													Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade													
	R	L	R	L	R	L	R	L	R	L	R	L	
Vision													
Hearing													

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

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night	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)						
Ear/Hearing problems?	Yes	No		Parent/Guardian Signature		
Bone/Joint problem/injury/scoliosis?	Yes	No		Date		

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

HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				
LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ (Blood test required if resides in Chicago.)				
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____				
Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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 Antagonist) <input type="checkbox"/> Controllor medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting	DIETARY Needs/Restrictions
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SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

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

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes No If yes, please describe.
On the basis of the examination on this day, I approve this child's participation in _____ (If No or Modified,please attach explanation.)

PHYSICAL EDUCATION Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited

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

Address _____ Phone _____

(Complete both sides)

District 29 Medication Authorization

HEALTH SERVICES

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

Student Name _____	Grade _____
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Medication Allergies: _____ Food Allergies: _____ Other Allergies: _____

NON-PRESCRIPTION MEDICATION

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

Medical provider and parent signature required.

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

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

PRESCRIPTION MEDICATIONS-Valid for one school year only

Inhalers for asthma NEW FOR 2011!

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

Medications to manage severe allergic reactions and diabetes

A student may carry an EpiPen (epinephrine injection), Benadryl, Insulin and diabetic supplies with medical provider and parent authorization.

EpiPen with/without Benadryl: _____

Insulin and glucose monitoring: _____

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

Other Prescription Medications: Must be renewed at the beginning of each school year.

All medications must be brought to Nurse's Office by parent/guardian in a prescription-labeled container.

Medication: _____ Dosage: _____

Frequency: _____ Duration of order: _____

Medication: _____ Dosage: _____

Frequency: _____ Duration of order: _____

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

Medical Provider Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Physician Office Stamp

Please see reverse side for Administration of Medication Procedure/Guidelines.
06-11

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

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

PROCEDURES/GUIDELINES:

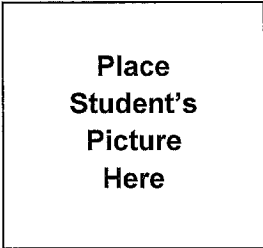
1. **Medication Authorization Form** - School personnel shall not administer to any student, nor shall any student possess or consume *any prescription or non-prescription medication* unless the student's parent has provided the school with a completed Medication Authorization form. The school nurse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

Food Allergy Action Plan

Name: _____ D.O.B.: ____ / ____ / ____

Allergy to: _____

Weight: _____ lbs. Asthma: Yes (higher risk for a severe reaction) No



Extremely reactive to the following foods: _____

THEREFORE:

- If checked, give epinephrine immediately for ANY symptoms if the allergen was *likely* eaten.
- If checked, give epinephrine immediately if the allergen was *definitely* eaten, even if no symptoms are noted.

Any SEVERE SYMPTOMS after suspected or known ingestion:

One or more of the following:

- LUNG: Short of breath, wheeze, repetitive cough
- HEART: Pale, blue, faint, weak pulse, dizzy, confused
- THROAT: Tight, hoarse, trouble breathing/swallowing
- MOUTH: Obstructive swelling (tongue and/or lips)
- SKIN: Many hives over body

Or combination of symptoms from different body areas:

- SKIN: Hives, itchy rashes, swelling (e.g., eyes, lips)
- GUT: Vomiting, crampy pain



1. **INJECT EPINEPHRINE IMMEDIATELY**
2. Call 911
3. Begin monitoring (see box below)
4. Give additional medications: *
 - Antihistamine
 - Inhaler (bronchodilator) if asthma

*Antihistamines & inhalers/bronchodilators are not to be depended upon to treat a severe reaction (anaphylaxis). USE EPINEPHRINE.

MILD SYMPTOMS ONLY:

- MOUTH: Itchy mouth
- SKIN: A few hives around mouth/face, mild itch
- GUT: Mild nausea/discomfort



1. **GIVE ANTIHISTAMINE**
2. Stay with student; alert healthcare professionals and parent
3. If symptoms progress (see above), USE EPINEPHRINE
4. Begin monitoring (see box below)

Medications/Doses

Epinephrine (brand and dose): _____
Antihistamine (brand and dose): _____
Other (e.g., inhaler-bronchodilator if asthmatic): _____

Monitoring

Stay with student; alert healthcare professionals and parent. Tell rescue squad epinephrine was given; request an ambulance with epinephrine. Note time when epinephrine was administered. A second dose of epinephrine can be given 5 minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping student lying on back with legs raised. Treat student even if parents cannot be reached. See back/attached for auto-injection technique.

