# New Trier Health Services

## School Health Requirements for Transfer Students

We hope your student has a great experience at New Trier. All students must provide a copy of a current physical and documentation of immunizations in compliance with Illinois regulations.

The following pages include:

State of IL Certificate of Child Health Exam form: Required physical exam to be completed by physician and parent. Please note any health conditions, disabilities and medications taken on a regular basis. In some circumstances, a copy of a school physical from previous school may meet the Illinois requirement.

Guidelines for Health Examinations and Immunization Records: Outlines Illinois requirements for physical exam, immunizations, and medical and religious objections.

Medication Authorization form: Any medication administered or carried at school requires both **physician** and **parent** signatures, including over the counter medications. Students may carry Epinephrine, Benadryl, and Insulin with a signed Medication Authorization form on file. Generic Tylenol, Advil, and Benadryl are stocked in Health Services and can be administered with this written consent.

**Forms can be mailed, faxed or emailed. Please keep a copy for your records. Contact a nurse in Health Services with questions or concerns.**

Winnetka Health Services
385 Winnetka Ave. Winnetka, Il. 60093

Phone: 847-784-2110
Fax: 847-835-9853
Email: healthservices@nths.net

**Forms also available at:**

**http://www.newtrier.k12.il.us/HealthServices/**

**Your most valuable health resource is a primary care provider.**
**Other community resources for physicals and immunizations include:**
**Minute Clinics at CVS and Take Care Clinics at Walgreens.**

# NEW TRIER HIGH SCHOOL HEALTH SERVICES

## Guidelines for Health Examinations and Immunizations Records

1. Student health records are required in compliance with Illinois law. A **physical examination is required within one year prior to the date of entering school** for all incoming freshman and for students transferring from out of state. Students transferring to New Trier from an Illinois high school may provide a copy of the physical exam from their former school. Students also must have immunizations completed as specified by the Illinois Department of Public Health (see below). Freshmen or transfer students attending summer school are considered to have entered New Trier and must have provided health records prior to attending classes. Health forms may be downloaded from the New Trier Health Services website. http://www.newtrier.k12.il.us/HealthServices/ *( Reference: New Trier Guidebook; Illinois Department of Public Health Rules and Regulations; Illinois Administrative Code part 665; School Code of Illinois 105/ILCS527-8.1)*

2. **Immunization History** must include specific dates (month, date, and year) and include at least the minimum number of doses at the intervals noted below:

A. **Diphtheria, Pertussis, Tetanus**: Requires a minimum of three doses, no less than 28 days apart. The last dose must be given on or after the fourth birthday and be received no earlier than six months after the former dose. A booster is required every 10 years.
**All students entering high school must provide evidence of having received one dose of Tdap** (first available in 2005).

B. **Polio**: Requires a minimum of three doses of the same type of polio vaccine or four doses if any combination of polio vaccine types is given. The minimum interval between doses is 28 days. The final dose must be received on or after the fourth birthday.

C. **Hepatitis B:** Requires a series of three doses. The first two doses must be no less than 28 days apart and the interval between the second and third doses at least 56 days. The interval between the first and third dose must be at least 4 months. Laboratory evidence of prior or current infection may be submitted for proof of immunization. A two dose schedule using Recombivax-HB for students 11-15 is allowed if started on or after the 11th birthday and completed prior to the 16th birthday. A minimum four month interval between the two doses is required.

D. **Measles**: Requires two doses, the first on or after the first birthday and the second at least 28 days later.

E. **Mumps**: Requires two doses, the first on or after the first birthday and the second at least 28 days later.

F. **Rubella:** Requires two doses, the first on or after the first birthday and the second at least 28 days later.

G. **Varicella (Chickenpox):** Requires two doses, the first on or after the first birthday and the second at least 28 days later. History of disease must be verified by the examiner and documented on the Certificate of Child Health Exam Form under Alternative Proof of Immunity.

H. **Meningitis (Menactra, MCV4):** Applies to Seniors only. Requires two doses after the 10th birthday or one dose after the 16th birthday.

3. **Medical Contraindication:** Requires an examiner's statement detailing the specific medical condition that prevents the child from receiving the vaccine and its projected duration. If the condition of the child later permits immunization, the requirement will have to be met.

4. **Religious Exemption:** Requires the filing of a signed statement detailing objections to physical exam, health screenings, and/or immunizations on religious grounds. This statement must be signed by the health care provider responsible for performing the child's health exam. The signature indicates that they have provided the parent with information about the benefits of immunization and health risks of communicable disease. Form: http://dph.illinois.gov/sites/default/files/forms/ohpformsil-certificate-religious-exemption-form-081815.pdf. .

5. In case of infectious disease outbreak, unprotected students must be excluded from school as directed by the Illinois Department of Public Health.

# State of Illinois
# Certificate of Child Health Examination

| Student's Name<br>Last First Middle | Birth Date<br>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 | | | | | | |
| **Varicella** (Chickenpox) | | | | | | |
| **Meningococcal conjugate (MCV4)** | | | | | | |
| **RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose** | | | | | | |
| **Hepatitis A** | | | | | | |
| **HPV** | | | | | | |
| **Influenza** | | | | | | |
| **Other: Specify Immunization Administered/Dates** | | | | | | |

**Comments:**

**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 / Yes | No / 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 | | | |
| Bone/Joint problem/injury/scoliosis? | Yes | No | | **Parent/Guardian Signature** | | **Date** | |

**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

# New Trier High School Medication Authorization

HEALTH SERVICES
Winnetka 847-784-2110 FAX: 847-835-9852 healthservices@nths.net
Northfield 847-784-7513 FAX: 847-784-3113 healthservices@nths.net

| Student Name | ID # |
|---|---|

**Medication Allergies:**_____

## NON-PRESCRIPTION MEDICATIONS

Health Services keeps these medications in stock: Ibuprofen (Advil), Acetaminophen (Tylenol), and Diphenhydramine (Benadryl). All other non-prescription medications must be brought to Health Services by a parent/guardian in a manufacturer-labeled container. Over-the-counter medication authorized by parent and physician are valid until graduation unless otherwise specified.

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

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

## PRESCRIPTION MEDICATIONS

**Medications for asthma, allergies, and diabetes:**

With physician and parent authorization, a student may carry a labeled inhaler, EpiPen/Benadryl or Insulin and diabetic supplies. Please review item #4 on reverse side regarding self-administration.
Back-up medication stored in Health Services is encouraged in case of emergency.

**Physician orders for:**

Inhaler: _____
EpiPen/ Benadryl: _____
Insulin and glucose monitoring: _____
_____

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

All medications must be brought to Health Services 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: _____

_____

All medications listed above, including non-prescription, require **physician** and **parent** signatures.

Medical Provider Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

**Office Stamp**

*Please see reverse side for Administration of Medication Policy and Procedures.*

12/15

## New Trier High School District 203
## ADMINISTRATION OF MEDICATION TO STUDENTS

**POLICY**:
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).
*Reference: Board Policy 7.270.*

**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* except after filing complete medication authorization information. The school nurse reviews the written authorization and consults with the parent/guardian, licensed prescriber or pharmacist for additional information as necessary. Authorization and any subsequent changes includes:
   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, non-prescription over-the-counter medication.

3. **Administration of Medication** will be by Certified School Nurse, Registered Nurse, or school administrator. Parents must provide advance notice to the school nurse of field trips or other off campus activities. Other certified 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. 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, however a completed Medication Authorization Form must be provided for their use. 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 medication order must be renewed each school year. Over-the-counter medication orders must also be renewed annually if specified by the physician.