STUDENT HEALTH FORMS

HEALTHY CPS
OFFICE OF STUDENT HEALTH & WELLNESS

Office of Student Health and Wellness | 773-553-3560 | oshw@cps.edu | www.cps.edu/oshw
Dear Parent/Guardian,

Thank you for your continued participation in the health services programs offered by Chicago Public Schools, Office of Student Health and Wellness. We are dedicated to providing high quality health services for students.

Please review and return the student health forms for the 2017-2018 school year to the school clerk.

The health booklet includes the following:
- Vision Exam Parent Letter
- Vision Exam Consent Form
- Student Medical Information 2017-2018
- Healthcare Provider Statement For Food Substitution (Parents should complete this form, only if your child has allergies that require food substitutions in the dining area)
- Chronic Condition Reporting Process
- Medicaid and SNAP Enrollment Information
- Minimum Health Requirements 2017-2018
- Vision Exam Resource Flyer (additional opportunities for parents to take students to vision providers)
- Visionworks Voucher Program Flyer

All students are eligible for the health services in the packet. Sign the consent form if you want your child to participate in the school-based health programs and return to your child’s school as soon as possible. However, if you don’t want your child to participate in the health service, please don’t complete the consent form. Only students with completed consent forms will participate in the health service.

The vision exam program provides students with a comprehensive eye exam and eyeglasses if needed. Students that participate in the program are also eligible for replacement eyeglasses. As an additional resource we included the vision resource flyer that provides additional vision options. The dental program provides students with dental exam, cleaning fluoride treatment, dental sealants if needed and referral for treatment services if needed.

The Children and Family Benefits Unit (CFBU) can help families apply for Medicaid (low cost or free health insurance) and SNAP benefits (food stamps) at no cost. Parents may call 773-553-KIDS (5437) for more information or to make an appointment.

If you have any questions or concerns please contact Katheryn Stafford-Hudson, Project Manager 773-535-8675, kgstafford-h@cps.edu or Iman Little, Program Coordinator 773-535-8674, ilittle4@cps.edu.

Sincerely,

[Signature]

Dr. Kenneth L Fox
Chief Health Officer
Office of Student Health and Wellness
Dear Parent/Guardian,

Good vision is essential for success in school. We are pleased to announce that the Chicago Public Schools (CPS) Vision Program will be serving your school this year! CPS provides access to vision exams for students so that they may succeed in school.

The CPS Vision Program provides eye exams and glasses (if needed) at NO COST to the student. If the student does not have insurance, the vision exam and eyeglasses are provided at no cost to the family. If available, Medicaid health insurance will be billed.

Below are signs that indicate your child may benefit from an eye exam:

- My child is entering kindergarten
- My child is entering Illinois schools for the first time at any grade level
- My child failed the vision screening
- My child has an IEP
- My child’s teacher recommended they receive an eye exam
- My child experience any of the following:
  - Squinting
  - Tilting the head
  - Sitting too close to the television
  - Losing place while reading
  - Rubbing eyes
  - Excessive tearing or headaches

Complete the consent form by:

1. **Signing the two signature lines.**
2. Completing the last page with your child’s medical history.
3. Returning the form to your child’s school as soon as possible – Your child will not be able to participate without a signed consent form.

Following the eye exam, if your child requires glasses, an optician will assist your child with selecting the frame. Glasses will be delivered within 4-5 weeks to the school.

If you do not want your child to participate in the program, you do not need to complete or return the form to the school. However, if your child received an eye exam from an eye doctor outside of the CPS Vision Program please ensure your child’s health records are up to date by having the doctor complete the State of Illinois Eye Examination Report found here: [http://cps.edu/OSHW/Documents/VisionExaminationForm.pdf](http://cps.edu/OSHW/Documents/VisionExaminationForm.pdf) and return the completed form to your child’s school.

If you have any questions or concerns please contact Katheryn Stafford-Hudson, Project Manager 773-535-8675, kgstafford-h@cps.edu or Iman Little, Program Coordinator 773-535-8674, ilittle4@cps.edu.

