PARENT CHECKLIST

ALL PARENTS MUST COMPLETE
- Student Medical Information 2019-2020 ................................................................. Page 5
- Request for Emergency and Health Information ......................................................... Page 25
- School Messaging Consent Form (Robo Call) ............................................................... Page 27
- Media Consent Form and Release ............................................................................. Page 29
- Family Income Information Forms ............................................................................ Page 31

PARENTS MUST COMPLETE IF YOU WANT DENTAL AND/OR VISION SERVICES FOR STUDENTS
- Dental Consent Form ................................................................................................. Page 9
- Vision Consent Form ................................................................................................. Page 13

DOCTOR MUST COMPLETE THE FORMS AND PARENT MUST RETURN TO SCHOOL CLERK
- Proof of Dental Examination Form - For students that have private dentist ................. Page 15
- Vision Examination Report - For students that have a private eye doctor ................. Page 16
- Asthma Action Plan - For students with asthma, see school clerk or nurse ............... Page 19
- Healthcare Provider Statement for Food Substitution
  For students with food allergies, see the school clerk or nurse ................................. Page 21
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Dear Parent and Families,

The health and wellness of your children is a top priority. Every child deserves to have access to trusted health care providers who specialize in preventive care and can address medical issues that arise. At CPS, we organize medical and dental services for children who need access to medical providers. We also collect key medical information confidentially to ensure that we are equipped to meet the unique needs of your child.

Please read through this packet carefully for information about our health requirements and services. All parents and guardians are required to submit the following forms to their school clerk as soon as possible.

- Student Medical Information 2019-2020 (page 5)
- Request for Emergency and Health Information (page 25)
- School Messaging Consent Form (page 27)
- Media Consent Form and Release (page 29)
- Family Income Information Forms (page 31)

Information about our dental and vision services, which are available to all students, can be found on pages 8 and 12, and the consent forms to enroll in these services are on pages 9 and 13. If you take your child to a private dentist or eye doctor, please make sure to have those doctors’ complete pages 15 and 16.

Additional actions are required if the following pertain to your child:

- Chronic health condition: Schedule an appointment with your school nurse, who will provide forms for your doctor to complete.
- Food allergy: Submit the Healthcare Provider Statement for Food Substitution Form on page 21.
- Asthma: Ask your doctor to complete the Asthma Action Plan on page 19.

For assistance with signing up for health insurance and food stamps, please call our hotline at (773) 553-KIDS or visit one of our enrollment sites. For a complete list of sites, visit bit.ly/enrollmentsites or www.cps.edu/cfbu.

Healthy students are better learners, and we are here to support you in ensuring the health and wellness of your child. If you have questions, please contact Project Manager Katheryn Stafford-Hudson at (773) 535-8675 or kgstafford-h@cps.edu.

Sincerely,

Dr. Kenneth L Fox
Chief Health Officer
Minimum Health Requirements
2019-2020

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, 2019, or they will face exclusion from school.

**Health Insurance**
Health insurance can provide children and their families with comprehensive health care coverage that can be used for doctor’s visits, immunizations, prescription medications, dental care, eye exams, glasses and more!

If you would like help enrolling your child in health insurance, call the Healthy CPS Hotline: 773-553-KIDS (5437) or visit www.cps.edu/cfhu

All Kids Health Insurance provides coverage for children in Illinois, regardless of immigration status.

If you need help finding a health center near you please call: 773-553-KIDS (5437) or visit https://findahealthcenter.hrsa.gov

**Recommended Vaccine**
To prevent HPV cancers
HPV (human papillomavirus) vaccination is recommended for preteen girls and boys at age 11 to 12 years. Preteens need HPV vaccinations for protection from HPV infections that cause cancer. CDC recommends that 11 to 12 year olds receive two doses of HPV vaccine at least six months apart. Teens and young adults who start the series later, at ages 15 through 26 years, need three doses of HPV vaccine to protect against cancer-causing HPV infection. For more information: www.cdc.gov/vaccines/vpd/HPV/public/index.html

For more information about CPS health requirements, contact your School Nurse.

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**EXAMINATION REQUIREMENTS**

**Physical Examination** requirements due upon enrollment, or by 10/15/19
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 10/15/19
- Entering the State of Illinois for the first time at any grade level.
- Entering kindergarten

**Dental Examination (NEW)** requirements due 5/15/20 for kindergarten, 2nd, 6th grade and 9th grade.

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**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**
- 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.
Student Medical Information 2019 – 2020

This form must be updated and returned to school each school year.

Please let your school know about your child’s health and health care. This is a good way to keep your child safe. The information is CONFIDENTIAL and will be shared only with CPS staff who need to know (Nurse, Principal, Designee, or Clerk).

<table>
<thead>
<tr>
<th>Student Name</th>
<th>Date of Birth</th>
<th>Student ID Number</th>
</tr>
</thead>
</table>

School | Grade
---|---

1. Please indicate your child’s health status below

☐ My child has no known health conditions

My Child has a known condition(s). Please check all that apply:

☐ Allergies (food or other) – please specify: ____________________________

☐ Asthma Year Diagnosed _________

☐ Diabetes – please circle one: Type 1 Type 2 Year Diagnosed _________

☐ Seizures/Epilepsy Year Diagnosed _________

☐ Sickle Cell Disease Year Diagnosed _________

☐ Other: __________________________ Year Diagnosed _________

2. My child has a primary doctor.

YES NO

If yes, please provide the healthcare provider’s name and phone number:

Name: _______________________________ Phone number: _______________________________

☐ I give permission for my child’s school nurse or designee to talk to the doctor about my child’s health.

