Re-Enrollment Checklist 2026-2027 School Year

Student Name:_____Student Birthdate_____
Rising Grade:_____ Parent Name:_____
Parent Phone Number:_____
Address:_____
Parent Email:_____
Please Select Program: Residential_____ Day_____

To secure placement for the upcoming school year, Re-Enrollment documents must be submitted by May 25, 2026.

Only COMPLETED paperwork will be accepted

Forms - Due May 25, 2026:

_____ Income Tax Return
_____ W2, Social Security Award Letter, Unemployment
_____ Updated Student Pick-Up List
_____ Copy of Driver's License
_____ Zero Tolerance Against Staff Policy
_____ Counseling and SEL (social emotional learning) Consent Form
_____ Educational Evaluation Consent Form
_____ Parent Placement Agreement Contract

Medical Section Forms- Must be submitted to Health Department

_____ Annual Physical - No Exceptions
_____ Medication Order Sheet from Doctor
_____ Food Allergy Action Plan / EpiPen - Yes or No
_____ Medical Consent Form
_____ Over the Counter Consent Form
_____ Medical Authorization Form
_____ Concussion Sheet
_____ Covid Consent Form
_____ Asthma Action Plan
_____ Dental Form (grades 2,6 and 9)
_____ Sports Physical (7-12 need a yearly sport's Physical)
_____ Copy of Insurance Card/Medical Card
_____ Eye Exams (students entering grade 2 and students with glasses)
_____ Copy of updated vaccine history (students entering 6th grade and 12th grade)

Items to be Completed at Orientation in August:

_____ Activity fee
_____ Contract
_____ Handbook
_____ Anti-Bullying Policy/Cyber Policy/Parent Expectations
_____ Signature Page

June 2, 2025

Dear Day Students Parents/Guardians,

I hope this letter finds you well. I am writing to inform you of some significant changes to our After-School Program for the upcoming school year. Beginning in August, **ALL** students are required to stay until 4:00 pm for mandatory military drill practice on Mondays and Wednesdays. This is a non-negotiable part of being a Glenwood Academy student.

If you want your student to participate in After School Programs after 3:00 pm on Tuesdays, Thursdays, or Fridays, there will be a weekly charge of $50 for the first child and an additional $25 for each additional child. These fees will cover the staff, after-school snack, activities, and dinner. If you choose not to have your child participate in the After School Program, they must be picked up by 3:15 pm on non-military drill days. Payments for the After-School Program can be made to the Business Office at 708-756-5431. If payments are not made in advance, your child will not be able to attend.

If you are interested in your child becoming a residential student, please contact Mr. Harvey as soon as possible at 708-756-6552.

Thank you,

Colleen Carter, Ed.D.

Student Emergency Pick-Up List

Student Name_____

Parent (s)/Guardian(s)_____

Parent Cell_____ Home Phone_____Work_____

Emergency Pick-Up Contacts:

1st Contact Name_____ Realationship_____

Cell _____Phone_____Work_____

2nd Contact Name_____ Realationship_____

Cell _____Phone_____Work_____

3rd Contact Name_____ Realationship_____

Cell _____Phone_____Work_____

***Please list below the name of any individual(s) <u>not allowed</u> on campus and not allowed to have contact with the student.**

Name _____ Relationship_____

Name _____ Relationship_____

Are both parents allowed to pick up the student and/or to receive information from Glenwood Academy? Yes____ No____

No person or persons other than the legal guardian(s) are permitted to take a student off campus unless they are listed on the Emergency Pick-Up List. Persons on the above Pick-Up List must be at least 21 years of age. This rule is to safeguard your child and will be strictly enforced.

Parent/Guardian Printed Name_____

Parent/Guardain Signature_____ **Date**_____

2024/AB

ZERO TOLERANCE FOR ABUSE TOWARDS GLENWOOD ACADEMY STAFF

We expect all family members of Glenwood Academy students to act with courtesy and respect when interacting with Glenwood Academy staff. Glenwood Academy has zero tolerance for violence, abuse and discriminatory behavior directed at staff or those working on our behalf.

Who this applies to

This policy applies to all family members/guardians or anyone else associated with Glenwood students.

Responsibilities

- All family members/guardians or anyone else associated with Glenwood Academy students (identified as family members) are responsible for treating Glenwood Academy staff/contractors with respect and courtesy.
- All staff/ contractors are responsible for handling and reporting unacceptable family behavior as outlined in this policy.
- Management is responsible for making sure this policy is applied fairly and consistently.

Key principles

Glenwood Academy will not tolerate aggressive or abusive behavior directed towards staff during any form of interaction, i.e. face to face, online, over the phone, or any other form of communication. This includes:

- Any form of physical, hostile or abusive behavior.
- Use of inappropriate language, verbal or written, which may cause a member of staff to feel scared, abused, intimidated, threatened or offended.
    - using a bullying tone or language
    - inappropriate religious, cultural or racial comments or insults; including racial stereotypes and judgements based on accent, such as asking to speak to someone who is 'from this country'
    - bi-phobic, homophobic or transphobic comments
    - sexist or other derogatory remarks

The policy in action

If inappropriate behavior is actively directed at staff and language becomes abusive and/or personal, the situation becomes unacceptable.