Sincerely,

[Signature]

Dr. Kenneth L Fox
Chief Health Officer
Office of Student Health and Wellness
Vision Services
Consent, Release of Liability, and Authorization Form

Please Print:

Student Name: ____________________________  Student’s Date of Birth: ____________  Male  Female

Parent Email Address: ____________________________

School Name: ____________________________  Student ID# ____________________________  Grade: _________  Room#: _________

Parent/Guardian Name: ____________________________  Home Address: ____________________________  Phone: ____________________________

Medicaid/ALLKids recipient #: ____________________________

Group ID: ____________________________  ID#: ____________________________  Cardholder Name: ____________________________  Birth Date: ____________

Other Insurance: _________________

As the parent/guardian of the above named student, I understand that my child failed a vision screening test performed at school, or was recommended for a comprehensive eye exam to determine if he/she needs prescription eyeglasses or other treatment by a vision care professional (Provider).

I understand that as part of this eye exam, pharmaceutical agents (eye drops) will be used for the purpose of dilating my child’s eyes. These drops are an important part of an eye exam to allow the Provider to conduct a thorough eye health exam. I further understand that the temporary effects of these eye drops may include blurred vision and sensitivity to light, both of which could restrict my child’s mobility making it unsafe for him/her to travel unassisted or to operate a vehicle for the rest of the day. I further understand that this eye exam may be performed by an Optometrist; an Ophthalmologist; qualified specialist; or an intern, a resident, or a student clinician or technician under the supervision of an Optometrist, Ophthalmologist, or another qualified specialist, and I consent to have my child receive the above exam and/or treatment. I consent to all of the following services unless the boxes below are checked “no.”

I further understand that neither the school nor the Board of Education of the City of Chicago (Board) are supervising or overseeing any services (such as an eye exam) or materials (such as eyeglasses) that may be furnished to my child and that the Board and the school will have no responsibility for the quality of any such services or materials.

In consideration for the services and materials that my child will receive, I hereby agree to indemnify, release and hold harmless, and defend the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, and representatives, and the Board and its members, trustees, agents, officers, contractors, volunteers, representatives, and employees from any liability which may accrue to me or my child, for any and all claims, losses, injuries, damages to me or my child, both known and unknown, foreseen and unforeseen, arising in connection with my child’s receipt of services and materials, whether or not said claims, losses, injuries, damages, or liabilities result in whole or in part from the negligence of the City of Chicago, its departments, employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the Board, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives. I further agree to release and hold harmless the Providers and Co-Sponsors, their employees, officers, volunteers, agents and representatives from and against any and all claims, demands, actions, complaints, suits or other forms of liability that will arise out of or by reason of, or be caused by any performance of services provided by such Providers or the quality of the eyeglasses or any other materials furnished by them under the Program, unless attributed to their willful or wanton misconduct. In the event that one provision of this form is held unenforceable, that provision shall be severed and the remainder of the form shall remain in effect.

I understand that the Provider will bill the Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable insurance for any reimbursable services and/or materials.

I understand that my child may be selected to be photographed, video taped, audio taped or interviewed as part of promotional documentation for the Vision Program. I consent to the use of my child’s photograph, voice or likeness by the Board or the Provider or CDPH, but not the use of my child’s last name. I understand there is no compensation, monies, or reimbursement for my child’s participation.

If you do NOT want your child to receive the following services, please check the appropriate box. Please note services will be performed unless indicated otherwise.