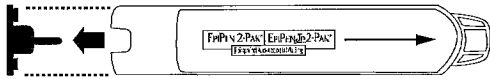
Parent/Guardian Signature _____ Date _____ Physician/Healthcare Provider Signature _____ Date _____

TURN FORM OVER

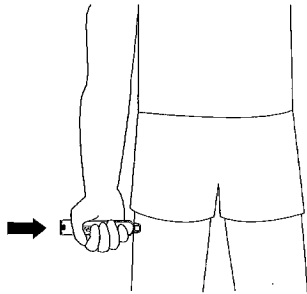
Form provided courtesy of FAAN (www.foodallergy.org) 7/2010

EPIPEN Auto-Injector and EPIPEN Jr Auto-Injector Directions

- First, remove the EPIPEN Auto-Injector from the plastic carrying case
- Pull off the blue safety release cap



- Hold orange tip near outer thigh (always apply to thigh)



- Swing and firmly push orange tip against outer thigh. Hold on thigh for approximately 10 seconds. Remove the EPIPEN Auto-Injector and massage the area for 10 more seconds



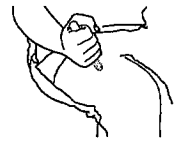
DEY™ and the Dey logo, EpiPen™, EpiPen 2-Pak™, and EpiPen Jr 2-Pak™ are registered trademarks of Dey Pharma, L.P.

Twinject® 0.3 mg and Twinject® 0.15 mg Directions



Remove caps labeled "1" and "2."

Place rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.



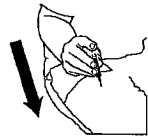
SECOND DOSE ADMINISTRATION: If symptoms don't improve after 10 minutes, administer second dose:

Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.

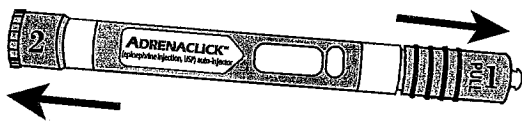


Slide yellow collar off plunger.

Put needle into thigh through skin, push plunger down all the way, and remove.



Adrenaclick™ 0.3 mg and Adrenaclick™ 0.15 mg Directions



Remove GREY caps labeled "1" and "2."



Place RED rounded tip against outer thigh, press down hard until needle penetrates. Hold for 10 seconds, then remove.

A food allergy response kit should contain at least two doses of epinephrine, other medications as noted by the student's physician, and a copy of this Food Allergy Action Plan.

A kit must accompany the student if he/she is off school grounds (i.e., field trip).

Contacts

Call 911 (Rescue squad: () -) Doctor: _____
 Parent/Guardian: _____

Phone: () - _____
 Phone: () - _____

Other Emergency Contacts

Name/Relationship: _____
 Name/Relationship: _____

Phone: () - _____
 Phone: () - _____



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete 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 October 15 of the year the child enters an Illinois school.

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

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

Parent or Guardian _____ (Last) _____ (First)

Phone _____ (Area Code)

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

County _____

To Be Completed By Examining Doctor

Case History

Date of Exam _____

Ocular History: Normal or Positive for _____

Medical History: Normal or Positive for _____

Drug Allergies: NKDA or Allergic to _____

Other Information _____

Examination

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity	20/	20/	20/	20/
Best Corrected Visual Acuity	20/	20/	20/	20/

Was refraction performed with cycloplegic agents? Yes No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (media, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Integrity (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"/>	_____
IOP (glaucoma)	<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"/>	_____

Diagnosis

Normal Myopia Hyperopia Astigmatism Strabismus Amblyopia

Other _____



State of Illinois Eye Examination Report

Recommendations

1. Corrective Lenses: No Yes, glasses 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 who provides eye examinations

Address _____

Phone _____

Signature _____
 Optometrist or Physician who provides eye examinations

Consent of Parent or Guardian
 I agree to release the above information on my child
 or ward to appropriate school or health authorities.

 (Parent or Guardian's Signature)

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