Homer Community Consolidated School District 33C

THINIMING CESPONG RESPONDENCES ON THE SPONGE CCSD PRINTING CCSD PRINTING

15733 Bell Road • Homer Glen, IL 60491-8404 (708) 226-7600 • FAX (708) 226-7627

Craig Schoppe, Superintendent Michael Szopinski, Assistant Superintendent for Instruction Aleksas Kirkus, Assistant Superintendent for Business Michael Portwood, Assistant Superintendent for Human Resources

2020-2021 Kindergarten Medical Information

All students entering Kindergarten must have a thorough physical exam with all state required immunizations complete and documented.

Physicals MUST BE TURNED IN by August 1st (Please upload front and back of form)

Eye Exams must be turned in by October 15th (can be uploaded here if complete)

Dental Exams must be turned in by May 15th (can be uploaded here if complete)

Requirements for acceptable physicals are as follows: (in addition to exam)

- 1. Complete Immunization series for: Dtap, Polio, MMR, and Varicella
- 2. Dated ONE year prior to the first day of school. Physicals dated before August 19, 2019 are not valid. Please be sure they are signed by your licensed provider.
- 3. Child health history filled out, signed, and dated by parent/guardian
- 4. TB, LEAD and DIABETES screen completed by provider

PHYSICALS MUST MEET THE ABOVE REQUIREMENTS FOR YOUR CHILD TO BE ALLOWED TO ATTEND THE FIRST DAY OF SCHOOL

If your child has: Allergies, Asthmas, Diabetes, Seizures, ADHD, Requires Administration of Medication during School Hours, or any other medical concern - please contact the Schilling School Nurse:

Rachel DeAngelis-Rush, RN

Schilling School Nurse

(708) 226-7658

rdeangelis@homerschools.org

First Page of Physical

Somple rence Plea Please complete the entire physical. The areas called out tend to be overlooked. Please be sure to check they are completed properly.



State of Illinois Certificate of Child Health Examination

Student's Name								Birth I	Date		Sex	Rac	e/Ethni	city	Sch	ool/Gr	de Lev	el/ID#
Last	Pirst			_	Mi	ddle		Month/i	Oxy/Year			_						
	reet		City		Zlp Code				Svandiao			Teleph	one# H	nnge			100	7ork
IMMUNIZATION	S: To b	e comp	leted t	y healt	h care	provid	ler. Th	e mo/d	a/yr fo	s <u>every</u>	dose a	dmelmie	tered i	e meand	ired. If	a spec	Me was	relmo la
medically contrains examination explain	dicated	i, a sepa	rate w	ritten :	tatem the co	ent mu	at be a	ttacher	by th	e health	carel	rovid	er resp	onsible	for co	mpleti	ng the i	health
REQUIRED		DOSE 1		1	DOSE:		T	DOSE:	3	T	DOSE 4		Т	DOSE :	5	r —	DOSE	6
Vaccine / Dose	Mic	.DA	YR.	МО	DA	YR	MC	DA C	YR	MO	DA	YR	MÓ DA YR			М		
DTP or DTaP	_	-	_	-	-	-	_	-	_	-	_	4	-	_				
Tdap; Td or	□Td	ap□Td	DDT	□T.d	ap□T∂	DDT	□Td	apLITe	DT	□ Tdi	ap 🗆 T d	DT	□Td	apCITc	IDDT	□ Td	ap Td	DDT.
Pediatric DT (Check specific type)				Ī				T						ľ	П			
	0.1	IPV 🗆	OPV	0.0	PV 🗆	OPV		PV 🗆	OPV	100	PV 🗆	OPV	ь,	PV D	OBY		IPV 🗆	OBY
Pullo (Check specific type)		T	T.,	-	_		 - '		T			OI V		FVL	OFY	<u> </u>	IPV L	TOPV
Hib Heemophilus	_		_	_	_	_	-	_	-		_	_			_	_		
influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B														\vdash		_		
MMR Messiles Missips. Eubella	-	_	-	-	-	-				Com	ments:			_				
Variceita (Chickenpoc)	_	_		-	-	-												
Meningococcal confugate (MCV4)		T								1								
RECOMMENDED, B	UT NO	TREQU	JRED	Vaccine	/Dose		_	_										
Hepatitis A										1								
HPV		T																
Influenza																		
Other: Specify Immunization																		
Administered/Dates				Ļ														
Health care provide If adding dates to the	r (MD, shove	DO, A	PN, PA	history	ol heat section	ih prot	essions	i l, heat	th offic	dal) ver	trying	above	lmmiu	uizatioi	n histor	y mus	t sign h	elow.
	40040	241 IV 64 646 64		matory	0001101	s par ye	MA HILL	iais Uy	ume(s)	entry 91R	H Hele.							
Signature			_					Ti	tle					Dat	te	_		
Signature.								Th	tle					Da	te			
ALTERNATIVE PI																		
l. Clinical diagnosis copy of lab result. 'MEASLES (Rubeola)				epatitis •MUMI													Attac	h
2. History of varicell										в м				ARICE				_
erson signing below ve locumentation of diseas	nnes th	at the pa	rent/gua	adian's	lescript	ion of vi	ricella	disease?	nistory i	indicati	ive of pa	st infect	ion and	is acce	or pting suc	nearrn h histor	описы у аз	l.
Date of Disease			Sign	thura										'Itle				
Laboratory Evide	nce of	Toman		77444	a 🗖	Vieasle	*	□Mu	mmess	CIE	Robella	-	Varie		Attach	00 WW 6	f lab r	omult.
*All measles cases d	iaenos	ed on or	after 1	ulv 1. 2	002. n	nist be	confirm	ed by	aborat	nrv evid	lence		· FREECT	- 46	estiată	copy e	a wan (evil.
Completion of Alter																		
hysician Statements	of Imm	nunity N	AUST I	e subm	itted to	IDPH	for rev	iew.	II D	-Grand								