☐ At this time I DO NOT consent for my child's eyes to be dilated
☐ At this time I DO NOT consent for my child to be photographed or interviewed
☐ At this time I DO NOT consent for my child to be surveyed to determine if glasses, if prescribed, are helping

By signing below, I understand that I am giving my authorization to the City of Chicago Department of Public Health (CDPH) and the Board of Education of the City of Chicago (Board) to release and furnish information regarding past vision screening data in my child’s education record to Providers to ensure that the Providers can effectively provide services. I authorize the Providers to release and furnish reports to my child’s school, including written and verbal reports concerning the results of any eye exam, for inclusion in my child’s education record. I also authorize CDPH to release to the Board, my child’s information, the date and type of vision services provided, whether my child was recommend for follow-up services, and other information the State of Illinois requests the Board to report. I understand that such records will be subject to the privacy rights afforded by state and federal law. I further authorize Providers to disclose vision exam information and billing information to the Illinois Department of Healthcare and Family Services (HFS), for the purpose of insurance billing. CDPH and Providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization.

This authorization is valid for one year. I may revoke this authorization at any time by sending written notification to CDPH, my child’s school, or the Board Office of Student Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

☐ At this time I DO NOT consent for my child's eyes to be dilated
☐ At this time I DO NOT consent for my child to be photographed or interviewed
☐ At this time I DO NOT consent for my child to be surveyed to determine if glasses, if prescribed, are helping

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This authorization is valid for one year. I may revoke this authorization at any time by sending written notification to CDPH, my child’s school, or the Board Office of Student Health and Wellness. Revoking this authorization will not have any effect on any information used or disclosed before the revocation. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

Parent/Guardian Signature: ____________________________  Date: ____________________________

I hereby give my consent for this child to be examined by a Provider for an eye exam and prescription eyeglasses, if prescribed during the eye exam. This consent does not authorize any treatments or service beyond what is stated. I understand my consent will be valid for one year from the date of signature.

Parent/Guardian Signature: ____________________________  Date: ____________________________

***Please sign and date both signature lines. Complete the medical history on reverse side of this form.***
Student Medical History Form

Please Print:
Student’s Name: ___________________________________ School Name: ______________

Student’s Date of last Eye Exam: _________________ Does your child currently wear glasses or contacts? □ Yes □ No

How did you find out about the Vision Program? (Circle all that apply)
School staff  Failed Vision Screening Letter  Friend  Other_________________________________

Does your child have any of the following conditions: (Check all that apply)

☐ Asthma  ☐ Behavioral problems  ☐ Attention Deficit Disorder  ☐ Glaucoma
☐ Neurological problems  ☐ Endocrine problems  ☐ High Blood Pressure  ☐ Musculoskeletal problems
☐ Heart Disease  ☐ Mental Health illness  ☐ Gastrointestinal problems  ☐ Genitourinary problems
☐ Hearing/Ear problems  ☐ Diabetes  ☐ Other Condition ___________________________________

Is your child taking any medications? □ No □ Yes Does your child have allergies? □ No □ Yes
List medications: ____________________________________________ List allergies: ________________________________________________

Does your child use eye drops? □ No □ Yes Has your child ever had eye surgery? □ No □ Yes
List eye drops: ____________________________________________ If yes, please explain: _________________________________________

Has s/he had any of the following?

Vision Therapy □ No □ Yes Eye Injury □ No □ Yes Trouble finishing work □ No □ Yes
Eye patch □ No □ Yes Eye Infection □ No □ Yes Lack of confidence □ No □ Yes
Eye Surgery □ No □ Yes Itching/Burning □ No □ Yes Difficulty sitting still □ No □ Yes
Pain in eyes □ No □ Yes Eye Discharge □ No □ Yes Avoids reading/writing □ No □ Yes
Difficulty Tracking □ No □ Yes Tearing/Watering □ No □ Yes Difficulty paying attention □ No □ Yes
Lazy/Wandering Eye □ No □ Yes Light sensitivity □ No □ Yes Reads below grade level □ No □ Yes
Blurred/Double Vision □ No □ Yes Redness □ No □ Yes Poor handwriting □ No □ Yes
Loses place while reading □ No □ Yes Drooping Lid □ No □ Yes Frustrates easily □ No □ Yes
Other____________________________________________________