- Staff will politely and respectfully ask the family member to stop using inappropriate language or engaging in negative behavior as outlined in this policy.
- If the language/behavior continues, staff will stop the conversation or remove themselves from the situation.
- Staff will immediately contact their supervisor requesting assistance or to report the situation.
- Written documentation detailing the interaction will be sent to staff's immediate supervisor, the departmental VP, COO and CEO.
- A follow up meeting will be held with the family member(s) to discuss the inappropriate behavior, expectations of conduct and consequence of any future infraction. Consequences may include the need for the family to seek alternative educational placement and possible police involvement.
- The departmental VP will meet with the staff member(s) involved to provide support and closure.

Students Name:_____

Parent Signature of Receipt of Document: _____

Date:_____

MH/2024

Glenwood Academy
Since 1887
LIVE LEARN SUCCEED

Counseling/Social Emotional Learning/Small Group Permission Form

Dear Glenwood Academy Parent/Guardian,

We want your child to be as successful as possible at Glenwood Academy. Success at Glenwood Academy is not just about reading and math; social-emotional skills are also key components of our program. We will be using the Second Step Social Emotional Learning Curriculum to help your child develop his/her social-emotional skills. Social-emotional learning is understanding and managing emotions, setting and achieving positive goals, showing empathy for others, establishing and maintaining positive relationships, and making responsible decisions.

At times your child may have the opportunity to participate in a Social-Emotional Learning Group through Glenwood Academy's Clinical Department. By signing below, you agree for your child to take part in a Social Emotional Learning Group.

In addition to Social-Emotional Learning Groups, your student may speak with a Clinical Services counselor. By signing below, you give permission for your child to speak to a counselor.

I give my child_____permission to take part in a Glenwood Academy Social-Emotional Learning Group.

I give my child_____permsion to speak with a Glenwood Academy counselor.

Parent/Guardian Printed Name:_____

Parent/Guardian Signature:_____

Date:_____

AB/2024

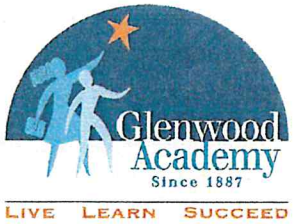
Glenwood Academy
Release for Educational Evaluations

Your student's school records, classroom performance, parental concerns, or teacher referral may indicate the need for an educational evaluation to determine the best educational programming for your child. The educational evaluation will consist of the appropriate diagnostic testing to determine your student's academic strengths and weaknesses. Educational evaluations may lead to a recommendation for your child to receive individualized or small group instruction in the Learning Resource Center and/or accommodations in the classroom. Your signature below indicates your agreement for your student to participate in an educational evaluation when deemed appropriate.

Student Name_____

Parent Printed Name_____

Parent Signature_____Date_____



PLACEMENT AGREEMENT

BETWEEN

GLENWOOD ACADEMY and _____(Parent/Guardian Name)

Student's Name: _____

I_____(parent/guardian full name) and student hereby agree to abide by the rules, parent/student handbook, regulations, and parent and student expectation statement of Glenwood Academy. Further, I (we) agree to cooperate with its personnel in promoting the welfare of the development of **Student's Name**. **I (we) understand that the relationship between Glenwood and ourselves is a partnership; working and communicating together for the end result of producing a more mature, responsible, and well-disciplined student. _____ (Parent/Guardian Initials)**

I (we) further agree to pay promptly for any and all of the above services and articles rendered or supplied by Glenwood to **Student's Name**, upon presentation of a bill for the cost of such services or articles._____**(Parent/Guardian Initials)**

In order that **Student's Name** might be able to adjust to the Glenwood routine, I (we) agree to visit only as agreed upon by Glenwood Academy and me (us). _____**(Parent/Guardian Initials)**

CONSENT FOR LEARNING:

I (we) consent to the participation of **Student's Name** in Social/Emotional learning as part of the academy curriculum at Glenwood. _____**(Parent/Guardian Initials)**

VISITS, TRIPS OR EXCURSIONS:

I (we) hereby give Glenwood permission to authorize **Student's Name** to travel to and participate in such off-campus visits, trips, excursions, camps, athletic or other community or Glenwood activities as deemed beneficial to the welfare of **Student's Name**._____

WEARING APPAREL, FOOTWEAR, INCIDENTALS:

I (we) agree to provide basic clothing, footwear and incidentals needed to fulfill the minimum clothing requirements as determined by Glenwood. The laundering of clothing is the responsibility of the Parent(s). All clothing for **Student's Name** at Glenwood is to be marked, and I (we) **understand I (we) am (are) responsible to mark all clothing with the student's Student's Name prior to his arrival for his first day**. ***Glenwood is not responsible for lost personal articles.*** _____**(Parent/Guardian Initials)**