Please make sure the provider signed and

dated the physical.

Your child must have these vaccines to enter Kindergarten.

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

11/2015

(COMPLETE BOTH SIDES)

Printed by Antherity of the State of Illinois



Second Page for Reverse Side of Physical

The top half of this page is to be completed by the parent., not

the doctor. Please fill out before returning.

		Birth Date	Sex	School	Grade Level/		
<u>Laci</u> First	Middle	Month/Dis / Year			23,0		
HEALTH HISTORY TO BE	COMPLETED AND SIGNED BY PAREN	T/GUARDIAN AND VERIFIED	BY H	RALTH CARE P	ROVIDER		
ALLERGIES Yes List: Frid, drug, speed, ether) No		MEDICATION (Preparitied or					
Diagnosis of authma? Child wakes during night coughing?	Yes No	Loss of function of one of pa organs? (eye/ear/kidney/testi-	ired	Yes N	•		
Birth defects?	Yes No	Hospitalizations?		Yes N	0		
Developmental delay?	Yes No	When? What for?					
Blood disorders? Hemophilia, Sickle Cell Other? Explain.	Yes No	Surgery? (List all.) When? What for?		Yes N			
Diabetes?	Yes No	Serious injury or illness?		Yes No			
Head injury/Concussion/Passed out?	Yes No	TB skin test positive (past/pro	sent)?	Yes* No			
Seizures? What are they like?	Yes No	TB disease (past or present)?		Yes* No	department.		
Heart problem/Shortness of breath?	Yes No	Tobacco ine (type, frequency)?	Yea No			
Heart mumuu/High blood pressure?	Yes No	Alcohol/Drug use?		Ves No			
Dizziness or chest pain with exercise?	Yes No	Family history of sudden desi before age 50? (Cause?)	h	Yes No			
Byt/Vision problems? Glasses Other concerns? (crossed sys; drouping lide	Confects C Last exam by eye doctor	Dental □ Braces □ i	Bridge	□ Plate Other			
Bar/Hearing problems?	Yes No.	Information may be shared with an	propriat	e personnel for bealth	and educational purpores.		
Bone/Joint problem/injury/scoliosis?	Ves No	Parent/Guardian Signature			Date		

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA HEIGHT WEIGHT INC HEAD CIRCUMFERENCE If < 2-3 years old

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMD-85% age/sex Yes [] No [] And any two of the following: Family History Yes [] No [] Ethnik Minority Yes [] No [] Signs of insulin Resistance (hypertension, dynipidemia, polycystic ovarian syndrome, acanthosis nigricand) Yes [] No [] At Risk Yes [] No []

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.) Questionnaire Administered? Yes D No D Blood Test Indicated? Yes D No D Blood Test Date

in high prevalence countries or those exposed to solide in high-risk groups including children immunosuppressed due to HIV infection of office conditions, frequent travel to or board in high prevalence countries or those exposed to solide in high-risk categories. See CDC guidelines. http://www.cdc.eav/hb/publications/factsheets/testing/TB_testing.htm.