Does your child have an IEP (Individualized Education Plan)? □ No □ Yes
Is the child performing at: □ above grade level □ grade level □ below grade level
If below grade level, please select the class (Check all that apply)
□ Reading  □ Writing  □ Math  □ Social Studies  □ Other_________________________________

Is the child currently receiving any of the services below? (Check all that apply)
□ Special Education  □ Tutoring  □ Speech Therapy  □ Occupational Therapy (OT)  □ Physical Therapy (PT)

List any of your child’s Hobbies or Special Interests: ________________________________________________

Is there anything else you would like us to know about your child? Does your child’s immediate family member have any of the following? (Check all that apply and the relationship to child)

□ Wears glasses  □ Wandering Eye  □ Diabetes  □ Cardiovascular problems
□ Glaucoma  □ Blindness  □ Musculoskeletal problems  □ Neurological problems
□ Lazy eye  □ Macular Degeneration  □ Heart Disease  □ Mental Health illness
□ High Blood Pressure
Student Medical Information 2017/2018 School Year

INFORMATION MUST BE UPDATED AND SUBMITTED ANNually AT THE BEGINNING OF THE SCHOOL YEAR

PLEASE PRINT ALL INFORMATION and RETURN FORM TO SCHOOL

SCHOOL NAME: ____________________________

Student Name: ___________________ Date of Birth: _______________ Grade: ___________

Student ID: ___________________ Medicaid Number: ___________________

To ensure the safety of your child during the school day, extracurricular activities, on any field trip, and when being transported by CPS it is important that the school is aware of any health conditions that may impact your child. We are asking you to please complete this form. For confidentiality purposes, this information will only be shared with relevant CPS staff. Thank you for your cooperation in this important matter.

Please check below if applicable:

□ Food Allergies: (Type) ____________________________

□ Other Allergies: (Type) ____________________________

□ Asthma

□ Diabetes: Type 1 □ Type 2 □

□ Seizures

□ Other Medical Condition

________________________________________________________________________

□ My child has NO allergies, medical conditions and/or does not take any medications during school hours

□ My child has a primary healthcare provider (e.g., Doctor, Nurse Practitioner, Physician Assistant, etc.)

For the medical condition identified above which requires prescribed medication during school hours, please provide written verification from your healthcare provider with diagnosis, type of medication, dosage, and time to be given. An Emergency Action Plan (Allergy, Asthma, or Diabetes) can also be requested from your healthcare provider. Your child may qualify for a 504 Accommodation Plan due to his/her condition. Please make sure you follow up with your school nurse and/or case manager once you have submitted this form.

Parent Name: (Please Print): ____________________________ Date: __________

Parent Signature: ____________________________

Phone Number: ____________________________ Email: ____________________________

Revised: April 24, 2017
HEALTHCARE PROVIDER STATEMENT
FOR FOOD SUBSTITUTION

This form must be completed if a parent/student is requesting menu substitutions be made in the dining center for a student’s food allergy or intolerance.

<table>
<thead>
<tr>
<th>CHILD’S NAME:</th>
<th>DATE:</th>
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Dear Parent/Guardian:
Your child’s school participates in a federally-funded School-Based Child Nutrition Program that requires CPS to offer meals and/or milk to students. However, when a disability (for example, a food allergy) or special dietary need or restriction documented by a healthcare provider exists, reasonable menu accommodations must be made. Please provide your contact information and ask your child’s healthcare provider to complete this form. Please then return the completed form to your child’s school along with a Food Allergy Action Plan (found at cps.edu/OSHW). Contact food@cps.edu with any additional questions:

Parent/Guardian Name

School Name

Parent/Guardian Phone Number

Address (Street)

Address (City, State, Zip Code)

Healthcare providers’ note: Food allergies are a “disability” under the Americans with Disabilities Act. If the child has a food allergy, please check “Yes” for question 1 below.