Military uniforms and insignia issued by Glenwood to **Student's Name** for use in required military formations remain the property of Glenwood and are to be returned when requested. _____**(Parent/Guardian Initials)**

MEDICAL SERVICES:

Acceptance by Glenwood of this agreement is based on the information given and representations made by me (us) in the Application for Admission dated the _____ of _____ and I (we) hereby certify that such information and representations are true, correct, and complete. _____**(Parent/Guardian Initials)**

I (we) further **agree to keep Glenwood advised of any change of address and telephone number** and until such changes are communicated to Glenwood, it is authorized to rely on those given on the Application for Admission. _____**(Parent/Guardian Initials)**

I (we) further agree that Glenwood, before officially accepting **Student's Name**, shall require a physical examination made of the student by a physician, with the right of rejection at the option of Glenwood. _____**(Parent/Guardian Initials)**

I (we) agree to disclose pertinent information regarding past and/or current mental health services. Not disclosing pertinent information may impact student's admission or retention. I (we) agree to have student evaluated and/or receive mental health services if Glenwood deems necessary. _____**(Parent/Guardian Initials)**

PHOTOGRAPHS:

I (we) hereby give and grant to you the right to photograph **Student's Name** and to use for publication in any manner which you deem advisable for advertising, publicity or other purposes related to or in connection with Glenwood, whether or not enrolled in Glenwood at the time of any such use, and to copyright any such photographs or any part or parts of them, and in connection with any use thereof to use the name of or a fictitious name for **Student's Name**, I (we) hereby waive any right to inspect or approve of the finished photographs or any of them, and any right to complain of any blurring, distortion, optical illusion or other imperfections in

any of them hereby is waived by the undersigned. _____**(Parent/Guardian Initials)**

I (we) hereby consent to required attendance for specific activities by **Student's Name** at Glenwood's Non-Sectarian Chapel. _____**(Parent/Guardian Initials)**

Fees:

Fees for your student are based on a flat rate of **$**_____ combined with scholarships which cover the cost of education and care. The parent/guardian agrees to pay the full amount within the academic year.

This may be paid in full at the signing of the addendum or in interest free monthly installments of $50.00 due on the agreed date by Glenwood Academy and parent/guardian. The yearly parental portion is spread over the 10-month academic period of September through June. There is no further discount of tuition fees for the student during vacation and/or the summer.

All fees MUST be paid in full by the end of June 2025. Failure to do so will result in the student no longer being able to attend Glenwood Academy. This applies to all students, Elementary and High School.

I agree to share my financial status so that Glenwood may apply for federal free and reduced milk and food for the student in our care._____**(Parent/Guardian Initials)**

I agree to support and adhere to all Glenwood Academy's policies and procedures stated in the Student Handbook and/or sent via memorandum. _____**(Parent/Guardian Initials)**

The first installment is due at the signing of this placement agreement._____**(Parent/Guardian Initials)**

TERMINATION OF AGREEMENT:

Throughout the students' tenure at Glenwood Academy, Glenwood will continue to assess its ability to address the student's needs academically, socially, emotionally and medically. If in the judgment of Glenwood Administration, it is determined that Glenwood Academy is unable to meet the needs of my student or the continued presence of my student might endanger or create an unacceptable hardship on other students at Glenwood, I (we) agree to remove **Student's Name** immediately. Glenwood agrees to provide reasonable notice should the removal of a student be requested for other reasons. _____**(Parent/Guardian Initials)**

I (we) also understand that my student is being enrolled in Glenwood Academy for a probationary period. Within the first 60 days my student's progress will be re-evaluated to determine if he/she can continue enrollment in the program._____**(Parent/Guardian Initials)**

_____	_____
Chief Operating Officer	**Parent or Guardian**
Date:_____	**Date:**_____

State of Illinois

Certificate of Child Health Examination

Student's Name (Last, First, Middle)	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#

Street Address, City, ZIP Code	Parent/Guardian, Telephone (home/work)

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

ALLERGIES (Food, drug, insect, other)	☐ Yes ☐ No	List:	MEDICATION (Prescribed or taken on a regular basis)	☐ Yes ☐ No	List:

Diagnosis of Asthma?	☐ Yes ☐ No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	☐ Yes ☐ No	
Child wakes during night coughing?	☐ Yes ☐ No		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Diabetes?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Seizures? What are they like?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No				
Dizziness or chest pain with exercise?	☐ Yes ☐ No				

Eye/Vision problems? _____ ☐ Glasses ☐ Contacts Last exam by eye doctor _____ ☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other

Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____ Additional Information:

Ear/Hearing problems?	☐ Yes ☐ No	
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No	

Information may be shared with appropriate personnel for health and educational purposes.