3. My child is covered by health insurance.

YES NO

If your child needs health insurance call Healthy CPS 773-553-KIDS (5437)

This Form is NOT the same as a “Plan of Care” (detailed medical care instructions to keep your child safe). If your child has a health condition that may require action at school, please provide school with documentation from your physician and schedule an appointment with your school nurse. Complete a “Medical Plan of Care Form” at: www.cps.edu/oshw (or get it from the school nurse), and return it to school. If your child has a health condition, please schedule an appointment with the school nurse.

Parent Name: _______________________________ Date: _______________________________

Parent Signature: _______________________________

Phone Number: _______________________________ Email: _______________________________

PLEASE RETURN THE FORM TO THE SCHOOL NURSE
IF THE STUDENT HAS A HEALTH CONDITION PARENTS MUST SCHEDULE A MEETING WITH THE SCHOOL NURSE

Nurses Use Only
Reviewed by: _______________________________
Date and Initial: _______________________________

Revised April 25, 2019
The Children and Family Benefits Unit (CFBU) of the Office of Student Health and Wellness (OSHW) can help you apply for low cost or free health insurance (Medicaid) and SNAP at no cost. In partnership with the Greater Chicago Food Depository the CFBU will:

- Walk you step-by-step through the Medicaid and SNAP application.
- Help you understand your eligibility & the documents needed to apply.
- Assist you with renewing your Health Insurance or SNAP case.
- Help you choose a Health Plan and a Primary Care Physician.
- Help you set up “Manage My Case”—so you can view your benefit information, update case information, or submit renewals.

HEALTH INSURANCE (MEDICAID OR ALL KIDS)

Medicaid provides children & their families with comprehensive health care coverage that can be used for doctor’s visits, immunizations, prescription medications, dental care, eye exams, glasses, & more!

NOTE: In Illinois children may qualify for low-cost/free health insurance regardless of Immigration Status.

The Children and Families Benefit Unit (CFBU) of the Chicago Public Schools (CPS) is funded by the Supplemental Nutrition Assistance Program (SNAP) of the United States Department of Agriculture. This institution is an equal opportunity provider.
Dear Parent/Guardian,

Healthy teeth are important for your child’s overall health and wellbeing, and one way to help your child maintain healthy teeth is to ensure he or she receives a dental cleaning every six months. Illinois law requires every child in Kindergarten, 2nd, 6th, and 9th grade to have a dental exam by May 15 of each year, and to help families meet this requirement, CPS and the Chicago Department of Public Health have partnered to provide high-quality dental services to students who do not have access to a dentist. It is recommended that students see the dentist every six months.

The CPS Dental Program provides the following services:

- Dental Examination
- Dental Cleaning
- Fluoride Treatment
- Dental Sealants as needed
- Referral for other treatment, if needed

If your child does not have a private dentist and has not received dental care in the last 6 months, he or she is eligible to participate in the CPS Dental Program at their school. Dental services are available to your child at no cost, to you. However, if you have public health insurance (Medicaid), your benefits will be used. The dentist will come to your child’s school once during the school year.

To enroll your child in the CPS Dental Program, please complete and sign both sides of the following two forms in this packet and return them to school as soon as possible.

1. School-Based Oral Health Program, Dental Consent, Release of Liability and Authorization Form
2. School-Based Oral Health Program Authorization Form- HIPAA

If your child has a private dentist and will not need to participate in the CPS Dental Program, please have your dentist complete the Illinois Dental Examination Report Form and return it to your child’s school. This form is on the back of this letter and can also be found on page 15 or at http://cps.edu/OSHW/Documents/ProofDentalExam.pdf.

If you have any questions, please contact Katheryn Stafford-Hudson, Project Manager (773) 535-8675, kstafford-h@cps.edu.

Sincerely,

Dr. Kenneth L Fox
Chief Health Officer
As the parent/guardian of the above named student, I understand that through the City of Chicago Department of Public Health and the Chicago Public School’s SCHOOL-BASED ORAL HEALTH PROGRAM (the “PROGRAM”), licensed dentists will be coming to my child’s/ward’s school in the near future to provide a DENTAL EXAM/SCREENING, DENTAL CLEANING, FLUORIDE TREATMENT and apply DENTAL SEALANTS (AS NEEDED) at NO COST to students or their families in the school. Dental sealants, in addition to regular brushing and flossing, protect your child’s/ward’s teeth from DECAY. Dental Sealants are thin, plastic coatings put on the tops of the back-teeth to SEAL OUT food and germs. Sealants are applied on teeth that appear not decayed, and they don’t hurt.

I further understand that as evidenced by my signature below, I acknowledge that a licensed dentist providing medical or dental care, treatment, diagnosis, or advice without charge on behalf of the City of Chicago Department of Public Health is not liable for civil damages resulting from his or her acts or omissions in providing such medical or dental care, treatment, diagnosis, or advice under the Program except for willful or wanton misconduct. To authorize dental providers and the Chicago Department of Public Health to share information relating to PROGRAM dental services provided to your child/ward, please sign the Authorization Form that is on the other side of this page. This signed consent form is valid for 365 days from the date that it is signed by the child/ward’s parent or guardian.