PHYSICIAN STATEMENT

1. Does child have a disability that requires food accommodation?
   - No If no, go to item 2 below.
   - Yes If yes, provide the following information and complete items 3, 4, and 5
     a) What is the disability? ________________________________
     b) What major life activity is affected? ________________________________
     c) What does the disability mean for the child’s diet? ________________________________

2. Child has no disability, but requires a special diet. Identify the medical problem that warrants the child’s special diet and complete item 3, 4, & 5 below.

3. List specific foods to be omitted.

4. List specific acceptable food substitutions. Please attach a menu if applicable.

5. ____________________________________________ Date

Signature of Health Care Provider

FOR SCHOOL USE ONLY: Please mail, scan or fax completed form to 312-448-8270 ATTN: Aramark RD

- Form received on: ________________________________
- Form complete and accommodations will begin on: ________________________________
- Form complete, but accommodation will not be made (circle one):
  - Child does not have a disability/parent declined accommodation
  - Request not reasonable
- Form incomplete. Parent Contacted on: ________________________________

Registered Dietitian Signature & Date: ________________________________
CPS ANNUAL CHRONIC CONDITION REPORTING PROCESS

CPS CHRONIC CONDITION-RELATED POLICIES:
» Include asthma, diabetes, and food allergy
» Apply to all CPS students impacted by these conditions
» Establish guidelines for daily management, emergency response, and staff training requirements
» Provide necessary accommodations through 504 Plans or Individualized Education Plans (IEPs) to ensure student success in school
» To review the policies, please visit: http://policy.cps.k12.il.us/Policies.aspx

IF YOUR CHILD HAS A CHRONIC HEALTH CONDITION, FOLLOW THESE 4 EASY STEPS TO REPORT THE CONDITION AT THE BEGINNING OF EACH SCHOOL YEAR!
USE THESE CHECKLISTS TO MAKE SURE YOU COMPLETE THE REQUIRED FORMS!

**Asthma Checklist**
- Student Medical Information (SMI) form
- Consent to Exchange Information and Medical Records
- Physician Report on Child with Asthma
- Parent/Guardian Request for Self-Administration of Medication form
- Copy of asthma medication prescription and original asthma medication box/container*
- Physician Request for Administration of Medication form (only for students who need assistance administering asthma medication)
- Asthma Action Plan

**Diabetes Checklist**
- Student Medical Information (SMI) form
- Consent to Exchange Information and Medical Records
- Physician Report on Child with Diabetes
- Parent/Guardian Request for Administration/Self-Administration of Medication form
- Physician Request for Administration/Self-Administration of Medication form
- Delegated Care Aide Authorization form
- Physician’s Diabetes Care Plan

**Food Allergy Checklist**
- Student Medical Information (SMI) form
- Consent to Exchange Information and Medical Records
- Physician Report on Child with Allergies
- Parent/Guardian Request for Administration/Self-Administration of Medication form
- Physician Request for Administration/Self-Administration of Medication form
- Copy of epinephrine auto-injector prescription and original medication box/container
- Food Allergy & Anaphylaxis Emergency Care Plan

**WHY DOES A CHRONIC CONDITION NEED TO BE DIAGNOSED BY A HEALTHCARE PROVIDER?**

1. Healthcare providers work with families to establish Action Plans at school – Action Plans are important in case of a medical emergency.
2. Healthcare provider diagnosis may allow your child to qualify for a 504 Plan, a document that can provide your child with special accommodations while he/she is at school.
3. Proper documentation informs the school about how medication should be administered and if staff are responsible for administering medication or assisting your child administer medication.

**QUESTIONS? Please contact the CPS Office of Student Health and Wellness at oshw@cps.edu**
CHILDREN AND FAMILY BENEFITS UNIT

MAKING "HEALTHY" ACCESSIBLE
The Children and Family Benefits Unit (CFBU) of the Office of Student Health and Wellness (OSHW) can help you apply for Medicaid (low cost or free health insurance) and SNAP benefits (food stamps) at no cost. In partnership with the Greater Chicago Food Depository and Patient Innovation Center, the CFBU will:

- Walk you step-by-step through the Medicaid and SNAP application
- Help you understand your eligibility and the documents needed
- Assist you with renewing your medical or SNAP case
- Help you choose a medical plan and a doctor

PROGRAMS OVERVIEW
Health Insurance (Medicaid or All Kids)
Medicaid provides children and their families with health care coverage that can be used for doctor’s visits, prescription medications, dental care, eye exams, glasses, and more! All children in Illinois are eligible for health insurance regardless of their immigration status.