Parent/Guardian Signatures: _____ Date: _____

IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine/Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments: * indicates invalid dose

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

Signature _____ Title _____ Date _____

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

*MEASLES (Rubeola) (MO/DA/YR) _____ **MUMPS (MO/DA/YR) _____ HEPATITIS B (MO/DA/YR) _____ VARICELLA (MO/DA/YR) _____

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

Date of Disease _____ Signature _____ Title _____

3. Laboratory Evidence of Immunity (check one) ☐ Measles* ☐ Mumps** ☐ Rubella ☐ Varicella Attach copy of lab result.

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____

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

HEAD CIRCUMFERENCE if < 2-3 years old _____ HEIGHT _____ WEIGHT _____ BMI _____ BMI PERCENTILE _____ B/P _____

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high-risk zip code.)

Questionnaire Administered? ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** _____ **Result** _____

TB SKIN OR BLOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines, http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

☐ No test needed ☐ Test performed **Skin Test:** Date Read _____ Result: ☐ Positive ☐ Negative mm _____

Blood Test: Date Reported _____ Result: ☐ Positive ☐ Negative Value _____

LAB TESTS (Recommended)	Date	Results	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	☐		Endocrine	☐	
Ears	☐	Screening Result:	Gastrointestinal	☐	
Eyes	☐	Screening Result:	Genito-Urinary	☐	LMP:
Nose	☐		Neurological	☐	
Throat	☐		Musculoskeletal	☐	
Mouth/Dental	☐		Spinal Exam	☐	
Cardiovascular/HTN	☐		Nutritional Status	☐	
Respiratory	☐	☐ Diagnosis of Asthma	Mental Health	☐	
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g., Short Acting Beta Agonist) ☐ Controller medication (e.g., inhaled corticosteroid)			Other	☐	

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES (e.g., safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup)

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?

If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?

☐ Yes ☐ No If yes, please describe:

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

PHYSICAL EDUCATION ☐ Yes ☐ No ☐ Modified **INTERSCHOLASTIC SPORTS** ☐ Yes ☐ No ☐ Modified

Print Name _____ ☐ MD ☐ DO ☐ APN ☐ PA Signature _____ Date _____

Address Phone

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten, 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 require 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)

Student's Name: Last	First	Middle	Birth Date: (Month/Day/Year)
Address: Street	City		ZIP Code
Name of School:	ZIP Code	Grade Level:	
Parent or Guardian: Last Name	First Name		

Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races

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To be completed 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 Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present on Permanent Molars**

☐ 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 **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs (check all that apply). Please list appointment date or date of most recent treatment completion date.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date:_____
☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date:_____
☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date:_____

Dental Office Address: _____ Office phone number: _____

Signature of Dentist _____ Date _____

State of Illinois
Illinois Department of Public Health

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 _____ (Last) _____ (First) _____ (Middle Initial)

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

Parent or Guardian _____ (Last) _____ (First)

Phone _____ (Area Code)

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

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	❑	❑	❑	_____
Internal exam (vitreous, lens, fundus, etc.)	❑	❑	❑	_____
Pupillary reflex (pupils)	❑	❑	❑	_____
Binocular function (stereopsis)	❑	❑	❑	_____
Accommodation and vergence	❑	❑	❑	_____
Color vision	❑	❑	❑	_____
Glaucoma evaluation	❑	❑	❑	_____
Oculomotor assessment	❑	❑	❑	_____
Other _____	❑	❑	❑	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other _____

Continued on back

State of Illinois
Eye Examination Report

Recommendations

1. Corrective lenses: ❑ No ❑ Yes, glasses or contacts should be worn for:
   ❑ Constant wear ❑ Near vision ❑ Far vision
   ❑ May be removed for physical education

2. Preferential seating recommended: ❑ No ❑ Yes
   Comments _____

   _____

3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months
   ❑ Other _____

4. _____

5. _____

Print name _____
Optometrist or physician (such as an ophthalmologist) who provided the eye examination ❑ MD ❑ OD ❑ DO

License Number _____

Address _____

_____

Phone _____

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)

_____
(Date)

Signature _____ Date _____

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

Printed by Authority of the State of Illinois

IOCI 15-391

Asthma Action Plan

Patient Name: _____
Date of Birth: _____ Today's Date: _____

Asthma Severity (check one): ☐Intermittent ☐Mild Persistent* ☐Moderate Persistent* ☐Severe Persistent*
Asthma Triggers: ☐Colds ☐Exercise ☐Animals ☐Dust ☐Pollution ☐Weather ☐Allergies
*Patients with any type of persistent asthma should be prescribed a controller medication.

