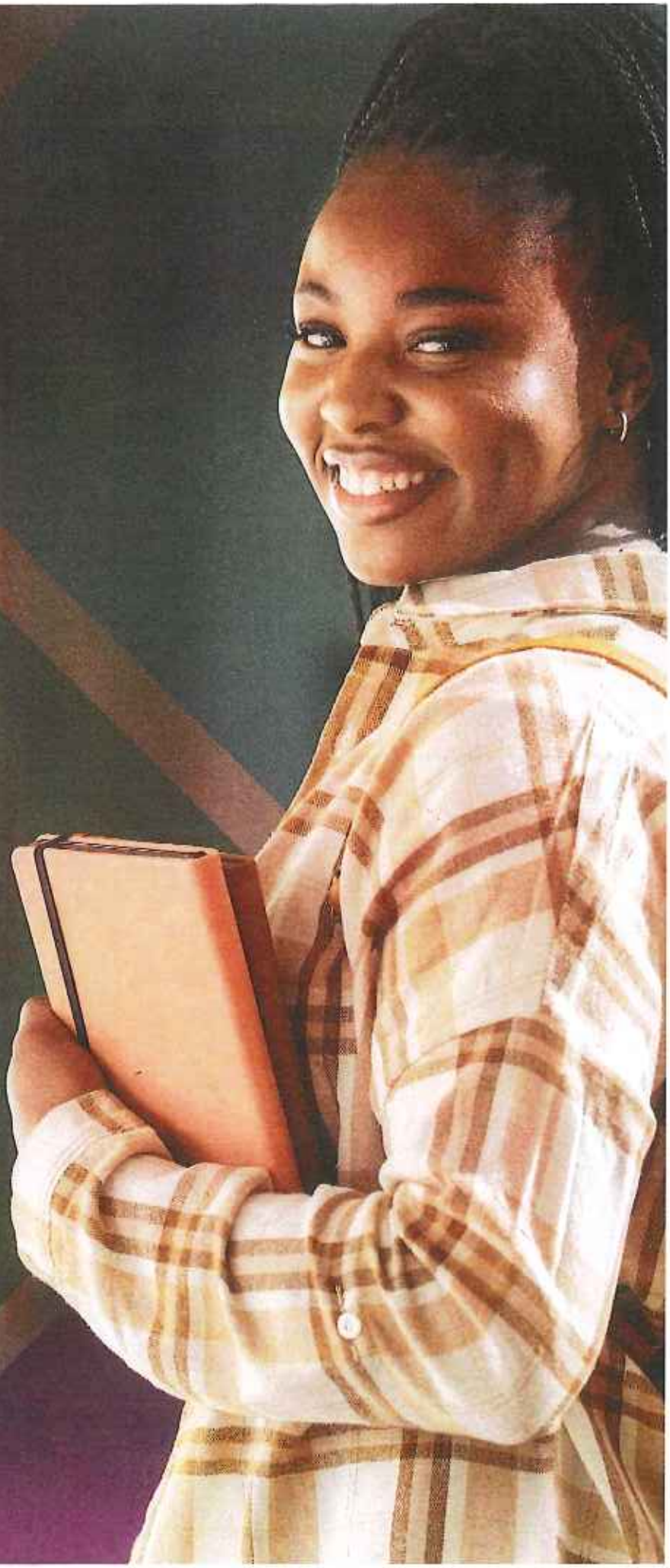
Chicago Public Schools

HEALTHY CPS

2025-2026

Student Health & School Forms Booklet



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Chicago Public Schools

HEALTHY CPS

2025-2026

Student Health & School Forms Booklet

All parents must complete these forms:

- Student Medical Information Form 2025–2026
- Request for Emergency and Health Information Form
- School Messaging Consent Form (Robo Call)
- Media Consent and Release Form
- Family Income Information Form

(Optional)
Parents must complete these forms if you want dental and/or vision services for students:

- Dental Consent Form
- Vision Consent Form

Medical Provider must complete these forms and parent must return to school clerk:

- **Proof of School Dental Examination Form**
  For students that have a private dentist
- **Healthcare Provider Statement for Food Substitution**
  For students with food allergies, please see school nurse or clerk for additional forms
- **State of Illinois Eye Examination Report Form**
  For students with a private eye doctor

→ **Please return the entire booklet.**

Chicago Public Schools

HEALTHY CPS

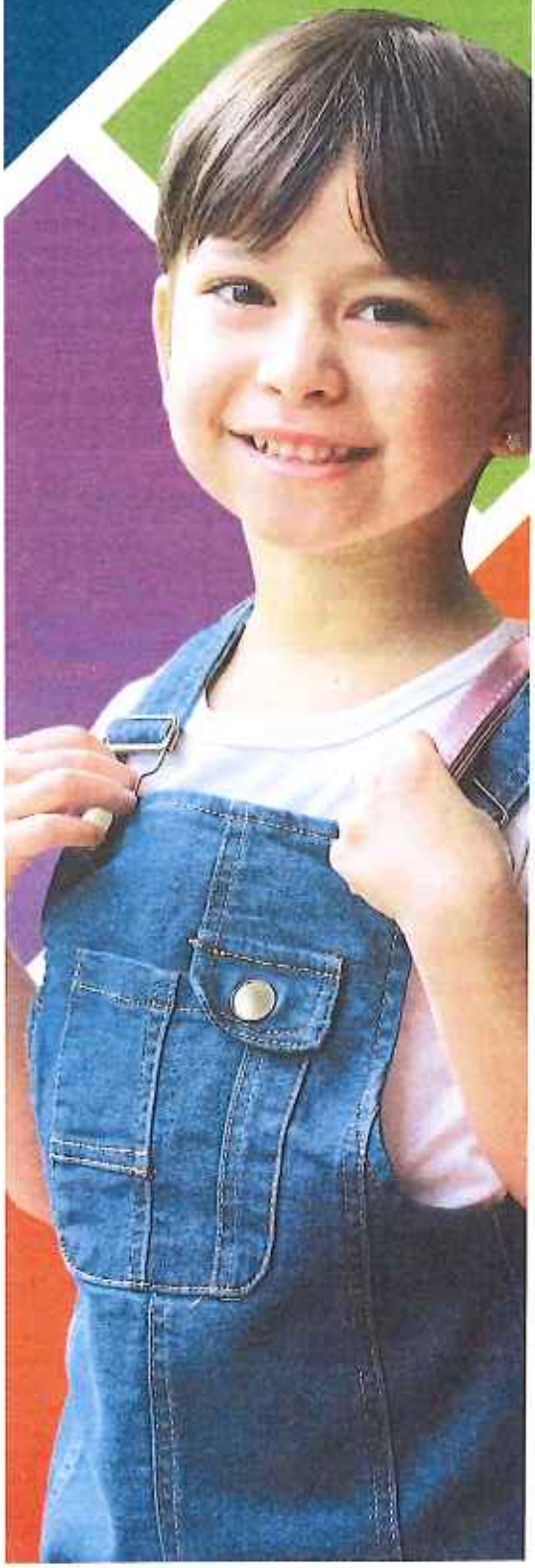

Table of Contents

Office of Student Health and Wellness
42 W. Madison St., Chicago, IL 60602

Dear CPS Parents and Families,

The health and safety of your children is always our top priority. Every child has a fundamental right to high-quality health care. We want our students to have access to healthcare providers specializing in preventive care and can address acute and chronic conditions and health issues unique to children. This booklet aims to share CPS health requirements, recommendations, and forms to facilitate families' access to transparent, reliable information and the basic health care all students need to thrive in school.