The Supplemental Nutrition Assistance Program (SNAP/Food Stamps)
SNAP benefits provide families with a monthly amount of money that can be spent on nutritious food at the grocery store. Food is purchased with an electronic card, called the LINK card.

DOCUMENTS NEEDED
The following documents are needed to complete the Medicaid or SNAP application:

- Proof of income for the past 30 days (pay stubs, letter from employer, or self employment log)
- Proof of income from other sources (Social Security, child support, unemployment benefits)
- Proof of identification (driver’s license, state ID, passport, or school ID)
- Proof of Illinois residency (Illinois ID, utility bill, or lease)
- Copy of current or previous Medical Card (if you already have one for a member of your family)
- Copy of Birth Certificate or passport (for U.S. citizens applying)
- Copy of Social Security Cards
- Copy of both sides of Legal Permanent Resident cards (green card)

Call 773-553-KIDS (5437)
for more information or to make an appointment.

SCHOOL-BASED ENROLLMENT SITES

Northside
- Burbank Elementary
  2035 N Mobile Ave, 60639
- Garfield Park Offices
  2651 W Washington Blvd, 60612
- Hibbard Elementary
  3244 W Ainslie St, 60625
- Kellman Elementary
  3030 W Arthington St, 60612
- Lowell Elementary
  3320 W Hirsch St, 60651
- Monroe Elementary
  3851 W Schubert Ave, 60647
- Orozco Elementary
  1940 W 18th St 60608
- Sullivan High School
  6631 N Bosworth Ave, 60626

Southside
- Fiske Elementary
  6020 S Langley Ave, 60637
- Lindblom High School
  6130 S Wolcott Ave, 60636
- Marquette Elementary
  6550 S Richmond St, 60629
- Nathan Davis Elementary
  3014 W 39th Pl, 60632
- New Sullivan Elementary
  8331 S Mackinaw Ave, 60617
- Saucedo/Telpochcalli Elementary
  2850 W 24th Blvd 60623
- Shoop Elementary
  11140 S Bishop St, 60643
- Stevenson Elementary
  8010 S Kostner Ave, 60652
“Evidence shows that healthy students have better attendance patterns and perform better academically.” The following health requirements apply to all children enrolled in a Chicago Public School. Children must provide proof of required immunizations and health exams before October 15, 2017, or they will face exclusion from school.

**EXAMINATION REQUIREMENTS**

**Physical Examination** requirements due upon enrollment, or by 10/15/17
Physical Examination must be completed within one year prior to entry to:
- Preschool and kindergarten (physical exam and lead screening through age 6)
- 6th grade and 9th grade (ages 5.11, 15 for un-graded programs)
- Any student entering CPS for the first time

**Vision Examination** requirements due upon enrollment, no later than 10/15/17
- Entering the State of Illinois for the first time at any grade level.
- Entering kindergarten

**Dental Examination** requirements due 5/15/18 for kindergarten, 2nd and 6th grade.

**IMMUNIZATION REQUIREMENTS**

**Diphtheria, Pertussis (Whooping Cough), Tetanus (DTP, DTaP & Tdap)**
- Four (4) or more doses. The first 3 doses with intervals of 4 weeks apart. The interval between the 3rd and 4th dose is at least 6 months.
- The last dose qualifying as a booster and received on or after the 4th birthday
- One (1) dose of the Tdap vaccine for 6th to 12th grades.