Green Zone **Doing Well!**	**Controller Medicines - Take these every day.**		
	Which medicine?	**How much do I take?** ☐Use With Spacer	**When do I take it?**
• Breathing well • No coughing • No wheezing • Can play or work	**Which Inhaler?** ☐Advair Inhaler _____ ☐Advair Diskus _____ ☐Flovent Inhaler _____ ☐Pulmicort Inhaler _____ ☐Qvar _____ ☐Symbicort _____ ☐Other: _____ **Which Tablet?** ☐Montelukast _____ ☐Other: _____	**Inhaler:** ☐1 Puff ☐2 Puffs ☐1 Nebulizer Treatment ☐Other: _____ **Tablet:** ☐1 Tablet ☐Other: _____	**Inhaler:** ☐Once a day ☐2 times a day ☐Other: _____ **Tablet:** ☐Once a day at bedtime ☐Other: _____
Yellow Zone **Use Caution!**		**Rescue Medicines - Take these when you have a flare-up.** (Continue to take Controller Medicines, as shown above.)	
Symptoms	**Which medicine?**	**How much do I take?** ☐Use With Spacer	**When do I take it?**
• Breathing is worse • Coughing • Wheezing • Hard to play or work	☐Albuterol Inhaler _____ ☐Albuterol Nebulizer Solution _____ ☐Other: _____	☐2 Puffs ☐1 Nebulizer Treatment ☐Other: _____	☐Every 4 hours ☐Every 6 hours ☐As needed ☐Other: _____
Red Zone **Emergency!**		**Medical Alert – TAKE THESE AND CALL YOUR DOCTOR OR 911!**	
Symptoms	**Which medicine?**	**How much do I take?** ☐Use With Spacer	**When do I take it?** Get Help Fast!
• Rescue medicine is not helping • Very short of breath • Hard to talk or walk	☐Albuterol Inhaler _____ ☐Albuterol Nebulizer Solution _____ ☐Other: _____	☐2 Puffs ☐1 Nebulizer Treatment ☐Other: _____	☐Every 20 minutes ☐Every 2 hours ☐As needed ☐Other: _____

Doctor's Signature _____ Date _____
Office Number: _____

ILLINOIS FOOD ALLERGY EMERGENCY ACTION PLAN AND TREATMENT AUTHORIZATION

CHILD'S PHOTOGRAPH

NAME: _____ D.O.B: _____

TEACHER: _____ GRADE: _____

ALLERGY TO: _____

ASTHMA: ☐ YES (HIGHER RISK FOR A SEVERE REACTION) ☐ NO WEIGHT: _____ lbs

ANY SEVERE SYMPTOMS AFTER SUSPECTED INGESTION:

LUNG: Short of breath, wheeze, repetitive cough
HEART: Pale, blue, faint, weak pulse, dizzy, confused
THROAT: Tight, hoarse, trouble breathing/swallowing
MOUTH: Obstructive swelling (tongue)

Or COMBINATION of symptoms from different body areas:

SKIN: Hives, itchy rashes, swelling
GUT: Vomiting, crampy pain

→

INJECT EPINEPHRINE IMMEDIATELY

- Call 911
- Begin monitoring (see below)
- Antihistamine
- Inhaler (bronchodilator) if asthma

Inhalers/bronchodilators and antihistamines are not to be depended upon to treat a severe reaction (anaphylaxis)→use Epinephrine

When in doubt, use epinephrine. Symptoms can rapidly become more severe.

MILD SYMPTOMS ONLY:

MOUTH: Itchy mouth
SKIN: A few hives around mouth/face, mild itch
GUT: Vomiting, crampy pain

→

GIVE ANTIHISTAMINE

- Stay with child, alert health care professionals and parent.

IF SYMPTOMS PROGRESS (see above), INJECT EPINEPHRINE

☐ **If checked, give epinephrine for ANY symptoms if the allergen was likely eaten.**
☐ **If checked, give epinephrine before symptoms if the allergen was definitely eaten.**

MEDICATIONS/DOSES

EPINEPHRINE (BRAND AND DOSE): _____

ANTIHISTAMINE (BRAND AND DOSE): _____

OTHER (E.G., INHALER-BRONCHODILATOR IF ASTHMA): _____

MONITORING: Stay with the child. Tell rescue squad epinephrine was given. A second dose of epinephrine can be given a few minutes or more after the first if symptoms persist or recur. For a severe reaction, consider keeping child lying on back with legs raised. Treat child even if parents cannot be reached.

☐ Student may self-carry epinephrine ☐ Student may self-administer epinephrine

CONTACTS: Call 911 Rescue Squad: _____

Parent/Guardian: _____ Phone: _____

Name/Relationship: _____ Phone: _____

Name/Relationship: _____ Phone: _____

LICENSED HEALTHCARE PROVIDER SIGNATURE: _____ Phone: _____ Date: _____

(REQUIRED)

I hereby authorize the school district staff members to take whatever action in their judgment may be necessary in supplying emergency medical services consistent with this plan, including the administration of medication to my child. I understand that the Local Governmental and Governmental Employees Tort Immunity Act protects staff members from liability arising from actions consistent with this plan. I also hereby authorize the school district staff members to disclose my child's protected health information to chaperones and other non-employee volunteers at the school or at school events and field trips to the extent necessary for the protection, prevention of an allergic reaction, or emergency treatment of my child and for the implementation of this plan.