MEDICAL INFORMATION:

Asthma Diabetes Currently has Heart Murmur Rheumatic Fever or Rheumatic Heart Disease Epilepsy Blood Disorder / Disease Hepatitis

Race: (Please circle one) White Black Asian / Pacific Islander American Indian/ Native Alaskan Hispanic (Please circle one) Yes No

Is your child/ward taking any medication? If YES, Please list medication:

Does your child/ward have any Allergies? If YES, Please list Allergies:

Any other medical related conditions? If YES, Please list the conditions:

As the parent or guardian of the above named child or ward, I consent for my child or ward to participate in the SCHOOL-BASED ORAL HEALTH PROGRAM, which includes a dental exam/screening, dental cleaning, gel or varnish fluoride treatment, the application of dental sealant(s) if appropriate, and the receiving of Quality Assurance exams. I authorize the dental provider to use my child’s or ward’s Medicaid, ALL KIDS number for billing purposes only. I understand that if I fail to sign this Dental Consent Form and Release of Liability, my child or ward will not receive any services under this program.

Please sign both sides:

Parent/Guardian Date:
School - Based Oral Health Program Authorization Form – HIPAA

Student Name:______________________________      Student Date of Birth: _____________________

School Name: _________________________   Parent/Guardian Name: ______________________________

By signing below, I understand that I am giving my authorization to the dental provider and the City of Chicago Department of Public Health to use and/or disclose my child’s/ward’s protected health information, to the following person(s) or organization(s) for the purposes of reports, documentation of oral health trends, and Medicaid and grant billing: City of Chicago, Department of Public Health, 333 S. State Street, 2nd Floor, Chicago, IL 60604; Individual School Principal; Illinois Department of Healthcare and Family Services, 201 So. Grand Avenue East, Springfield, IL, 62763; Illinois Department of Public Health - Oral Health Division, 535 W. Jefferson Street, 2nd Floor, Springfield, IL, 62761. Chicago Public Schools, Office of Student Health and Wellness, 42 West Madison, Garden Level, Chicago, Illinois 60602. Federally Qualified Health Centers, Infant Welfare Society of Chicago (IWS), 3600 W. Fullerton Ave, Chicago, Oak Park-River Forest Infant Welfare Clinic, 320 Lake Street, Oak Park, IL 60302 and Chicago Public Schools approved Dental Vans.

CDPH and dental providers may not condition treatment, payment, or eligibility for benefits on this authorization or my refusal to sign such authorization. This Authorization is voluntary and I may refuse to sign it. I understand that there is a potential that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA) and federal privacy regulations. I may revoke this Authorization in writing by sending notice to the HIPAA Privacy Officer, City of Chicago, Department of Public Health, 333 S. State Street, 2nd Floor, Chicago, IL 60604. Revocation is not effective with respect to actions taken prior to the revocation. This authorization is valid for 365 days from the date that it is signed by the child’s/ward’s parent or guardian.

Please sign both sides:

Parent/Guardian ___________________________ Date __________________

10
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. If insurance is available it will be billed. If uninsured, vision services will be provided at no charge.

**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.

**Tropical Optical**
Call Elizabeth Ramos for an appointment at (773) 762-5662
Families can walk-in from 10:30 am - 2:00 pm
Must have the student's ID number (school can provide)
For children 5 yr and above

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

Call for appointment 312-949-7990

**All ages welcome**

**For more information about the CPS Vision Program, please contact**
(773) 535-8674 or (773) 535-8675

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**TROPICAL OPTICAL LOCATIONS**

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>6141 West Cermak Rd</td>
<td>Cicero, IL 60804</td>
</tr>
<tr>
<td>3624 West 26th Street</td>
<td>Chicago, IL 60623</td>
</tr>
<tr>
<td>2250 South 49th Avenue</td>
<td>Cicero, IL 60804</td>
</tr>
<tr>
<td>3213 West 47th Place</td>
<td>Chicago, IL 60632</td>
</tr>
<tr>
<td>2767 North Milwaukee Ave</td>
<td>Chicago, IL 60647</td>
</tr>
<tr>
<td>9137 South Commercial Ave</td>
<td>Chicago, IL 60617</td>
</tr>
</tbody>
</table>
Dear Parent/Guardian,

Did you know one in four children have an undiagnosed vision problem that may affect their ability to learn? Every child needs an annual vision exam, especially if any of the following apply to your child:

- My child is entering kindergarten
- My child has never received a vision exam
- My child is entering Illinois schools for the first time at any grade level
- My child failed the school vision screening
- My child has an IEP (Individual Education Plan)
- My child’s teacher recommended they receive an eye exam
- My child is performing below grade level
- My child experiences any of the following:
  - Squinting
  - Blurred or double vision
  - Tilting of the head
  - Holding reading materials close to face
  - Losing place while reading
  - Rubbing eyes
  - Excessive tearing or headaches

All kindergarten students and any child entering the State of Illinois for the first time must have a vision exam per state law by October 15.

- **If your child has a private eye doctor**, please have your child’s eye doctor complete the State of Illinois Eye Examination Report on page 16. The form can also be found online at: [http://cps.edu/OSHW/Documents/VisionExaminationForm.pdf](http://cps.edu/OSHW/Documents/VisionExaminationForm.pdf).