At CPS, we are committed to providing access to health and dental services for all students who need them. Our district also collects key health information annually to ensure we can meet every child's unique needs. This information is kept on file at your child's school and will remain confidential.

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

- Student Medical Information
- Request for Emergency and Health Information
- School Messaging Consent Form
- Media Consent Form and Release
- Family Income Information Form

Information about dental and vision exam services available to all students and the consent forms to enroll in these services are included in this packet.

- Consent must be completed before services are received.
- If you take your child to a private dentist or optometrist, ask those doctors to complete the Proof of Dental Examination Form or Eye Examination Report.
- Return the completed form to your child's school.

If any of the following pertains to your child, additional action is required:

- **Chronic health condition:** Consult with your child's school nurse, who will provide forms to be completed by your healthcare provider.
- **Food allergy:** Ask your healthcare provider to complete the Healthcare Provider Statement for Food Substitution and submit the completed form to your child's school.

For help with health insurance, SNAP benefits, or questions, call our hotline at (773) 553-KIDS (5437); go to www.cps.edu/oshw; or email oshw@cps.edu.

Sincerely,

TaShunda Green MSN, MBA, RN, NEA-BC
Deputy Chief - Office of Student Health and Wellness

Chicago Public Schools | STUDENT HEALTH AND WELLNESS

RENEW MEDICAID TODAY

Keep your families healthy and strong!

CPS parents and guardians, get empowered and take advantage of the healthcare benefits for the upcoming school year.

We can help you:

- Get screened for Medicaid and other public benefits
- Manage your benefits online
- Report changes (i.e. income, household members, address)
- Understand letters about your benefits

LEARN MORE!

Call the Healthy CPS Hotline at

773-553-KIDS (5437)

or visit cps.edu/cfbu

to connect with your local school coordinator today!

In partnership with:

HFS Illinois Department of Healthcare and Family Services

HealthChoice Illinois

Student Medical Information Form 2025-2026

Chicago Public Schools

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).

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER (F/M/X/N)	STUDENT DATE OF BIRTH	SCHOOL NAME

STUDENT ID #	GRADE	ROOM #

1. DOES YOUR CHILD HAVE ANY KNOWN HEALTH CONDITIONS?

YES **NO**

If your child has a health condition, please schedule an appointment with your school nurse. Please check all that apply:

Allergies (food or other)

List Allergies: _____

Asthma

Year Diagnosed _____

Seizures/Epilepsy

Year Diagnosed _____

Diabetes (please select one) Type 1 Type 2 Other

Year Diagnosed _____

Sickle Cell Disease

Year Diagnosed _____

Other _____ Year Diagnosed _____

2. MY CHILD HAS A PRIMARY CARE PROVIDER 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 medical order, action plan, or plan of care. If your student has a health condition listed above, please visit cps.edu/oshw to view the CPS Health Forms required for that particular health condition. CPS Health Forms must be completed by a medical provider and submitted to the school nurse in order to keep your student healthy and safe at school. If you have any questions about required medical forms, please schedule a call or meeting with your school nurse.

Please return the form to the school nurse. If the student has a health condition, parents must schedule a meeting with the school nurse.

Parent/Guardian Name _____ Date _____ Phone Number _____

Parent/Guardian Signature _____ Email _____

Nurses Use Only Reviewed by (Initials) _____ Date _____

Revised February 2025

RETAIN IN THE STUDENT HEALTH RECORD

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Minimum Health Requirements 2025-2026

Chicago Public Schools

Evidence shows that healthy students have better attendance patterns and perform better academically. The State of Illinois requires parents/guardians to provide proof of required immunizations and school physical exams before October 15, 2025, or their child will face exclusion from school. For more information about CPS health requirements, contact your School Nurse.

Health insurance can provide children and their families with health care coverage that can be used for doctor's visits, immunizations, medications, dental care, eye exams, glasses, and more! Medicaid Insurance provides coverage for children in Illinois, regardless of immigration status.

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

If you need help finding a health center near you, visit findahealthcenter.hrsa.gov.

Examination Requirements

Physical Examination

Due upon enrollment or no later than 10/15/25

- Must be completed within 12 months prior to entry to: PE/PK, Kindergarten, 6th Grade, 9th Grade, and any student entering CPS for the first time.

Vision Examination

Due upon enrollment or no later than 10/15/25 for:

- Entering the State of Illinois for the first time at any grade level.
- Entering kindergarten.

Dental Examination

Due 5/15/26 for Kindergarten, 2nd, 6th, and 9th Grade.

Recommended Vaccines

CPS recommends that If you have questions about which vaccines are best for you and your child, talk to your doctor or another healthcare professional who knows your health history.

HPV: Recommended to prevent some HPV (human papillomavirus)-related cancers. Recommended at age 11 or 12 years.

COVID-19: Helps protect you from severe illness, hospitalization, etc. Recommended for everyone 6 months and older.

Influenza: Recommended for all people 6 months and older to get a flu vaccine every year.

These vaccines are recommended by medical providers. They are not required in Illinois for a child to attend school. For more information visit: cps.edu/vaccine

Minimum Health Requirements 2025-2026

Chicago Public Schools

Immunization Requirements

Due upon Enrollment or No Later Than 10/15/25

The Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP) recommend children catch up on routine childhood vaccinations and get back on track for school, childcare, and beyond. Getting your child caught up with recommended and school-required vaccinations is the best way to protect them from a variety of vaccine-preventable diseases. The vaccines below are required by the State of Illinois for students attending school unless CPS receives an Illinois Certificate of Religious Exemption Form.

To learn more about each vaccine type, talk with your child's healthcare provider or visit: cdc.gov/vaccines/parents.

Diphtheria, Pertussis, Tetanus

- **Early Childhood (PE/PK):** 3 doses of DTP or DTaP by 1 year of age. One additional booster dose by 2nd birthday.
- **First Entry into School (Kindergarten or 1st Grade):** 4 or more doses of DTP/DTaP with the last dose being a booster and received on or after the 4th birthday.
- **First Entry into School (Other Grades):** 3 or more doses of DTP/DTaP or Td; with the last dose qualifying as a booster if received on or after the 4th birthday.
  - Entering 6th grade, for students (under age 11), one dose of Tdap.
  - A dose of Tdap or DTaP administered at 10 years of age or later may now be counted as the adolescent Tdap booster.
- **Minimum interval between series doses:** 4 weeks (28 days). Between series and booster: 6 months.

Polio

- **Early Childhood (PE/PK):** 2 doses by 1 year of age. One additional dose by 2nd birthday. 3 doses for any child 24 months of age or older appropriately spaced.
- **First Entry into School (Kindergarten or 1st Grade):**
  - Any child entering Kindergarten shall show proof of 4 doses with the last dose on or after the 4th birthday.
  - In accordance with the ACIP catch-up series a 4th dose of Polio is not needed if the 3rd dose was administered at age four or older and at least six months after the previous dose was administered.
- **First Entry into School (Other Grades):**
  - 3 or more doses of polio vaccine with the last dose on or after the 4th birthday.
- The 4-dose requirement applies to grades K-8.
- **Minimum interval between series doses:** 4 weeks (28 days).
- 4th dose at least 6 months after previous dose.