Parent/Grardian Signature: _____ Date: _____

GLENWOOD ACADEMY

500 W. 187th Street, Glenwood, IL 60425

MEDICAL CONSENT FORM

I hereby give consent to have my student, _____

Student's Name

while under the care and supervision of Glenwood Academy, given all necessary medical treatment. In case of any emergency, I hereby consent without further notice , that the physicians selected by Glenwood School, primarily:

1) Ingalls Memorial Hospital

One Ingalls Dr.

Harvey, IL 60426

708-333-2300

2) or any other medical facility required

be the primary medical care providers for the student named herein, be the sole judge in their absolute discretion of the existence of such emergency; in which case, the student will be provided with such medical treatment as deemed necessary by said physicians.

I further agree to promptly pay the charges for such medical services, including hospitalization upon presentation of a statement for such services.

Date:_____

_____

Parent / Guardian Signature

Mailing Address:_____

Home phone _____Cell _____ Work_____

Emergency Name & Phone _____

A CURRENT COPY OF YOUR MEDICAL INSURANCE CARD OR MEDICAID CARD MUST BE RETURNED WITH COMPLETED FORM.

Glenwood Academy
Since 1887
LIVE LEARN SUCCEED

Medication Orders

_____ was seen in my office on _____

(Student's name) (Date)

Diagnosis: _____

Medication ordered (medication name, dosage, frequency and duration to be given):

_____

_____

Labwork/X-rays/test results: _____

List restrictions, if indicated: _____

Return appointment, if required: _____

Physician's signature _____ Date _____

Physician's name _____

(please print)

Address _____

Phone number _____

I give my permission to release any pertinent information regarding the diagnosis, medication, and/or treatment of my student, _____ to Glenwood Academy, 500 W. 187th Street, Glenwood, IL. 60425. (708) 756-6375.

Signature: _____

(Parent/Guardian)

Concussion Information Sheet

What can happen if my child keeps on playing with a concussion or returns too soon?

Athletes with the signs and symptoms of concussion should be removed from play immediately. Continuing to play with the signs and symptoms of a concussion leaves the young athlete especially vulnerable to greater injury. There is an increased risk of significant damage from a concussion for a period of time after that concussion occurs, particularly if the athlete suffers another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even to severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often fail to report symptoms of injuries. Concussions are no different. As a result, education of administrators, coaches, parents and students is the key to student-athlete's safety.

If you think your child has suffered a concussion

Any athlete even suspected of suffering a concussion should be removed from the game or practice immediately. No athlete may return to activity after an apparent head injury or concussion, regardless of how mild it seems or how quickly symptoms clear, without medical clearance. Close observation of the athlete should continue for several hours. The Return-to-Play Policy of the IESA and IHSA requires athletes to provide their school with written clearance from either a physician licensed to practice medicine in all its branches or a certified athletic trainer working in conjunction with a physician licensed to practice medicine in all its branches prior to returning to play or practice following a concussion or after being removed from an interscholastic contest due to a possible head injury or concussion and not cleared to return to that same contest. In accordance with state law, all schools are required to follow this policy.

You should also inform your child's coach if you think that your child may have a concussion. Remember it's better to miss one game than miss the whole season. And when in doubt, the athlete sits out.

For current and up-to-date information on concussions you can go to:
http://www.cdc.gov/ConcussionInYouthSports/

Student/Parent Consent and Acknowledgements
By signing this form, we acknowledge we have been provided information regarding concussions.

Student

Student Name (Print): _____ Grade: _____

Student Signature: _____ Date: _____

Parent or Legal Guardian

Name (Print): _____

Signature: _____ Date: _____

Relationship to Student: _____

Each year IESA member schools are required to keep a signed Acknowledgement and Consent form and a current Pre-participation Physical Examination on file for all student athletes.

Adapted from the CDC and the 3rd International Conference on Concussion in Sport
Document created 7/1/2011, Reviewed 4/24/2013, 7/2015, 7/2017, 6/2018

AUTHORIZATION FOR EXCHANGE OF HEALTH INFORMATION

This form is used to authorize Glenwood Academy to obtain from or release protected health information to another person/institution in order to facilitate the planning and coordination of treatment services.

Client Name: _____ Date of Birth: _____
Address: _____
Telephone: _____

I hereby authorize Glenwood Academy to:

_____ release mental health information to:

_____ obtain health information or service records from:

Person/Facility: _____
Address: _____

I authorize the release of information covering the period of care from (specify dates) _____ *to* _____

TYPE OF INFORMATION TO BE RELEASED/EXCHANGED:

HEALTHCARE/PSYCHIATRIC (check all that apply):

- o Discharge /Treatment Summary
- o Treatment Plan/Progress reports
- o Medication recommendations
- o Results of any diagnostic testing/evaluation
- o History and physical examination
- o Other_____

SCHOOL (check all that apply):

- o Academic record
- o Truancy/behavioral reports
- o Copy of most recent IEP
- o Results of Case Study Evaluation
- o Other_____

OTHER SERVICE ORGANIZATIONS (check all that apply):

- o Status of case and service requirements
- o Current service plan/agreement
- o Compliance with service plan
- o Other_____

☐ *I also authorize Glenwood Academy and the listed institution to have ongoing consultation and exchange to coordinate care and assess the progress of services, until this consent expires.*

This authorization will expire on the following date _____, or on the occurrence of the following event (e.g. case termination): _____.