- **If your child does not have a private eye doctor**, your child is eligible to participate in the CPS Vision Program. Through this program, your child will receive eye exams. If your child requires glasses, an optician will help your child select the frame, and glasses will be delivered to your child’s school within four weeks. Students who receive glasses are eligible for replacement glasses due to loss or damage for up to 12 months from the initial eye exam. Private vision insurance or government insurance such as Medicaid, Medicare or any Managed Care Organization will be billed, if available. If a student does not have vision insurance, services are provided at no cost to the family.

To enroll your child in the CPS Vision Exam Program, please complete the Vision Services Consent Form on page 13 and the Student Medical History Form on page 14.

If you have any questions please contact Katheryn Stafford-Hudson, Project Manager, at (773) 535-8675 or kgstafford-h@cps.edu, or the CPS Vision Team at Princeton (773) 535-8674.

Sincerely,

Dr. Kenneth L. Fox
Chief Health Officer
Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible

Vision Services Consent, Release of Liability, and Authorization Form

Please Print: _____________________________ Parent Email Address ____________________________

Student Name: ___________________________ Student’s Date of Birth __________________________

□ Male □ Female

School Name: _____________________________ Student ID# ____________________________

Grade: _________ Room# ___________

Parent/Guardian Name: ____________________ Home Address: _____________________________

Phone: __________________________

Medicaid/Medical Card/ALLKids recipient # ____________________________ Race/Ethnicity ____________________________

Private Vision Insurance: ____________________________ Group ID ____________________________

ID# ____________________________ Cardholder Name: ____________________________ Birth Date ____________________________

Private Medical Insurance: ____________________________ Group ID ____________________________

ID# ____________________________ Cardholder Name: ____________________________

As the parent/guardian of the above name student, I understand that my child will receive a comprehensive eye exam to determine if he/she needs prescription glasses or other treatment by a vision care professional (Provider).

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 a vision exam and/or treatment.

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 eye glasses) 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 to 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 any government or private insurance Illinois Department of Healthcare and Family Services (HFS) or any other currently applicable private insurance for any reimbursable services and/or materials.

If your child has an allergy, please consult your primary care physician before selecting

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.

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 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.

☐ At this time I DO NOT consent for my child's eyes to be dilated

I understand that by refusing dilation I may limit the doctor’s ability to detect and treat certain conditions.

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.

☐ At this time I DO NOT consent for my child to be photographed or interviewed

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 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.

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

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: ____________________________
Parents please sign the vision consent and medical history forms if you want your child to have an eye exam and return to school as soon as possible

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
List medications: __________________________________________________________

______________________________________________________________

Has your child ever had eye surgery? □ No □ Yes
If yes, please explain:

Does your child use eye drops? □ No □ Yes
List eye drops: __________________________________________________________

______________________________________________________________

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

______________________________________________________________

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

______________________________________________________________
**PROOF OF SCHOOL DENTAL EXAMINATION FORM**

To be completed by the parent (please print):

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student's Name:</td>
<td></td>
</tr>
<tr>
<td>Last</td>
<td></td>
</tr>
<tr>
<td>First</td>
<td></td>
</tr>
<tr>
<td>Middle</td>
<td></td>
</tr>
<tr>
<td>Birth Date: (Month/Day/Year)</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>ZIP Code</td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
</tr>
<tr>
<td>Name of School:</td>
<td></td>
</tr>
<tr>
<td>Grade Level:</td>
<td></td>
</tr>
<tr>
<td>Gender:</td>
<td></td>
</tr>
<tr>
<td>□ Male □ Female</td>
<td></td>
</tr>
<tr>
<td>Parent or Guardian:</td>
<td></td>
</tr>
<tr>
<td>Address (of parent/guardian):</td>
<td></td>
</tr>
</tbody>
</table>

To be completed by dentist:

**Oral Health Status (check all that apply)**

- □ Yes □ No **Dental Sealants Present**
- □ Yes □ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.
- □ Yes □ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.
- □ Yes □ No **Soft Tissue Pathology**
- □ Yes □ No **Malocclusion**

**Treatment Needs (check all that apply)**

- □ Urgent Treatment — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling
- □ Restorative Care — amalgams, composites, crowns, etc.
- □ Preventive Care — sealants, fluoride treatment, prophylaxis
- □ Other — periodontal, orthodontic

Please note______________________________________________________

Signature of Dentist ____________________________________________ Date of Exam ____________________

Address ______________________________________________________ Telephone ______________________

Street City ZIP Code

Dentist must complete form, parents please return to your child’s school or send to Katheryn Stafford-Hudson, kgstafford-h@cps.edu or fax 773-535-8675 or Princeton Vision Clinic GSR 45
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 15th of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the child beginning school.