Measles, Mumps, and Rubella

- **Early Childhood (PE/PK):** 1 dose on or after the 1st birthday.
- **Kindergarten through 12th Grade:** 2 doses of measles/mumps/rubella vaccine, the first dose must have been received on or after the 1st birthday and the second dose no less than 4 weeks (28 days) later.
- Proof of prior **measles** disease shall be verified by a physician and laboratory evidence.
- Proof of prior **mumps** disease shall be verified by a physician or laboratory evidence.
- Laboratory evidence of **rubella** immunity.

Haemophilus influenzae type b (Hib)

- **Early Childhood (PE/PK):** Proof of immunization that complies with the ACIP recommendation for Hib vaccination. Children 24-59 months of age without series shall show proof of 1 dose of Hib vaccine at 15 months or older.
- **Kindergarten through 12th Grade:** Not required for any child 5 years of age or older.

Invasive Pneumococcal Disease (PCV)

- **Early Childhood (PE/PK):** Proof of immunization that complies with ACIP recommendations for PCV. Children 24 to 59 months of age without a primary series of PCV, shall show proof of receiving 1 dose of PCV after 24 months of age.
- **Kindergarten through 12th Grade:** Not required for any child 5 years of age or older.

Hepatitis B

- **Early Childhood (PE/PK):** 3 doses appropriately spaced. (see doses under minimum interval). Third dose must have been administered on or after 6 months of age.
- **First Entry into School (Kindergarten or 1st Grade):** Kindergarten through 5th grade is not a requirement.
- **First Entry into School (Other Grades):** Students entering 6th thru 12th grade, three doses of hepatitis B vaccine administered at appropriate intervals.
- **Minimum intervals between doses:** Between 1st and 2nd doses must be at least 4 weeks. Between 2nd and 3rd must be at least 8 weeks. Between 1st and 3rd must be at least 16 weeks.
- Proof of prior or current infection, if verified by laboratory evidence, may be substituted.

Varicella (Chickenpox Vaccine)

- **Early Childhood (PE/PK):** 1 dose on or after 1st birthday.
- **Kindergarten through 12th Grade:** 2 doses for students entering all grades; The 1st dose must have been on or after the 1st birthday and the 2nd dose no less than 4 weeks (28) days later.
- Proof of prior varicella disease shall be verified by a physician or a healthcare provider or laboratory evidence.

Meningococcal Disease (MCV4), (MenACWY)

MenACWY vaccines may be administered at same time with Men B vaccines, but at a different anatomic site.

- **First Entry into School (Other Grades):**
  - **Applies to students entering 6th - 11th grades:** 1 dose of meningococcal conjugate vaccine.
  - **12th grade entry:** 2 doses of meningococcal conjugate vaccine.
- **Minimum intervals for administration:**
  - **For 6th grade entry:** the first dose received on or after the 11th birthday.
  - If earlier vaccination (between ages 10 and 11) then follow Illinois Department of Public Health protocols.
  - **For 12th grade entry:** 2nd dose on or after the 16th birthday and an interval of at least 8 weeks after the first dose.
  - Only 1 dose is required if the 1st dose was received at 16 years of age or older.

School Based Health Centers (SBHCs) Directory

HEALTHY CPS
OFFICE OF STUDENT HEALTH & WELLNESS

CPS' School Based Health Centers - Open to ALL CPS Students

BEETHOVEN ES *Friend Health*
Grand Boulevard (N9; N17)
25 W 47th St, Chicago, IL, 60609
312-682-6110
Hours: Th-F: 8a-5p

CHICAGO VOCATIONAL HS *CFHC*
Avalon Park (N12; N17)
2100 E 87th St, Chicago, IL, 60617
773-768-5000
Hours: M-F: 8:30a-5:00p

DAVIS N ES *UI Health*
Brighton Park (N8; N16)
3050 W. 39th Pl, Chicago, IL, 60632
312-413-3090
Hours: M/Tu/W/F: 8:00a-4:30p, Th: 10a-6p

DRAKE ES *UI Health*
Douglas (N9; N17)
2710 S Dearborn St, Chicago, IL, 60616
312-355-5746
Hours: M-F: 8a-4p

ENGLEWOOD STEM HS *UI Health*
Englewood (N11; N16)
6835 S Normal Blvd, Chicago, IL, 60621
312-355-5801
Hours: M-F: 8:00a-4:30p

FARRAGUT HS *LCHC*
South Lawndale (N7; N16)
2345 S Christiana Ave, Chicago, IL, 60623
872-588-3540
Hours: M-F: 8:30a-5:00p

JOHNSON ES *Erie Family Health Centers*
North Lawndale (N5; N15)
1420 S Albany Ave, Chicago, IL, 60623
312-666-3494
Hours: M-F: 8:00a-4:30p

JUAREZ HS *Alivio Medical Center*
Lower West Side (N7; N16)
1450 W Cermak Rd, Chicago, IL, 60608
773-579-2691
Hours: M/W/Th: 8:30a-4:30p

MARINE LEADERSHIP AT AMES HS *PCH CHC*
Logan Square (N4; N14)
1920 N Hamlin Ave, Chicago, IL, 60647
Contact: 773-772-7202
Hours: M-F: 9a-5p

MARQUETTE ES *Esperanza*
Chicago Lawn (N10; N16)
6550 S Richmond St, Chicago, IL, 60629
773-584-6200
Hours: M: 7:30a-5:00p, Tu: 7:30a-5:00p,
W:7:30a-5:00p, Th (1st, 3rd of the month):11:30a-6:30p,
Th (2nd, 4th, 5th of the month):7:30a-5:00p,
F: 7:30a-1:00p, Sa (rotating):7:30a-3:30p

NOBLE-COMER *ACCESS*
Greater Grand Crossing (N12; N17)
7200 S Ingleside Ave, Chicago, IL, 60619
773-324-6942
Hours: M/W/F: 8:30a-5:00p, Tu/Th: 9:30a-6:00p
(open hours) scheduling hours vary

OROZCO *Alivio Medical Center*
Lower West Side (N7; N16)
1940 W 18th St, Chicago, IL, 60608
773-254-1400
Hours: M-F: 8:30a-4:15p

SIMPSON HS *RushU Medical Center*
Near West Side (N6; N15)
1321 S Paulina St, Chicago, IL, 60608
773-534-7202
Hours: M-Th: 9:00a-3:30p, F: 9a-1p

STEINMETZ HS *PCC CWC*
Belmont Cragin (N3; N15)
3030 N Mobile Ave, Chicago, IL, 60634
773-622-5679
Hours: M-F: 8a-5p, W (3rd, 4th of the month): 9a-5p,
Th: 8a-8p (depending on doctor availability). If doctor is not available SBHC will close at 5p on Th.

WARD L ES *Erie Family Health Centers*
Humboldt Park (N5; N15)
646 N Lawndale Ave, Chicago, IL, 60624
312-666-3494
Hours: M/Tu/Th/F: 8:00a-4:30p, W:10:00a-4:30p

SBHCs offer services that include, but are not limited to: immunizations and physical exams.

If none of these SBHCs work with a family's schedule, they may locate a Federally Qualified Health Center (FQHC) by visiting https://findahealthcenter.hrsa.gov/ where the same services are offered by zip code.

Reach out to https://www.cps.edu/services-and-supports/health-and-wellness/medical-food-benefits/ to learn more about what benefits your family might qualify for, including Medicaid, SNAP, and TANF (773-553-5437).