According to the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1), all of my health information is confidential, and cannot be shared with anyone. I understand that by signing this release, I am waiving that right, and giving permission for my information to be shared as outlined in this Authorization. This is limited solely to the documents in the care and custody of Glenwood Academy, and does not extend to any other mental health provider or facility.

I also understand that no person or agency to whom any of this information is disclosed may re-disclose the information to anyone else unless I specifically consent to that re-disclosure.

- **This Authorization is voluntary.**
- **You may revoke this authorization at any time prior to the release of information.**
- **We will not refuse to treat you based on your refusal to sign this authorization.**

Signature of client (if 12 or older): _____ Date: _____

Signature of parent/guardian: _____ Date: _____

Witness: _____ Date: _____

Glenwood Academy
Over-The-Counter (OTC) Medication Consent Form

Student Name: _____ **DOB:** _____

This form authorizes Glenwood Academy staff to administer approved over-the-counter (OTC) medications to students during the school or residential times when medically appropriate.

Parent/Guardian Consent

I hereby give my consent for my student, _____, while under the care and supervision of Glenwood Academy, to be administered the following over-the-counter (OTC) medications as deemed necessary by authorized Glenwood Academy staff. These medications are intended for short-term relief of common, minor health concerns that may occur during the school and residential hours.

Approved Over-the-Counter Medications

Emergency Medications

May be administered in emergency situations according to school policy and applicable laws:

EpiPen Undesignated Epinephrine- A single-use device used for the automatic injection of a pre-measured dose of epinephrine

Undesignated Asthma Medication -Albuterol Inhaler

Pain Relief and Fever Management

Used for pain, discomfort, headaches, muscle aches, swelling, or fever:

Acetaminophen (Tylenol)
- 325 mg tablets
- 160 mg per 5 mL liquid or suspension

Ibuprofen (Motrin)
- 200 mg tablets
- 100 mg per 5 mL liquid or suspension

Allergy Relief

Used for allergic reactions, itching, rashes, or skin irritation:

Phenylephrine (5 mg tablets)-one tablet ages 7-11 years / two tablets ages 12-18 years every 4-6 hours for rhinitis, nasal congestion, allergy symptoms. Not used if asthmatic wheeze or hypertension exists.

Benadryl (Diphenhydramine) – 25 mg- One capsule ages 7-11 years / two capsules ages 12-18 years every 4-6 hours for allergy symptoms, allergic reactions, bee stings, hives. Acute allergic reactions/ respiratory involvement would be immediately referred for medical intervention.

Hydrocortisone Acetate – 1% ointment or cream

Cough and Cold Relief

Used to relieve cough, congestion, or cold symptoms:

Guaifenesin Syrup (100 mg per 3 mL)- one tsp. ages 7-11 years / two tsp. ages 12-18 years every 4-6 hours PRN for cough associated with viral symptoms. Not used if asthmatic/ chest wheezing.

Dimetapp Cold/Congestion

Nasal Spray or Nasal Gel

Throat Lozenges

Digestive Relief

Used for upset stomach or heartburn:

Pepto-Bismol

Tums

Minor Injury and Skin Care

Used for minor cuts, scrapes, insect bites, fungal irritation, or dry skin:

Bactine Max Spray

Triple Antibiotic Ointment

Sting-Eze Topical Solution

Tolnaftate Powder (1%)

Eucerin Cream

Oral Pain Relief

Used for tooth pain or mouth sores:

Ora-Relief Anesthetic Spray

Orajel (Oral Pain Relief Gel)

Eye Wash

Multi-vitamins- As directed on bottle for age group

****OTC Medication Order Additions****

Acetaminophen (Tylenol) and Ibuprofen (Motrin) Dosage Guidelines
These dosage guidelines will be followed by Glenwood Academy staff when administering Acetaminophen or Ibuprofen.

Acetaminophen (Tylenol)

Indications: Pain, headaches, muscle aches, and fever (101°F or higher)
Maximum Dosage: No more than 5 doses in a 24-hour period

Tablet Dosage (325 mg tablets)
Ages 7–11 years: 1 tablet every 4 hours as needed
Ages 12–18 years: 2 tablets every 4 hours as needed

Liquid Dosage (Suspension)
Ages 6–8 years (48–59 lbs): 10 cc (mL)
Ages 9–10 years (60–71 lbs): 12.5 cc (mL)
Age 11 years (72–95 lbs): 15 cc (mL)

Chewable Tablet Dosage
Ages 6–8 years (48–59 lbs): 2 chewable tablets
Ages 9–10 years (60–71 lbs): 2½ chewable tablets
Age 11 years (72–95 lbs): 3 chewable tablets