**Polio** (New) for 2017-2018 School Year
- Four (4) or more doses. The first 3 doses with intervals of 4 weeks apart. The interval between the 3rd and 4th dose is at least 6 months.
- The last dose qualifying as a booster and received on or after the 4th birthday.
- A 4th dose is not needed if the 3rd dose was administered at age 4 or older and 6 months after the previous dose.

**Measles, Mumps, and Rubella (MMR)**
- One (1) dose required for preschool, & a second dose required for all students kindergarten to 12th grade.
- 1st dose received at 12 months or later
- 2nd dose must be administered at least four weeks (28 days) after 1st dose

**Hepatitis B**
- Three (3) doses required for all students.
- 1st dose at birth.
- 2nd dose received no less than 28 days or 4 weeks after 1st dose.
- 3rd dose received no less than 2 months after the 2nd dose and 4 months after the 1st dose.

**Varicella (Chicken Pox)**
- Two (2) doses of varicella are required for kindergarten, 1st, 2nd, 3rd, 6th, 7th, 8th, 9th, 10th, 11th, & 12th grades. The first dose on or after the first birthday and the second dose no less than four weeks (28 days) after the first dose.
- One (1) dose required on or after the first birthday for Prek, 3rd, 4th, 5th, grades.

**Haemophilus Influenzae, Type B (HIB)**
- Three (3) doses required for primary series.
- If none received before age 15 months, only one (1) dose required from age 15 months to 59 months of age. Not required age 5 years or older.

**Pneumococcal Conjugate (PCV)**
- Four (4) doses required for primary series.
- If none received before age 24 months, only one (1) dose required from age 24 to 59 months of age. Not required age 5 years or older.

**Meningitis Conjugate (MCV4)**
- One (1) dose of the meningitis vaccine for 6th, 7th and 8th grades
- Two (2) doses of the meningitis vaccine for 12th grade.
- 2nd dose must be administered at least 8 weeks after 1st dose
- If the 1st dose was given at age 16 or older; only one (1) dose will be required for 12th grade.
Chicago Public Schools has partnered with Illinois Eye Institute at Princeton and Tropical Optical to provide vision exams for CPS students. Seven locations throughout the city have been provided for your convenience. Please review the list of vision service locations listed below.

You may select any of the locations listed or your own healthcare provider.

### Illinois Eye Institute at Princeton (IEI)
5125 S. Princeton Ave.
Chicago, IL 60609

Families can walk-in
Monday-Friday
from 8:30 a.m. - 9:30 a.m.

All ages welcome

### Tropical Optical
Select from a location below
Families can walk-in
from 10:30 a.m. - 2:00 p.m.
or
call Elizabeth Ramos
at (773) 762-5662
for additional appointment hours

For children 5 yr and above

### Illinois Eye Institute at Princeton (IEI)
5125 S. Princeton Ave.
Chicago, IL 60609

For afternoon appointments
call (312)-949-7990

All ages welcome

### TROPICAL OPTICAL LOCATIONS

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>6141 West Cermak Rd</td>
<td>Cicero, IL 60804</td>
<td></td>
</tr>
<tr>
<td>3624 West 26th Street</td>
<td>Chicago, IL 60623</td>
<td></td>
</tr>
<tr>
<td>2250 South 49th Avenue</td>
<td>Cicero, IL 60804</td>
<td></td>
</tr>
<tr>
<td>3213 West 47th Place</td>
<td>Chicago, IL 60632</td>
<td></td>
</tr>
<tr>
<td>2767 North Milwaukee Ave</td>
<td>Chicago, IL 60647</td>
<td></td>
</tr>
<tr>
<td>9137 South Commercial Ave</td>
<td>Chicago, IL 60617</td>
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CPS Vision Program offers Free Eye Exams and Glasses Voucher Program

Chicago Public Schools has partnered with Visionworks to offer Let’s Go See vouchers. The vouchers provide free eye exams and eyeglasses (if needed) for CPS students.

You can use the voucher at any Visionworks store in the Chicagoland area.

To request a voucher for your child or learn more about the program, contact the CPS Vision Team at (773) 535-8674 or (773) 535-8675.