CPS' Mobile Care Services are available to provide immunizations and physical exams (when available) at our Elementary School and High School/Charter School locations here: https://events.juvare.com/IL-IDPH/jm7yr/.

For more information, call 773-553-5437 or email schoolhealth@cps.edu.

Chicago Public Schools

Office of Student Health and Wellness
42 W. Madison St., Chicago, IL 60602

Dear Parent/Guardian,

Healthy teeth are essential for your child's overall health. One way to help your child maintain healthy teeth is to ensure they receive an annual dental exam and a 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.

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. If your child does not have a private dentist and has not received dental care in the last 6 months, we encourage you to participate in the CPS Dental Program. It's been designed for your child.

Dental services are available to your child at no cost; however, your benefits will be used if you have public health insurance (Medicaid). The dentist will visit your child's school once during the school year. The CPS Dental Program provides the following services:

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

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

Important CPS Dental Program Updates:

- Dental cavities are common in children. Our dentist has a safe, painless alternative to traditional cavity drilling called Silver Diamine Fluoride (SDF). SDF is an FDA-approved antibiotic liquid used to help prevent cavities from forming, growing, or spreading to other teeth. The dentist simply brushes SDF on the back teeth only. The treated tooth may become discolored.
- Parallel billing allows students with Medicaid to receive dental exams from the school-based program and their private dentist without additional cost to the parents.
- If your child has received a dental exam within the past six months, the child will only receive a dental examination and dental sealants as needed. The student will not receive a dental cleaning.

If your child has a private dentist and will not need to participate in the CPS Dental Program, please have the dentist complete the Proof of School Dental Examination Form and return it to your child's school.

For help with health insurance, SNAP benefits, or questions about dental services, call our hotline at (773) 553-KIDS (5437); go to www.cps.edu/oshw; or email oshw@cps.edu.

Sincerely,

TaShunda Green MSN, MBA, RN, NEA-BC
Deputy Chief - Office of Student Health and Wellness

School-Based Oral Health Program
Dental Consent, Release of Liability and Authorization Form

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

GENDER (F / M / X / N)	STUDENT DATE OF BIRTH	SCHOOL NAME

STUDENT ID #	GRADE	ROOM #

PARENT / GUARDIAN NAME	MEDICAID/ALL KIDS — 9 DIGIT RECIPIENT #

PHONE	HOME ADDRESS (include unit number if applicable)	CITY	STATE	ZIP

PRIVATE INSURANCE NAME OF COMPANY

PRIVATE INSURANCE COMPANY POLICY #	GROUP #	PRIVATE INSURANCE COMPANY PHONE #

NAME OF PARENT / GUARDIAN INSURED	DATE OF BIRTH OF THE INSURED

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 Schools' SCHOOL-BASED ORAL HEALTH PROGRAM (the "PROGRAM"), licensed dentists or hygienists will be coming to my child's/ward's school in the near future to assess oral health, gather information on height/weight, to provide a DENTAL EXAM/SCREENING and as needed a DENTAL CLEANING, FLUORIDE TREATMENT, SDF TREATMENT(S), and DENTAL SEALANT(S) 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. PROGRAM SERVICES DO NOT INCLUDE DRILLING OR SHOTS.

I understand that in consideration for my child's/ward's participation in the PROGRAM, and as evidenced by my signature below, I hereby release and hold harmless the CITY OF CHICAGO, its departments, including the Department of Public Health, and its employees, officers, volunteers, agents and representatives, and THE BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, agents, officers, contractors, volunteers and employees from any liability which may accrue to me or to my child/ward, for any and all losses, injuries, damages to me or my child/ward, both known and unknown, foreseen and unforeseen, arising in connection with my child's/ward's participation in the PROGRAM whether or not said losses, injuries, damages, or liabilities result in whole or part from the negligence of the CITY OF CHICAGO, its departments, including the Department of Public Health, its employees, officers, contractors, volunteers, agents, or representatives, or from the negligence of the BOARD OF EDUCATION OF THE CITY OF CHICAGO, its members, trustees, employees, officers, contractors, volunteers, agents, or representatives.

I further understand that as evidenced by my signature below, I acknowledge that a licensed dentist/ hygienist 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's/ward's parent or guardian.

RACE? (Please check one)

White Black Asian Pacific Islander American Indian Native Alaskan Hispanic

MEDICAL INFORMATION: DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

YES NO

If YES: Please check all conditions that apply

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

IS YOUR CHILD TAKING ANY MEDICATIONS? YES NO

If YES, Please List Medications:

DOES YOUR CHILD HAVE ANY ALLERGIES? YES NO

DOES YOUR CHILD HAVE A SILVER ALLERGY? YES NO

If YES, Please List Allergies:

ANY OTHER MEDICAL-RELATED CONDITIONS? YES NO

If YES, Please List Conditions:

Please sign front and back

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 and as needed a dental cleaning, fluoride treatment and dental sealant(s) and the receiving of quality assurance exams. I authorize the dental provider to use my child's or ward's Medicaid, ALL KIDS and private dental insurance 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.

X _____
Parent/Guardian Signature

_____
Date

Chicago Public Schools

RETAIN IN A BINDER FOR 2 YEARS

School-Based Oral Health Program Authorization Form - HIPAA

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

please print or type:

STUDENT LAST NAME	FIRST NAME	MIDDLE NAME

STUDENT DATE OF BIRTH	PARENT / GUARDIAN NAME

SCHOOL NAME

NEW Silver Diamine Fluoride (SDF) Authorization

A new dental treatment to fight cavities!

Before SDF

After SDF

BENEFITS OF SDF: Dental cavities are common in children, but now our dentists have a safe, painless alternative to traditional cavity drilling procedures called Silver Diamine Fluoride (SDF). SDF is an FDA-approved antibiotic liquid used to help prevent cavities from forming, growing, or spreading to other teeth. The dentist simply brushes SDF on back teeth only Reason to avoid SDF treatment: silver allergy, history of mouth sores, or painful sores on the gums.

Alternatives

- No treatment: The tooth may continue to decay and cause pain.
- Other options: fluoride varnish, a filling or crown, or extraction of the tooth.

Risks

- SDF treatment may not eliminate the need for a traditional filling.
- It's normal for SDF to stain the cavity brown or black–it means it's working.
- The healthy parts of the tooth will not be stained.
- SDF can cause temporary staining if it comes into contact with skin. The stain is harmless and should disappear in less than a week.
- SDF may cause a temporary metallic taste.
- For more information, scan the QR Code.

Consent for SDF Treatment

I certify that I have read and fully understand the information for the proposed SDF application(s), or I had discussed this with my dental care provider and have had my questions answered. I understand the possible risks associated with SDF treatment and verify that I have no (or the patient I am representing has no) contraindications for its use. I consent to SDF application.

X _____ _____

Parent/Guardian Signature for Silver Diamine Fluoride (SDF) — Date

HIPAA Authorization

By signing below, I understand that I am giving my authorization to the dental provider and the City of Chicago Department of Public Health (CDPH) 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, 111 W. Washington, 4th Floor, Chicago, IL 60602; 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 Section, 535 W. Jefferson Street, 2nd Floor, Springfield, IL, 62761, Chicago Public Schools, Office of Student Health and Wellness, 42 West Madison, Chicago Illinois 60602. Federally Qualified Health Centers (FQHC), Oral Health Forum (OHF), 1100 West Cermak Road, Suite 518, Chicago, IL 60608. 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 School 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 redisclosure by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act (HIPAA) 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, 111 W. Washington, 4th Floor, Chicago, IL 60602. 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.