No lest needed \(\text{Test} \) Test performed \(\text{Test} \) Skin Test: \(\text{Date Read} \) / Result: \(\text{Positive } \text{D} \) Neosettee \(\text{Test} \) Neosettee \(\text{Test} \) Blood Test: Date Reported Result: Positive [] Value LAB TESTS (Recommended) Date

							Translation .		
Hemoglobin or Hematocrit				Sickle Cell (when in	dicated)	1			
Urinalysis				Dévelopmental Scree	ning Tool				
SYSTEM REVIEW	Normal	Comments/Follow-u	p/Needs		Normal	Comments/Follow-up/Needs			
Skin				Endocrine					
Ears			Screening Result:	Gastrointestinal					
Eyes			Screening Result:	Genito-Urinary		LMP			
None				Neurological					
Thiroat				Musculoskeletal					
Mouth/Dental				Spinal Exam					
Cardiovascular/HTN				Nutritional status					
Respiratory			☐ Diagnosis of Asthma	Mental Health					
Currently Prescribed and Quick-relief med Controller medical	edication: g. Short Acting Beta / inhaled corticosteroid)	Agonist)	Other						

DIETARY Needs/Restrictions SPECIAL INSTRUCTIONS/DEVICES e.g. saidty glasses, glass bye, chest protector for unhythmia, pacemaker, prosthetic device, dental bridge; false treth, athletic support/cop

NEEDS/MODIFICATIONS required in the school setting

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

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seigures, estima, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)? Yes 🗆 No 🗀 If yes, please despribe.

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

these are filled out.

Please check that

Please make sure the doctor has signed and dated the physical.



State of Illinois Certificate of Child Health Examination

Student's Name	udent's Name Birth Date Sex Race/Ethnicity School/Grade Level/ID#																	
Last	First Middle Month/Day/Year																	
	reet		City		Zip Code			Parent/G										
IMMUNIZATIONS	S: To be	comp	leted b	y healt	h care	provid	er. The	mo/da	a/yr for	<u>every</u>	dose ad	minis	tered is	s requi	red. If	a speci	fic vac	cine is
medically contraind examination explain	licated, ning the	a sepa medic	rate w al rese	ritten s son for	tateme	ent mus ntraind	st be at lication	tached 1	by the	health	care p	rovide	r respo	onsible	for co	mpletir	ig the l	ealth
REQUIRED		DOSE 1		1	DOSE 2		T	DOSE 3	3		DOSE 4			DOSE 5		T -	DOSE	6
Vaccine / Dose	мо	DA	YR	МО	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							YR						
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check	□Tda	p□Td[□DT	□Td	ap□Td	□DT	□Td	ap□Td	□DT	□Tda	ap□Td□	JDT	OT □Tdap□Td□D			DT □Tdap□Td□DT		
specific type)																		
Polio (Check specific		PV 🗆	OPV		PV 🗖	OPV		PV 🗆	OPV		PV 🗆 (OPV		PV 🗆	OPV		PV 🗆	OPV
type)																		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella Comments:																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A										7								
HPV																		
Influenza																		
Other: Specify																		
Immunization Administered/Dates																		
Health care provide If adding dates to the												above	immu	nizatio	n histo	ry mus	t sign b	elow.
Signature	100VC 1	111111111111	Zation	mstory	section	ı, put y	our mit	•	tle	and sig	n nere.			Dav	4			
Signature								Tit						Da Da				
ALTERNATIVE PI	ROOF (OF IM	MUNI	TY				111	це			_		Da	te			
					R) is :	allowed	l when	verifie	d hv n	hvsicia	n and s	Innor	ted wit	h lah c	onfirm	ation	Attac	h
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR									.11									
2. History of varicel Person signing below ve	erifies tha																	1.
documentation of disease. Date of																		
Disease Signature Title																		
3. Laboratory Evide			- `			Measle			mps**		Rubella]Varic	ella	Attach	copy o	of lab r	esult.
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.																		
Completion of Alter									sician S	ignatu	re:							
Physician Statements	OI HIIII	unity N	UOSI	oc suon	muca to	מאלוגט	r for ter	ICW.										