Student Name: ___________________________________________  Birth Date: _____________  Sex: _____ Grade: _____

Parent or Guardian: ____________________________________________________  Phone:  ________________________

Address: ______________________________________________________________  County: _______________________

(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

To Be Completed By Examining Doctor

Date of Exam: ________________

Case History

<table>
<thead>
<tr>
<th>Ocular History</th>
<th>Medical History</th>
<th>Drug Allergies</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal or Positive for:</td>
<td>Normal or Positive for:</td>
<td>NKDA or Allergic to:</td>
<td>_______________________________</td>
</tr>
</tbody>
</table>

Examination

<table>
<thead>
<tr>
<th>Refraction:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance Near</td>
</tr>
<tr>
<td>Right</td>
</tr>
<tr>
<td>Unaided Visual Acuity: 20 / 20 / 20 / 20 /</td>
</tr>
<tr>
<td>Best Corrected Visual Acuity: 20 / 20 / 20 / 20 /</td>
</tr>
</tbody>
</table>

Was refraction performed with cycloplegic agents? Yes No

| External Exam (eye and adnexa) |
| Internal Exam (media, lens, fundus, etc.) |
| Neurological Integrity (pupils) |
| Binocular Function (stereopsis) |
| Accommodation and Vergence |
| Color Vision |
| IOP (glaucoma) |
| Oculomotor Assessment |
| Other: _______________________________ |

<table>
<thead>
<tr>
<th>Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
</tr>
</tbody>
</table>

Other: _______________________________

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Corrective Lenses: No Yes</td>
</tr>
<tr>
<td>2. Preferential seating recommended: No Yes</td>
</tr>
<tr>
<td>3. Recommend re-examination: 3 months 6 months 12 months Other</td>
</tr>
</tbody>
</table>

Print Name: ___________________________________________  Phone:  ________________________________

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)

State of Illinois
Eye Examination Report

Doctor must complete report, parents please return report to your child’s school or send report to Katheryn Stafford-Hudson, kgstafford-h@cps.edu or fax 773-535-8677 or Princeton Vision Clinic GSR 45.
FOR STUDENTS WITH ASTHMA

Asthma is the most common chronic illness in childhood. Chicago has an especially high number of children with asthma, and kids in some Chicago neighborhoods suffer more than others. **We want all students, including those with asthma, to be in school and safe while they are there.**

Please use the forms in this packet to tell your school about your child’s asthma. These forms must be updated each school year. They are reviewed by the School Nurse and relevant CPS staff and kept on file for use during the school year.

**YOU MUST TURN IN THESE FORMS EACH SCHOOL YEAR:**

- Asthma Action Plan – **signed and dated by the health care provider**
- Request for Administration of Medication – **signed and dated by parent/guardian**
- Original (or clear copy) of asthma medication container or pharmacy label with your child’s information

**IF YOUR CHILD HAS A CHRONIC HEALTH CONDITION FOLLOW THESE 4 STEPS:**

- Any student with asthma, food allergies, diabetes, or any other chronic condition can have a Section 504 Plan to support their care during the school day.
- A 504 Plan provides the needed changes the school must make to help your child succeed in school.
- Contact your school nurse to set up a 504 Plan.
Why is it important to tell the school about my child’s asthma?
» Your child’s asthma may flare up at school. Knowing their medical history helps staff know what to if there is an emergency during the school day.
» The information lets the school know what medicine your child may need, so staff can be ready to help if necessary

Are school staff able to help a student manage their asthma?
Yes. School staff complete a training every year on asthma awareness, including how to recognize and handle asthma emergencies.

Can a student self-manage their asthma?
Yes. CPS students are allowed to carry and use their own “quick-relief” or “rescue” asthma medicine if written parent permission and a prescription label is provided to the school.

What is the school’s asthma emergency response?
» Schools will follow the steps outlined in your child’s Asthma Action Plan and 504 Plan/IEP.
» If the medication is not working or the student’s medicine has not been sent to the school, 911 will be called. Parents will be called after 911.

What if a student has an asthma attack but has no plan on file?
The school will follow an Emergency Asthma Action Plan and call 911. Parents are notified after calling 911.

Does the student need a Section 504 Plan?
» A Section 504 Plan must be offered. Speak to your child’s school nurse and doctor to know what is needed.
» Choosing not to have a 504 Plan does not prevent a student from using medicine at school.
» A 504 Plan does not mean the student has a disability. The 504 Plan will outline any needed changes a school must make so your student is safe at school.

I would like more information about asthma care in school:
» Read the CPS Asthma Policy at http://policy.cps.k12.il.us
» Visit the Office of Student Health and Wellness website at http://cps.edu/oshw
» Talk to your child’s school nurse
» Contact the Office of Student Health and Wellness at oshw@cps.edu
### Asthma Action Plan

#### 5 years above

<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Parent/Guardian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Doctor's Office Phone Number: Day</th>
<th>Parent's Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact After Parent</th>
<th>Contact Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Student is able to self medicate
  - [ ] Yes
  - [ ] No

#### GO (GREEN)

Use these medicines every day.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For asthma with exercise, take:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### CAUTION (YELLOW)

Continue with green zone medicine and ADD:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>2 puffs or 1 vial by nebulizer</td>
<td>Every 4 hours as needed</td>
</tr>
<tr>
<td>Next</td>
<td>Call Doctor if no improvement</td>
<td></td>
</tr>
</tbody>
</table>

IF QUICK RELIEVER/YELLOW ZONE MEDICINE IS NEEDED MORE THAN 2-3 TIMES A WEEK, THEN CALL YOUR DOCTOR.

#### DANGER (RED)

Take these medicines and call your doctor.

<table>
<thead>
<tr>
<th>Medicine</th>
<th>How Much to Take</th>
<th>When to Take It</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2 puffs or 1 vial by nebulizer</td>
<td>Immediately - Call Doctor</td>
</tr>
</tbody>
</table>

Get help from a doctor now! Do not be afraid of causing a fuss. Your doctor will want to see you right away. It is IMPORTANT! If you cannot contact your doctor, go directly to the emergency room. DO NOT WAIT. Make an appointment with your primary care provider within two days of an ER visit or hospitalization.