X _____ _____

Parent/Guardian Signature for HIPAA Authorization — Date

Please sign front and back

Chicago Public Schools

Dentist must complete the form. Parents, please return the form to your child's school or send to healthforms@cps.edu

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 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 and 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 be 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*
School: *Name*	*ZIP Code*	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: *Last Name*	*First Name*		

Student's Race/Ethnicity:
☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian ☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander ☐ Middle Eastern or North African ☐ Two or More Races ☐ Unknown

To be completed by the dentist:

Date of Most Recent Examination: _____ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Silver Diamine Fluoride ☐ Restoration of teeth due to caries

Oral Health Status *(check all that apply)*

☐ Dental Sealants Present on Permanent Molars

☐ 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 first molars.

☐ 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.

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

Treatment Needs *(check all that apply)*
For Head Start Agencies, please also list the appointment date or date of the most recent treatment.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date: _____

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date: _____

☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date: _____

Office Address: _____ Office Phone: _____

Signature of Dentist: _____ License #: _____ Date: _____

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

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IOCI 25-1275

RETAIN IN THE STUDENT HEALTH RECORD

Students in Temporary Living Situations (STLS)

Notice of Rights of Homeless Students

Chicago Public Schools

The Board of Education of the City of Chicago (Board) shall provide an educational environment that treats all students attending the Chicago Public Schools (CPS) with dignity and respect. Every student in a temporary living situation shall have equal access to the same free and appropriate educational opportunities as students who are permanently housed. This commitment to the educational rights of students in a temporary living situation, youth, and youth not living with a parent or guardian, applies to all services, programs, and activities provided or made available by the Board.

A student is considered to be in a temporary living situation if he or she lacks a fixed, regular, and adequate nighttime residence and includes children and youth who are:

- sharing the housing of other persons due to loss of housing, economic hardship, or similar reason;
- living in a motel/hotel, trailer park or camping ground, due to lack of alternative, adequate housing;
- living in emergency or transitional shelters;
- living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train station, or similar setting;
- abandoned in hospitals;
- migratory children living in one of the above settings;
- youth not in the custody of a parent/guardian (unaccompanied youth) of any age, in one of the above settings.

Students who temporarily reside outside of Chicago due to homelessness and attend their CPS school of origin receive transportation assistance as do students experiencing homelessness who live in the City of Chicago but attend a school of origin outside of CPS.

Dispute Resolution: When a school official denies a student in a temporary living situation enrollment, eligibility, school selection and/or transportation, the parent or student may file a complaint with the CPS STLS Department. The STLS Department will attempt to resolve the dispute in a timely manner. The STLS Department will refer you to free and low-cost legal services to help you, if you wish. During the dispute, the student must be immediately enrolled in the school with participation in school activities and/or provided transportation until the dispute is resolved. Every Chicago Public School, including charter schools, has an STLS Liaison who will assist you in making enrollment decisions, provide notice of the dispute resolution process, if needed assist you in completing the dispute resolution forms and refer you to low-cost legal assistance.

All STLS Students Have Rights To

Immediate school enrollment. A school must immediately enroll students even if they lack health, immunization or school records, proof of guardianship, or proof of residence. "Enrollment" means enrolled into the school, attending classes and participating fully in school activities.

Enroll in:

- the school they attended when permanently housed or the school in which they were last enrolled (school of origin).
- any school that permanently housed students living in the same attendance area in which the STLS student or youth is actually living are eligible to attend (attendance area school).
- preschool

Remain enrolled in his/her selected school for as long as they remain in a temporary living situation or, if the student becomes permanently housed, until the end of the academic year.

Access to charter schools, selective enrollment schools, magnet schools, and all other CPS programs in the same manner as students who are permanently housed and assistance with application process will be provided upon request.

Participate in tutoring services beyond those provided to all students; school-related activities; and/or receive other support services.

Receive free school meals, fee waivers, free uniforms, and low-cost or free medical referrals.

Transportation services: If parents/caregivers choose to continue their child's education in the school of origin and transportation is requested, CPS will provide transportation to and from the school of origin, and all school-related activities, for as long as the student is in a temporary living situation or, if the student becomes permanently housed, until the end of the academic year.

- **Eligible students receive CTA transportation cards and adult caregivers of eligible students in grades PK-6 receive CTA transportation cards to accompany the student to/from school. Eligible students in grades PK-6 whose caregiver is unable to accompany them on public transportation due to a hardship may apply for yellow school bus service by submitting documentation or affidavit of their inability to transport the student. Examples of a "hardship" situation are:**
  - Parent/caregiver employment, job training, or education program.
  - Parent's/caregiver's mental and/or physical disability.
  - Children need to be transported to and from schools at different locations.
  - Court order, DCFS, or DCFS contract agent requires activities that do not enable parent/guardian to transport children to and from school.
  - Rules of shelter or similar facility will not permit parent/caregiver to leave to transport children to and from school.
  - Other good cause why parent/caregiver cannot use public transportation to transport children to and from school.

For more information about the rights of STLS students in Chicago Public Schools, call the STLS program at **(773) 553-2242**, fax at **(773) 553-2182**, email at STLSInformation@cps.edu, go to cps.edu/STLS, or visit the STLS policy at cps.edu/STLSpolicy.

Vision Program: Schedule An Eye Exam

HEALTHY CPS
OFFICE OF STUDENT HEALTH & WELLNESS

Chicago Public Schools has partnered with Illinois Eye Institute, Tropical Optical and Ageless Eye Care to provide vision exams for CPS students.

Seven locations throughout the city have been provided for your convenience. Please review the list of vision service locations listed below.

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

Tropical Optical

Select from a location below

Please call to schedule your appointment.

For children ages 5 through high school.

Tropical Optical Locations

6104 West Cermak Road, Cicero, IL 60804,
call 708-780-0090

3624 West 26th Street, Chicago, IL 60623
call 773-762-5662

3205 West 47th Place, Chicago, IL 60632
call 773-247-2360

2767 North Milwaukee Avenue, Chicago, IL 60647
call 773-276-4660

9137 South Commercial Avenue, Chicago, IL 60617
call 773-768-3648

Illinois Eye Institute (IEI)

Lewenson Center
3241 South Michigan Avenue, Chicago, IL 60616

Please call to schedule your appointment
at 312-225-6200.

For children ages 3 through high school.

Ageless Eye Care

329 W. 18th Street #311
Chicago, IL 60616

Please call to schedule your appointment
at (312) 929-3340.

For children ages 5 through high school.

For more information about the CPS Vision Program, please contact **(773) 553-5437** or email **oshw@cps.edu**.

Chicago Public Schools

HEALTHY CHICAGO
CHICAGO DEPARTMENT OF PUBLIC HEALTH

Chicago Public Schools

Office of Student Health and Wellness
42 W. Madison St., Chicago, IL 60602

Dear Parent/Guardian,

Good vision is essential for success in school. The CPS Vision Program provides students with eye exams and glasses (if needed) at NO COST. If the student does not have insurance, the vision exam and eyeglasses are provided at no cost to the family. If available, health insurance will be billed.