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

Last		First			Middle		Birtl	1 Date Month/Day/ Year	Sex	School Grade Level					
HEALTH HISTORÝ			OMPL	ETED		D BY PARENT	GUA	RDIAN AND VERIFIED	BY HEA	LTH CA	RE PR	OVIDER			
ALLERGIES		List:		_			М	EDICATION (Prescribed or	Yes L	ist:					
(Food, drug, insect, other) Diagnosis of asthma?	No		Yes	No			_	en on a regular basis.) OSS of function of one of pai	No	Yes	No	1			
Child wakes during ni	ght cough	ing?	Yes	No			or	gans? (eye/ear/kidney/testic							
Birth defects?			Yes	No				ospitalizations? Then? What for?		Yes	No				
Developmental delay? Blood disorders? Hem			Yes	No No						77	- >1				
Sickle Cell, Other? E			168	140				rgery? (List all.) hen? What for?		Yes	No				
Diabetes?			Yes	No			_	rious injury or illness?		Yes	No		WIC C		
Head injury/Concussion		out?	Yes	No				3 skin test positive (past/pre	esent)?	Yes*	No	*If yes, refer to local health department.			
Seizures? What are the Heart problem/Shortne		rth9	Yes	No				B disease (past or present)? Obacco use (type, frequency)	\9	Yes*	No No				
Heart murmur/High bl			Yes	No				cohol/Drug use?):	Yes	No				
Dizziness or chest pair			Yes	No				mily history of sudden deat	h	Yes	No				
exercise? Eye/Vision problems?		Classes F	1 0	-t- D	I and amount has	4	\rightarrow	fore age 50? (Cause?)			0.1				
Other concerns? (cross					Last exam by culty reading)	eye doctor	- 100	ental □ Braces □ I	Bridge	□ Plate	Other				
Ear/Hearing problems? Yes No Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian											al purposes.				
Bone/Joint problem/in	jury/scolic	osis?	Yes	No				nature				Date			
PHYSICAL EXAMINATION REQUIREMENTS HEAD CIRCUMFERENCE if < 2-3 years old Entire section below to be completed by MD/DO/APN/PA HEIGHT WEIGHT BMI B/P															
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes No And any two of the following: Family History Yes No Ethnic Minority Yes No Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes No At Risk Yes No I															
LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school															
and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.) Questionnaire Administered? Yes □ No □ Blood Test Indicated? Yes □ No □ Blood Test Date Result															
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born															
in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm,															
No test needed Test performed Skin Test: Date Read / / Result: Positive Negative Mmm Blood Test: Date Reported / / Result: Positive Negative Value															
LAB TESTS (Recomme		Ι	Date]	Results				Γ	Date	Results			
Hemoglobin or Hemat	ocrit							Sickle Cell (when indica							
Urinalysis SYSTEM REVIEW	Normal	Commen	ts/Fall	OW UP	Noods		_	Developmental Screening	Common	4- /E- II	ow-up/Ne				
Skin	TOTMAL	Commen	165/1-011	on-up	ATTECUS			Normal Con		Commen	ts/F OII	eus			
					e : p	1.									
Ears					Screening Re	esult:		Gastrointestinal							
Eyes					Screening Re	esult:		Genito-Urinary			LMP				
Nose								Neurological							
Throat								Musculoskeletal							
Mouth/Dental								Spinal Exam							
Cardiovascular/HTN								Nutritional status							
Respiratory					☐ Diagno	osis of Asthma		Mental Health							
Currently Prescribed A Quick-relief med Controller medica	ication (e.	g. Short A	Acting 1		gonist)			Other							
NEEDS/MODIFICAT	NEEDS/MODIFICATIONS required in the school setting DIETARY Needs/Restrictions														
SPECIAL INSTRUC	TIONS/D	EVICES	e.g. sai	ety glas	ses, glass eye, c	hest protector for	arrhytl	l hmia, pacemaker, prosthetic d	levice, der	ıtal bridge,	false tee	eth, athletic s	upport/cup		
MENTAL HEALTH/ If you would like to discus						know about this s			Counselo	or 🗆 Pri	ncipal				
EMERGENCY ACTI	ON need s, please de	ed while at scribe.	school	due to c	hild's health co	ndition (e.g., seizu	ıres, as	thma, insect sting, food, pean			-	diabetes, he	art problem)?		
On the basis of the examin	On the basis of the examination on this day, I approve this child's participation in PHYSICAL EDUCATION Yes No Modified I INTERSCHOLASTIC SPORTS Yes No Modified I														
Print Name					(MD,DO,	APN, PA) Sig	nature	3					Pate		
Address	Carry System of the Carry														