Check all items that trigger your asthma and things that could make your asthma worse:

- [ ] Chalk dust
- [ ] Cigarette Smoke and second hand smoke
- [ ] Colds/Flu
- [ ] Dust mites, dust, stuffed animals, carpet
- [ ] Exercise
- [ ] Sudden temperature change
- [ ] Mold
- [ ] Ozone alert days
- [ ] Pests-rodsents and cockroaches
- [ ] Pets-animal dander
- [ ] Plants, flowers, cut grass, pollen
- [ ] Strong odors, perfumes,
- [ ] cleaning products
- [ ] Wood Smoke

---

### Asthma Triggers

- [ ] Other

---

Adapted from the original design by the Pediatric Asthma Coalition of New Jersey
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.

CHILD’S NAME: _____________________________ DATE: _____________________________

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 return the completed form to your child’s School Nurse along with a Food Allergy Action Plan (found at cps.edu/OSHW). Contact food@cps.edu with any additional questions:

________________________________________________________________________

Parent/Guardian Name

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. _____________________________ _____________________________

   Signature of Health Care Provider Date

Parent/Guardian: Return this form to your School Nurse

________________________________________________________________________

FOR SCHOOL USE ONLY: Please scan and email this form to food@cps.edu.

School Nurse Signature: _____________________________

Date reviewed: _____________________________

Date scanned to food@cps.edu: _____________________________

CLERK PLEASE GIVE A COPY TO THE SCHOOL NURSE AND THE LUNCHROOM MANAGER
STUDENTS LEARN BETTER AT HEALTHY SCHOOLS!

The Healthy CPS Indicator is the comprehensive health-focused measure included on the CPS school progress report. Stakeholders are able to identify if their school is meeting key policies and initiatives that focus on chronic disease, instruction, wellness (LearnWELL) and health services.

CHRONIC DISEASE
The Healthy CPS Chronic Disease badge measures whether schools are effectively providing a supportive environment for students with chronic conditions including asthma, food allergies, and diabetes. This is accomplished through:
- Student identification
- Proper accommodations
- Mandatory staff training as it relates to chronic condition management and emergency response

INSTRUCTION
The Healthy CPS Instruction badge measures whether schools provide students dedicated instructional time for the following content areas:
- Physical education required minutes in K-12
- Sexual health education required minutes in all grades K-12
- Nutrition education integration into K-12 classes

LEARNWELL
The Healthy CPS LearnWELL badge measures whether schools provide access to healthy foods and physical activity to students throughout the school day. This is accomplished through:
- School wellness team that meets quarterly
- Healthy fundraisers, rewards and celebrations
- Nutrition standards for food served in school
- School garden integration in curriculum
- Daily and active recess
- Integrating physical activity during the day
- Staff training on supporting LGBTQ students
- Pre-K wellness initiatives

HEALTH SERVICES
The Healthy CPS Health Services badge measures whether schools are providing student access to direct healthcare services that impact learning. This is accomplished through:
- Screening (Vision and Hearing)
- Vision Exam Program
- Dental Exam Program
- Medical compliance (physical exams and immunizations)

Help your school become Healthy CPS!
- Join your School Wellness Team
- Review resources and criteria for becoming Healthy CPS at www.cps.edu/healthycps
- Questions? Contact OSHW@cps.edu
Human Papillomavirus (HPV) vaccine is a safe and effective way to protect your child from cancer. Although HPV vaccine is not yet required for school entry in Illinois, pediatricians, family physicians, the American Academy of Pediatrics (AAP), the American Academy of Family Physicians (AAFP), American Cancer Society (ACS), the Centers for Disease Control and Prevention (CDC) and the Chicago Department of Public Health (CDPH) all strongly recommend that you take this step to protect your child now.

The best way to reduce HPV infection which may cause certain types of cancer is vaccination. The CDC recommends that all boys and girls ages 11-12 years old receive the HPV vaccine at the same time as the other required preteen vaccines like Tdap (which protects against tetanus, diphtheria and pertussis) and MCV4 (which protects against meningococcal disease).

HPV is a very common virus that causes over 31,000 cancers each year in the US. Nearly all these cancer cases could be prevented if all eligible people received the vaccine at the recommended time.

For more information about the HPV vaccine, go to the CDC website [www.cdc.gov/hpv](http://www.cdc.gov/hpv).

HPV vaccine is widely available across the city of Chicago. If your teen did not get the HPV vaccine at age 11-12, it’s not too late. Visit your child’s health care provider or a school-based health center to discuss HPV and protect your child from cancer!

---

**Don’t Wait to Vaccinate**

Doctors recommend that girls and boys get vaccinated against HPV at age 11 or 12. The series should be completed by age 13.

---

**Age Matters**

When you vaccinate your child on time, you help protect them from HPV cancers. The HPV vaccine is most effective when given at age 11 or 12. Cancer protection decreases as age at vaccination increases.

---

**Cancer Prevention Goes Down with Delayed Vaccination**

---

**Early**

Ages 9-10

2 Doses

6-12 months apart

**On Time**

Ages 11-12

2 Doses

6-12 months apart

**Critical**

Ages 13-14

2 Doses

6-12 months apart

**Last Chance**

Ages 15-26

3 Doses

1st dose at visit one

2nd dose 1-2 months later

3rd dose 6 months after 2nd

---

This tool was supported in part by Centers for Disease Control and Prevention Cooperative Agreement Number NH23IP000953-03. ©2017 American Cancer Society, Inc. No. 080329.
Request for Emergency and Health Information

School Name: ____________________________________________________________

PARENTS/GUARDIANS: The school must have on file emergency information that can be used to contact you. Please print clearly. Whenever there is a change in this information, immediately notify the school in writing.