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

- My child is entering kindergarten or entering Illinois schools for the first time at any grade level
- My child failed the vision screening
- My child has an IEP
- My child's teacher recommended they receive an eye exam
- Squinting
- Tilting the head
- Sitting too close to the television/device/screen
- 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: https://drive.google.com/file/d/1yowceXBFRaj5-Fpt66J1gTUcJKl5sEel/view.

- 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 the 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 and the Student Medical History Form. If you do not want your child to participate in the program, you do not need to complete or return the forms to the school.

For help with health insurance, SNAP benefits, or questions about vision services, call our hotline at (773) 553-KIDS (5437); go to https://www.cps.edu/oshw or email oshw@cps.edu.

Sincerely,

TaShunda Green MSN, MBA, RN, NEA-BC
Deputy Chief - Office of Student Health and Wellness

Vision Services Consent, Release of Liability, and Authorization Form

Chicago Public Schools

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

please print or type:

STUDENT LAST NAME	FIRST NAME		MIDDLE NAME
GENDER (F/M/X/N)	STUDENT DATE OF BIRTH	SCHOOL NAME	
STUDENT ID #	GRADE		ROOM #
PARENT/GUARDIAN NAME		PARENT EMAIL ADDRESS	
PHONE	HOME ADDRESS (include unit number if applicable)	CITY	STATE ZIP
MEDICAID/MEDICAL CARD/ALLKIDS RECIPIENT #	RACE/ETHNICITY		DATE OF BIRTH
PRIVATE VISION INSURANCE	CARDHOLDER NAME	DATE OF BIRTH / GROUP ID#	ID#
PRIVATE MEDICAL INSURANCE	CARDHOLDER NAME	DATE OF BIRTH / GROUP ID#	ID#

As the parent/guardian of the above named 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 by them under the Program, unless attributed to their willful or wanton misconduct. In the event that one provision of this form is held unenforceable, that provision shall be severed and the remainder of the form shall remain in effect.

I understand that the Provider will bill 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 you DO NOT want your child to receive the following services, please check the appropriate box. *If your child has an allergy, please consult your primary care physician before selecting dilation.*

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 consent for my child's eyes to be dilated.

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.

Please note services will be performed unless indicated otherwise.

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.

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

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

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 _____

Parent/Guardian Signature _____ Date _____

RETAIN IN A BINDER FOR 2 YEARS

Vision Services
Student Medical History Form

Chicago Public Schools

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

please print or type:

STUDENT NAME	STUDENT ID	STUDENT'S DATE OF LAST EYE EXAM

SCHOOL NAME	DOES YOUR CHILD CURRENTLY WEAR GLASSES/CONTACTS? YES NO

HOW DID YOU FIND OUT ABOUT THE VISION PROGRAM? (Check all that apply)

School Staff | Failed Vision Screening Letter | Friend | Other | Add Details _____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS? (Check all that apply)

Asthma	Diabetes	Genitourinary Problems	Heart Disease	Musculoskeletal Problems
Attention Deficit Disorder	Endocrine Problems	Glaucoma	High Blood Pressure	Neurological Problems
Behavioral Problems	Gastrointestinal Problems	Hearing/Ear Problems	Mental Health Illness	Other Condition _____

IS YOUR CHILD TAKING ANY MEDICATIONS? YES NO

List Medications:

DOES YOUR CHILD HAVE ANY ALLERGIES? YES NO

List Allergies:

DOES YOUR CHILD USE EYE DROPS? YES NO

List Eye Drops:

HAS YOUR CHILD EVER HAD EYE SURGERY? YES NO

If yes, please explain:

HAVE THEY HAD ANY OF THE FOLLOWING?

Vision Therapy	Blurred/Double Vision	Tearing/Watering	Difficulty Sitting Still	Frustrates Easily
Eye Patch	Loses Place While Reading	Light Sensitivity	Avoids Reading/Writing	Lack of Confidence
Eye Surgery	Eye Injury	Redness	Difficulty Paying Attention	Eye Discharge
Pain in Eyes	Eye Infection	Drooping Lid	Reads Below Grade Level	Lazy/Wandering Eye
Difficulty Tracking	Itching/Burning	Trouble Finishing Work	Poor Handwriting	

Other _____

DOES YOUR CHILD HAVE AN IMMEDIATE FAMILY MEMBER WITH ANY OF THE FOLLOWING? (Check all that apply)

Wears Glasses	Glaucoma	Lazy Eye	High Blood Pressure
Blindness	Macular Degeneration	Diabetes	Wandering Eye
Heart Disease	Cardiovascular Problems	Neurological Problems	Mental Health Illness
Musculoskeletal Problems			

DOES YOUR CHILD HAVE AN IEP (Individualized Education Plan or 504 Plan)? YES NO

IS YOUR CHILD PERFORMING AT: Above Grade Level | Grade level | Below grade level

IF BELOW GRADE LEVEL, PLEASE SELECT THE CLASS (Check all that apply)

Reading | Math | Social Science | Writing | 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?

RETAIN IN A BINDER FOR 2 YEARS

Doctor must complete the form. Parents, please return the form to your child's school or send to healthforms@cps.edu

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

Doctor must complete the form. Parents, please return the for
to your child's school or send to healthforms@cps.ed

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 _____ License Number _____

Optometrist or physician (such as an ophthalmologist) who provided the eye 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)

_____
(Date)

Address _____

_____

Phone _____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois
6/09

IOCH1271-09

RETAIN IN THE STUDENT HEALTH RECORD

For Students with Asthma

HEALTHY CPS
OFFICE OF STUDENT HEALTH & WELLNESS

Asthma is the most common chronic illness of childhood. Chicago has an especially high number of children with asthma, and children in some Chicago neighborhoods suffer more than others. All students, including those with asthma, should feel safe and supported at school.

Please use the forms in this packet to tell your school about your child's asthma. The school nurse or clerk may have additional forms to complete. Health 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 by a medical provider.
- **Request for Administration or Self-Administration of Medication**
- **Original (or clear copy) of asthma medication or pharmacy label with your child's information.**

CPS ANNUAL CHRONIC CONDITION REPORTING & VERIFICATION PROCESS

1. **Complete the necessary forms.**
   Access forms at cps.edu/medicalforms.
2. **Have your medical provider complete and sign the forms.**
   For assistance with accessing or using medical benefits, please contact us at 773-553-KIDS or visit cps.edu/cfbu.
3. **Bring the signed forms and the student's medication (with prescription labels) to your school for review by the school nurse.**
4. **Contact your school nurse to set up a 504 plan.**
   A 504 Plan is a legal document that ensures that the student is safe and supported at school.

For more information, contact the Office of Student Health and Wellness at 773-553-KIDS (5437)

Chicago Public Schools

HEALTHY CPS

If your child has a chronic health condition, follow these four steps:

- Any student with asthma, food allergies, diabetes, or any other chronic condition can have a Section 504 Plan so they are supported during the school day.
- A 504 Plan provides the needed changes the school must make to help your child succeed in school.
- For more information, contact the Office of Student Health and Wellness at cps.edu/oshw or **(773) 553-KIDS (5437).**

Chicago Public Schools

For Students with Asthma

HEALTHY CPS

FREQUENTLY ASKED QUESTIONS ABOUT ASTHMA CARE AT SCHOOL

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 do 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 and medication is provided to the school.

What is the school's asthma emergency response?