State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name								
D'all Data		(1	Last)	, ,			(First)	(Middle Initial)
Birth Date	nth/Day/Ye	ar)	(ender	Grac	le		
Parent or Guardian	-							
			(Last)				(First)	
Phone (Area Code)								
Address								
	(Numbe	er)		(Street)			(City)	(ZIP Code)
County								
			-	B 6				
			To	Be Comp	leted By I	Examinin	ig Doctor	
Case History Date of exam								
Ocular history:	☐ Non	mal or F	ositive fo	or				
Medical history:	□ Nor							
Drug allergies:	□ NKI	DA or A	Allergic to	·				
Other information _								
Examination								
		Distance			Near			
		Right	Left	Both	Both			
Uncorrected visual ac		20/	20/	20/	20/			
Best corrected visual	acuity	20/	20/	20/	20/			
Was refraction perform	rmed wit	h dilation?	☐ Yes	s 🖵 No				
				Normal	Ab	normal	Not Able to Assess	Comments
External exam (lids,	lashes, c	ornea, etc.)		110			Comments
Internal exam (vitreo								
Pupillary reflex (pup	ils)							
Binocular function (s	_	*						
Accommodation and	vergence	e						
Color vision)**************************************
Glaucoma evaluation								
Oculomotor assessme								i ?
OtherNot Able to A		ers to the ir	ahility of	the child to	complete th	a test not	the inability of the doctor t	o provide the test
		orb to the H	monny Of	are cillia to	complete th	e wai, mi	and maching of the doctor t	o provide die test.
Diagnosis) TT			D. 6	1.		
□ Normal □ Myo	_	Hyperopi	a ⊔ A	Astigmatisn	n 🖵 Str	rabismus	☐ Amblyopia	
Other								



State of Illinois Eye Examination Report

Recommendations

1. Corrective lenses: ☐ No	☐ Yes, glasses or contacts should be☐ Constant wear☐ Near vision☐	
	☐ May be removed for physical educ	cation
Preferential seating recomments		
	on: 3 months 6 months	12 months
4. ,		
5. 2		
Print name		License Number
who provided the ey	ysician (such as an ophthalmologist) re examination MD OD DO	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)
Phone		(Date)
Signature		Date
(Sou	urce: Amended at 32 Ill. Reg	, effective)



PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 III. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

To be completed by the parent or guardian (please print):

0											
Student's Name	e: Last	First	Middle	Birth Date: (Month/Day/Year)							
Address:	Street	City		ZIP Code							
Name of Schoo	l:	ZIP Code	Grade Level:	Gender:							
				D Male D Female							
Parent or Guard	dian: Last Name		First Name								
Student's Race	/Ethnicity:										
☐ White	☐ Black/African American	☐ Hispar	ic/Latino □] Asian							
	Native American Native Hawaiian/Pacific Islander Multi-racial Unknown										
To be completed	l by dentist:										
Date of Most Recent Examination: (Check all services provided at this examination date) Dental Cleaning Sealant Fluoride treatment Restoration of teeth due to caries											
Oral Health Stat	us (check all that apply)										
☐ Yes ☐ No	Dental Sealants Present on Pe	ermanent Molars									
☐ Yes ☐ No	Caries Experience / Restoration extracted as a result of caries OR miles	on History — A filling (tem issing permanent 1st molars	porary/permanent) OR a 	tooth that is missing because it was							
☐Yes ☐No	Untreated Caries — At least 1/2 walls of the lesion. These criteria ap root, assume that the whole tooth we considered sound unless a cavitated	ply to pit and fissure cavitate as destroyed by caries. Brok	ed lesions as well as those	e on smooth tooth surfaces. If retained							
☐ Yes ☐ No	Urgent Treatment — abscess, ne swelling.	erve exposure, advanced dis	sease state, signs or sym	ptoms that include pain, infection, or							
Treatment Need completion date.	s (check all that apply). For Head	d Start Agencies, please a	lso list appointment dat	e or date of most recent treatment							
Restorative	Care — amalgams, composites, cro	owns, etc. Appo	ntment Date:								
☐ Preventive	Care — sealants, fluoride treatment,		Appointment Date:								
Pediatric D	entist Referral Recommended	Treat	ment Completion Date:								
Additional com	ments:										
Signature of De	ntist	License	#:	Date:							

Illinois Department of Public Health, Division of Oral Health 217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.dph.illinois.gov