Student ID# Last Name First Name Middle Name Homeroom #

Birth Date (mm/dd/yyyy) Student Home Address Student Home Phone #

Confidential Information Box 1
Complete this box only if (1) it reflects your child’s current living situation; OR (2) it reflects your living situation if you are a youth not living with a Parent or Guardian. (Your answer will help school staff with enrollment and may enable the student to receive additional services.) Check one box:
☐ in a car/park/other public place
☐ doubled-up ☐ in a hotel/motel ☐ in a shelter ☐ in transitional housing

School Note: If any box is checked, see the CPS Policy 702.5.

Confidential Information Box 2
Is there a current Order of Protection or No Contact Order which concerns this student? ☐ Yes ☐ No

School Note: If “Yes,” follow CPS Policy 704.4 procedures. Enter information in Legal Alert field and update contact information, as needed, in SIM.

Parent/Guardian and Emergency Contact Information: Add extra contacts on the back of this form, if needed.

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Parent/Guardian Contact</th>
<th>Parent/Guardian Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship to Student</td>
<td>☐ Lives With ☐ Gets Mailings</td>
<td>☐ Lives With ☐ Gets Mailings</td>
</tr>
<tr>
<td>☐ Emergency ☐ Permission to Pickup</td>
<td>☐ Emergency ☐ Permission to Pickup</td>
<td></td>
</tr>
</tbody>
</table>

Home Address, if different from student’s
Home Phone Number, if different from student’s
Cell Phone Number
Email Address
Name and Address of Employer
Work Phone Number
* Communication Language

* CPS communicates via phone calls. Select the language that should be used to communicate with you. Languages available for mass communication at this time are English and Spanish (note: other languages upon availability).

List the name of a relative or neighbor who can also be notified in an emergency and has permission to pick up the student:

Name Home Address Telephone # Relationship

Family Doctor’s Name, Address, and Phone Number: I authorize you to call my family doctor, if necessary, in an emergency.

Student Health Insurance: (select only one of the three)
☐ Illinois Medical Card/All Kids: provide student’s medical ID # ________________________________ (9-digit number located on back of card)
☐ No Insurance: are you interested in applying for the Illinois Medical Card/All Kids? ☐ Yes ☐ No
☐ Private/Employer Health Insurance: no additional information needed

Children of Military Personnel (optional)
As the Parent or Guardian, are you a member of a branch of the armed forces of the United States? ☐ Yes ☐ No
If yes, are you either deployed to active duty or expect to be deployed to active duty during the school year? ☐ Yes ☐ No

I certify that the information on this form is correct:

(Parent/Guardian Signature) (Date)
School Messaging Consent Form

Dear Parent/Guardian/Student if age 18 or older,

Your school and the district will periodically want to send information regarding school or district events, updates or initiatives. We will utilize the phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, and more. To ensure you receive periodic school or district related notifications and reminders, your consent is needed below.

In the event of an emergency, whether or not consent is on file, you will be informed by all contact information provided. Emergency calls include weather closures, health risks, threats, unexcused absences, and other situations affecting the health or safety of students and faculty. Emergency calls will be sent to all the phone numbers, including cellular numbers, listed on the student’s record. Please make sure these numbers are updated with the school.

**Please fill out and return this form to ensure you receive informational calls**

By signing this form, you are authorizing Chicago Public Schools to use an automated system to periodically deliver automated informational calls or text messages to the phone number(s) provided below. If you change your phone number or no longer wish to receive automated calls, texts or e-mails, you agree to inform Chicago Public Schools immediately. By signing below, you agree that this consent will remain valid and you will continue to receive automated phone calls unless or until you revoke your consent. Please return this completed form to your school no later than December 1, 2019. Standard messaging rates and data charges may apply.

Instructions: Check Box for Consent or Do Not Consent

- [ ] I CONSENT as outlined in the above section.
- [ ] I DO NOT CONSENT as outlined in the above section.

<table>
<thead>
<tr>
<th>Signature of Parent/Guardian/Student if age 18 or older</th>
<th>Printed Name of Parent/Guardian/Student if age 18 or older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student’s Name</td>
<td>Student ID #</td>
</tr>
<tr>
<td>Date</td>
<td>School</td>
</tr>
</tbody>
</table>

Phone Number 1 for Messages: (___) _____ - _______

Phone Number 2 for Messages: (___) _____ - _______

E-mail Address: ____________________________________________
Media Consent Form and Release

Consent/Release

I hereby consent to have my child photographed, digitally recorded, video taped, audio taped and/or interviewed by the Board of Education of the City of Chicago (the “Board”) or the news media when school is in session or when my child is under the supervision of the Board. Further, I consent for these photos, digital recordings, video tapes, audio tapes and/or interviews to be shared with third parties who have received written approval from the Office of Communications. I understand in the course of the above described activities that the Board might like to celebrate my child’s accomplishments and work. Therefore, I further consent for the Board’s release of information on my child’s name, academic/non-academic awards and information concerning my child’s participation in school-sponsored activities, organizations and athletics.