- In the event a student is experiencing respiratory distress and does not have an Asthma Action Plan/504/IEP, or has an Asthma Action Plan/504/IEP but for whatever reason does not have access to their inhaler, the stock inhaler will be administered. Albuterol in the form of an HFA inhaler is stocked at ALL CPS and Charter schools.
- If the medication is not working, 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 CPS's stock inhaler protocol in the event a student without an Asthma Action Plan has an asthma attack. If symptoms do not resolve, 911 will be called. Parents will always be notified if their student is treated with the stock inhaler and/or if 911 is called.

Does the student need a Section 504 Plan?

- A Section 504 Plan must be offered. Speak to your child's school nurse and medical provider to know what is needed.
- 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 cps.edu/sites/cps-policy-rules/policies/700/704/704-12/.
- Visit the Office of Student Health and Wellness website at cps.edu/oshw.
- Talk to your child's school nurse.
- Contact the Office of Student Health and Wellness at oshw@cps.edu.

Healthcare Provider Statement for Food Substitution

Chicago Public Schools

This form must be completed if a parent/student is requesting menu substitutions be made in the lunchroom for a student's medical need (i.e. food allergy, intolerance, or other physical or mental impairment).

Under the Americans with Disabilities Act, a student with food allergies may be considered to have a physical or mental impairment that substantially limits one or more major life activities.

Chicago Public Schools (CPS) participates in federal Child Nutrition Programs that offer meals and milk to students. If a special dietary need is documented by a healthcare provider, reasonable meal modifications must be made.

Ask your child's healthcare provider to complete this form and return to your child's School Nurse with a Food Allergy Action Plan (cps.edu/healthforms).

DOES YOUR CHILD EAT OR PLAN TO EAT SCHOOL MEALS? YES NO

please print or type:

SCHOOL NAME | SCHOOL ADDRESS

STUDENT LAST NAME | STUDENT FIRST NAME | STUDENT MIDDLE NAME

STUDENT BIRTH DATE | PARENT/GUARDIAN NAME | PARENT/GUARDIAN EMAIL | PARENT/GUARDIAN PHONE

The section must be completed by a State Licensed Healthcare Professional (who is authorized to write medical perscriptions) or a Registered Dietitian.

1. DESCRIBE THE CHILD'S PHYSICAL OR MENTAL IMPAIRMENT AND HOW IT RESTRICTS THEIR DIET AND/OR ACCESS TO MEAL PROGRAMS.

2. ARE THERE ANY FOOD ITEMS AND/OR INGREDIENTS THAT MUST BE AVOIDED? YES NO
If YES, please list the food items and/or ingredients to be avoided.

3. LIST ALTERNATIVES THAT MAY BE PROVIDED FOR ANY ITEMS OR INGREDIENTS ABOVE.

4. LIST ANY ADDITIONAL MODIFICATIONS AND/OR SERVICES NEEDED TO ACCOMMODATE THE CHILD'S IMPAIRMENT OR DISABILITY DURING MEALTIMES.

5. SIGNATURE OF HEALTHCARE PROFESSIONAL DATE

SCHOOL USE ONLY:
A copy of this form must be shared with the school nurse and emailed to food@cps.edu with a school nurse's signature.

School Nurse Name and Email

School Nurse Signature | Date reviewed | Date scanned to food@cps.edu

This page is intentionally left blank

Request for Emergency and Health Information Form

Chicago Public Schools

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.

SCHOOL NAME | STUDENT ID#

STUDENT LAST NAME | FIRST NAME | MIDDLE NAME

STUDENT HOME ADDRESS (include unit number if applicable) | City | State | Zip

BIRTH DATE *(mm/dd/yyyy)* | HOMEROOM # | HOME/PRIMARY 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/abandoned building/substandard housing
- doubled-up
- in a hotel/motel/trailer park/camping ground
- 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 Civil No Contact Order which concerns this student? YES NO

Is there a current Temporary Restraining Order or Injunction 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 SIS.

PARENT/GUARDIAN AND EMERGENCY CONTACT INFORMATION: *Add extra contacts on additional page, if needed.*

	PRIMARY PARENT/GUARDIAN CONTACT DCFS Contact	PARENT/GUARDIAN CONTACT DCFS Contact	PARENT/GUARDIAN CONTACT DCFS Contact
Contact First Name, Last Name			
Relationship to Student			
Check all that apply:	Lives With Emergency Gets Mailings Permission to Pick up	Lives With Emergency Gets Mailings Permission to Pick up	Lives With Emergency Gets Mailings Permission to Pick up
Home Address, if different from student's *(include unit number if applicable)*			
Primary Phone Number	Cell Home Work	Cell Home Work	Cell Home Work
Secondary Phone Number	Cell Home Work	Cell Home Work	Cell Home Work
Third Phone Number	Cell Home Work	Cell Home Work	Cell Home Work
E-mail Address			
* Communication Language			
Requires Translator	YES NO	YES NO	YES NO

* 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, neighbor, family friend, or trusted adult who can also be notified in an emergency and has permission to pick up the student:

NAME | RELATIONSHIP | TELEPHONE #

ADDRESS

FAMILY DOCTOR'S NAME, ADDRESS, AND PHONE NUMBER:

I authorize you to call my family doctor, if necessary, in an emergency: YES NO

NAME | ADDRESS (include unit number if applicable) | City | State | Zip

TELEPHONE #

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

Parent/Guardian Signature | Date

RETAIN 1 YEAR AFTER SUPERSEDED OR STUDENT HAS PERMANENTLY WITHDRAWN

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School Messaging Consent Form

Chicago Public Schools

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 a phone messaging system to remind you about these events, updates, and initiatives; including report card distribution, field trips, community events, parent-teacher conferences, announcements, COVID-19 information and screenings, 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 through 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 phone numbers, including cellular numbers, listed on the student's record. Please make sure these numbers are updated with your school.

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

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 and texts, 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 and text messages unless or until you revoke your consent. Standard messaging rates and data may apply.

I CONSENT as outlined in the above section.

I DO NOT CONSENT as outlined in the above section.

please print or type:

Student Last Name _____ First Name _____ Middle Name _____ Birth Date (mm/dd/yyyy) _____

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

School Name _____ Grade _____ Student ID # _____

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

PRIORITY #1

Last Name _____ First Name _____

Primary Phone _____ Cell Home Work Secondary Phone _____ Cell Home Work Third Phone _____ Cell Home Work

PRIORITY #2

Last Name _____ First Name _____

Primary Phone _____ Cell Home Work Secondary Phone _____ Cell Home Work Third Phone _____ Cell Home Work

PRIORITY #3

Last Name _____ First Name _____

Primary Phone _____ Cell Home Work Secondary Phone _____ Cell Home Work Third Phone _____ Cell Home Work

RETAIN IN THE STUDENT CUMULATIVE FOLDER

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Media Consent and Release Form

Chicago Public Schools

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, either in person or hosted remotely, 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 which may include honorary banners/signs displayed in, near, or around the school building or community. I understand and agree that the Board and/or its authorized representatives retain the right to use any digital or print capture (including video, audio, photographs or likeness) for any purposes stated or related to the above and may be used by the District in subsequent years.

As the child's parent or legal guardian, I agree to release, indemnify 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 any digital file, or any other electronic/digital media or print media or in connection with my child's participation in virtual school events and/or celebratory activities.