Ibuprofen (Motrin)

Indications: Swelling related to sprains or fractures, joint pain, headaches, and muscle spasms
Maximum Dosage: No more than 4 doses in a 24-hour period

Important Safety Information:
- Must be **given with food**
- **Do not administer** if the student has an allergy to aspirin or ibuprofen

Tablet Dosage (200 mg tablets)
Ages 7–12 years: 1 tablet as needed
Ages 12–18 years: 2 tablets as needed

Liquid Dosage (100 mg per 5 cc)
Ages 6–8 years: 10 cc (mL)
Ages 9–10 years: 12.5 cc (mL)
Age 11 years: 15 cc (mL)

Chewable Tablet Dosage (100 mg per tablet)
Ages 6–8 years: 2 chewable tablets
Ages 9–10 years: 2½ chewable tablets
Age 11 years: 3 chewable tablets

Conditions for Medication Use

1.Medications will be administered according to age- and weight-appropriate dosing guidelines.

3.Medications are intended for short-term relief only.

4.Persistent, worsening, or recurring symptoms will result in parent/guardian notification and possible referral to the student's private physician.

Release of Liability

I agree to hold Glenwood Academy and its authorized staff harmless from any claims arising from the administration of the above-listed over-the-counter medications when given in accordance with established guidelines.

Parent/Guardian Acknowledgment

Parent/Guardian Name (Print): _____

Signature: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

Glenwood Academy 500 W. 187th St, Glenwood, IL 60425

Reminder from the Health Center:

Parents & Guardians:

Student ER Discharge Policy

If a child goes to the ER or has a hospital stay, while not in Glenwood Academy's care (during the weekends or if absent), Please try to get a copy of the discharge instructions from the facility, to ensure that the child is in fit condition to return to Glenwood Academy and not on any restrictions.

If they are on restrictions from an ER or Hospital stay, this needs to be in writing. The discharge instructions should have this information and should be handed in to the health center.

When you are able to get the discharge papers, please forward a copy of them to the Health Center, for our nurses. You can email the Program Manager and the Health Center that you have instructions regarding an incident and will be getting them to the proper staff. Alert then to any gym restrictions if applicable, for the next day.

Thank you for your cooperation,
Health Service
Phone: 708-756-6375
Fax: 708-756-6905

Glenwood Academy
Since 1897
LIVE LEARN SUCCEED

GLENWOOD ACADEMY 500 W. 187th Street, Glenwood, IL 60425

Reminder from the Health Center:

Parents & Guardians:

Please remember that we **MUST** have a written doctor's order for all medication brought to campus, this includes anything purchased over-the-counter (cold medicine, vitamins, creams, ointments, etc.). It also includes changes in dosages for current medications.

If we do not have the written orders we cannot give the medication.

Pharmacy receipts are NOT acceptable!

The doctor's written order must indicate the medication ordered, the dosage, and the diagnosis / reason for the medication. You may photocopy the actual prescription, have the doctor write it out or a separate sheet of paper, or have the doctor fill out one of our medication order forms (these are available in the Health Center for you to pick up).

Thank you,

Health Service

Phone: 708-756-6375

Fax: 708-756-6905

Email: healthdept@glenwoodacademy.org

Concussion Information Sheet

A concussion is a brain injury and all brain injuries are serious. They are caused by a bump, blow, or jolt to the head, or by a blow to another part of the body with the force transmitted to the head. They can range from mild to severe and can disrupt the way the brain normally works. Even though most concussions are mild, all concussions are potentially serious and may result in complications including prolonged brain damage and death if not recognized and managed properly. In other words, even a "ding" or a bump on the head can be serious. You can't see a concussion and most sports concussions occur without loss of consciousness. Signs and symptoms of concussion may show up right after the injury or can take hours or days to fully appear. If your child reports any symptoms of concussion, or if you notice the symptoms or signs of concussion yourself, seek medical attention right away.

Symptoms may include one or more of the following:	
• Headaches • "Pressure in head" • Nausea or vomiting • Neck pain • Balance problems or dizziness • Blurred, double, or fuzzy vision • Sensitivity to light or noise • Feeling sluggish or slowed down • Feeling foggy or groggy • Drowsiness • Change in sleep patterns	• Amnesia • "Don't feel right" • Fatigue or low energy • Sadness • Nervousness or anxiety • Irritability • More emotional • Confusion • Concentration or memory problems (forgetting game plays) • Repeating the same question/comment

Signs observed by teammates, parents and coaches include:
• Appears dazed • Vacant facial expression • Confused about assignment • Forgets plays • Is unsure of game, score, or opponent • Moves clumsily or displays incoordination • Answers questions slowly • Slurred speech • Shows behavior or personality changes • Can't recall events prior to hit • Can't recall events after hit • Seizures or convulsions • Any change in typical behavior or personality • Loses consciousness

Adapted from the CDC and the 3rd International Conference on Concussion in Sp...