I also consent to the Board’s use of my child’s name, photograph or likeness, voice or creative work(s) on the Internet or on a CD or any other electronic/digital media or print media.

As the child’s parent or legal guardian, I agree to release and hold harmless the Board, its members, trustees, agents, officers, contractors, volunteers and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the use of my child’s name, photograph or likeness, voice or creative work(s), on television, radio or motion pictures, or on the Internet, or on a CD, or any other electronic/digital media or print media.

It is further understood and I do agree that no monies or other consideration in any form, including reimbursement for any expenses incurred by me or my child, will become due to me, my child, our heirs, agents, or assigns at any time because of my child’s participation in any of the above activities or the above-described use of my child’s name, photograph or likeness, voice or creative work(s).

I understand that I may cancel this consent by providing written notice to the principal. I also understand that my consent to have my child photographed, digitally recorded, video taped, audio taped and/or interviewed by the Board or the news media when school is in session or when my child is under the supervision of the Board is valid for one school year, including the following summer.

Instructions: Check Box #1 or Box #2

1. ☐ I consent as outlined in the above consent/release section.

2. ☐ I DO NOT consent as outlined in the above consent/release section.

Signature of Parent/Guardian/Student if age 18 or older

Printed Name of Parent/Guardian/Student if age 18 or older

Student’s Name

Student ID #

Date

School

I understand that I have the right to inspect and copy my student’s records, challenge the contents of such records; and limit my consent to the designated records or designated portions of information within the records.
If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign. All other households, follow these instructions (Part 4) below. Avance a Sección 4: Siga las instrucciones bajo TODOS LOS DEMÁS HOGARES (Sección 4) más abajo. Avance a Sección 5: Skip to Part 5 ( página 32).
# CPS FAMILY INCOME INFORMATION FORM 2019-2020

**School Name (Nombre de Escuela):**

The purpose of this form is for CPS to obtain information about families’ income to determine school funding. CPS and your school may receive additional funding based on the number of low-income families enrolled. Please complete this form and return it to the school’s main office.

<table>
<thead>
<tr>
<th>Foster Child? (Hijo de Niño)</th>
<th>CPS Student? (Estudiante de CPS?)</th>
<th>All Household Member Names</th>
<th>Date of Birth (Fecha de Nacimiento)</th>
<th>DHS Case Number (Número de Caso del DHS)</th>
<th>Part 3 – Homeless, Migrant, Runaway Child, or child enrolled in Head Start (Niño sin Hogar, Emigrante, Fugitivo o Niño en el programa Head Start)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>First (Nombre) MI (Inicial)</td>
<td>/</td>
<td>/</td>
<td>□ Homeless  □ Migrant  □ Runaway  □ Head Start  Homeless, Migrant, Runaway or Head Start Liaison Signature  Date (Fecha)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Last (Apellido)</td>
<td>/</td>
<td>/</td>
<td></td>
</tr>
</tbody>
</table>

**Part 4 – List Household Members With Income (SKIP THIS if you answered any of steps 2 or 3)** Enter the amount of income and how often it is received for each household member. (Nombres de los integrantes de su hogar que perciben ingresos. Para cada uno, indique sus ingresos y cuánto los recibe. DEJE EN BLANCO si ha contestado la Sección 2 o 3 de esta solicitud.)

<table>
<thead>
<tr>
<th>Household Member Names With Income</th>
<th>Gross Income (before deductions) (Ingresos Brutos)</th>
<th>Other Income (Todos Otros Ingresos)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First (Nombre) MI (Inicial) Last (Apellido)</td>
<td>Weekly Every 2 Weeks Twice Monthly Monthly Annually</td>
<td>Weekly Every 2 Weeks Twice Monthly Monthly Annually</td>
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</tbody>
</table>

**Part 5 – Opt In of information about other benefits. (Otros Beneficios)**

- □ YES! I am interested in applying for a waiver of instructional fees. SI! Me interesa aplicar por la exoneración del pago de enseñanza.
- □ YES! I am interested in applying for the Supplemental Nutrition Assistance Program (SNAP) and/or health insurance. SI! Me interesa aplicar para el Programa de Ayuda en Nutrición Suplementaria (SNAP) y/o la tarjeta médica. If you have questions about these programs, please call 773-553-KIDS (5437). Si tiene preguntas sobre estos programas, llame al 773-553-KIDS (5437).

Signature (Firma):

**Part 6 – Signature (Firma)**

I certify that all above information is true and all income is reported. I understand that information gathered from this form will be used to calculate Federal funding eligibility for the school and that school officials may verify (check) the information as being accurate; and that if I purposely give false information, I may be prosecuted. (Certifico que toda la información indicada arriba es verdadera y que he reportado todos nuestros ingresos. Entiendo que la escuela recibirá fondos del gobierno federal basado en la información en este formulario y que los funcionarios escolares pueden verificar la fidelidad de la información; y si doy información falsa intencionalmente, me pueden llevar a juicio.)

Signature of adult household member (Firma del miembro adulto del hogar) Parent / Guardian First Name (Nombre del adulto del hogar) Parent / Guardian Last Name (Apellido del adulto del hogar)

Address (Dirección postal o de domicilio) Zip Code (Código Postal)

Date (Fecha)  

**SCHOOL USE ONLY Initial Determination:** □ ELIGIBLE (FREE OR REDUCED) □ INELIGIBLE (DENIED, N/A OR ?)