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 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.**

Please print or type:

Student Last Name _____ **First Name** _____ **Middle Name** _____ **Birth Date (mm/dd/yyyy)** _____

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

School Name _____ **Grade** _____ **Student ID #** _____

Signature of Parent/Guardian / Student if age 18 or older _____ **Date** _____

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. Department of Education Policy and Procedures 06.01.20.

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Directory and Recruiter Information Opt-Out Form

Department of Policy and Procedures

Chicago Public Schools

Complete this form only if you are opting out of any of the choices provided.

Dear Student, Parent or Guardian:

You have the right to inspect and copy your student's records, challenge the contents of such records, and limit your consent to the designated records or designated portions of information within the records.

If you DO NOT want directory information disclosed, complete this form and return it to the school clerk at time of enrollment/registration. If you do not submit a completed Opt-Out Form, your child's directory information may be provided to recruiters and external parties by CPS upon their request. If you submit this form but do not check at least one box, your child's directory information may be provided to recruiters and external parties upon their request. If you have more than one child attending CPS, you must submit a separate request for each child.

please print or type:

Student Last Name	First Name	Middle Name	Student ID Number (8 digits): *This is required*

School Name

Date

FOR ALL ELEMENTARY, MIDDLE AND HIGH SCHOOL STUDENTS

DO NOT disclose my child's directory information to any external party without my prior consent.

FOR HIGH SCHOOL JUNIOR AND SENIOR STUDENTS ONLY

You may block the release of your contact information specifically to military recruiters, colleges and universities, or both by checking the boxes below.

DO NOT disclose my child's directory information to military recruiters without my prior consent.

DO NOT disclose my child's directory information to colleges and universities without my prior consent.

Last Name	First Name	Middle Name

Relationship to Student: Select one

SELF PARENT / GUARDIAN

Signature

RETAIN IN THE STUDENT CUMULATIVE FOLDER

Directory and Recruiter Opt-Out Information Sheet

Department of Policy and Procedures

Chicago Public Schools

This Information Sheet for Students and Parents provides instructions on how you can use the "Directory and Recruiter Information Opt-Out Form" to prevent the release of your child's student directory information. An Opt-Out Form is enclosed for your convenience.

The Family Educational Rights and Privacy Act (FERPA), *Illinois School Student Records Act* (ISSRA), and Chicago Board of Education Policy 706.3 *Parent and Student Rights of Access to and Confidentiality of Student Records* require that Chicago Public Schools (CPS) obtain your written consent before disclosing personally identifiable information from your child's education records, with certain exceptions. **The Chicago Public Schools may disclose "directory information" without written consent, unless you have advised the District that you do not want the information shared by using the form attached.**
This form is to be turned in at time of enrollment or by December 1st.

Who will have access to this directory information?

CPS may share directory information with third parties (such as city agencies or educational service providers) who have an educational interest in the information and request it. All requests from external parties related to research are reviewed by the CPS Department of School Quality Measurement & Research or the CPS Office of College and Career Success to ensure the request is in the interest of students.

What is directory information?

Directory information is information that is generally not considered harmful or an invasion of privacy if released. CPS has designated the following as directory information: student's name; parents' names; home address; home telephone number; date of birth; grade level; dates of attendance; school photographs; and most recent CPS school attended.

How do I complete the CPS Directory Information Opt-Out Program Process?

A parent/guardian or student age 18 or older **must complete this form and return it to the school clerk annually at time of enrollment/registration.** The completed opt-out form must be returned to the school no later than December 1 annually. If you have more than one child attending CPS, you must submit a separate request for each child. The Opt-Out Form requires a student identification number. Please make sure you record the 8-digit ID number on the form accurately.

For parents/guardians of JUNIORS and SENIORS ONLY:

By law, if military recruiters request contact information (name, address, phone number) for 11th- or 12th-grade students, CPS is required to provide that information unless you choose to block it. Colleges and universities also may request student information. Using the Chicago Public Schools Opt-Out form, you may block the release of your contact information to military recruiters, or to colleges and universities, or to both.

Having your name placed on the Opt-Out list does not in any way limit your ability to request your school to send a transcript or any other material on your behalf to a college or university, a military recruiter, or others, upon request.

Questions or Concerns?

If you have questions about CPS policy related to the release of student information to third parties, recruiters, or universities please contact policy@cps.edu.

CPS Family Income Information Form 2025 - 2026

Chicago Public Schools

The purpose of this form is for CPS to obtain information about families' incomes 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.

Parents—Please return form to school by October 30, 2025.
Schools—Please enter into ODA by November 20, 2025.

please print or type:

STUDENT LAST NAME	STUDENT FIRST NAME	STUDENT MIDDLE NAME
SCHOOL NAME	STUDENT ID	DOES YOUR FAMILY HAVE INTERNET SERVICES AT HOME? YES NO

PART 1: Household Information — List all members of your household living with you.

**Foster Children (legal responsibility of welfare agency or court)*

PART 2: SNAP/TANF number of any member of your household *(go to part 6)*

FOSTER CHILD?	CPS STUDENT?	ALL HOUSEHOLD MEMBER NAMES Last	First	M.I.	DATE OF BIRTH	DHS SNAP OR TANF CASE NUMBER (LAST 9 DIGITS)

PART 3: Homeless, Runaway Child, or child enrolled in Head Start

HOMELESS
RUNAWAY
HEAD START

Homeless, Runaway or Head Start Liaison Signature _____ Date _____

PART 4: List Household Members With Income *(SKIP THIS if you answered any of parts 2 or 3)*

Enter the amount of income and how often it is received for each household member.
Frequency: Weekly, Every 2 Weeks, Twice Monthly, Monthly, Annually

OTHER INCOME can be but not limited to Welfare, Child Support, Retirement, Social Security, Worker's Compensation, and Unemployment.

HOUSEHOLD MEMBER NAMES WITH INCOME First	Last	M.I.	GROSS INCOME *(before deductions)* Weekly / Every 2 Weeks / Twice Monthly / Monthly / Annually	OTHER INCOME Weekly / Every 2 Weeks / Twice Monthly / Monthly / Annually
			$	$
			$	$
			$	$
			$	$
			$	$

PART 5: Opt in for information about other benefits.

YES! I am interested in applying for a waiver of instructional fees.

YES! I am interested in applying for the Supplemental Nutrition Assistance Program (SNAP) and/or the Medicaid Program. *Or call 773-553-5437*

YES! This student/these students have a parent who is a veteran or active military member. *Students with a parent who is a veteran or active military may qualify for a fee waiver.*

Signature _____

PART 6

Signature: 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 and screen CPS students for eligibility for other benefits and that school officials may verify (check) the information as being accurate; and that if I purposely give false information, I may be prosecuted. I consent to the district sharing eligibility status in order to receive benefits based on eligibility status.

Signature of adult household member _____ Parent / Guardian First Name _____ Parent / Guardian Last Name _____

Address _____ Zip Code _____ Date _____

RETAIN IN FIF FOLDER FOR 4 YEARS

CPS Family Income Information Form 2025 - 2026

Chicago Public Schools

PART 7: Children's Racial and Ethnic Identities *(Optional)*

MARK ONE ETHNIC IDENTITY:	MARK ONE OR MORE RACIAL IDENTITIES:		
Hispanic / Latino	Asian	Black / African American	Native Hawaiian / Other Pacific Islander
Not Hispanic / Latino	White	American Indian / Alaska Native	

Instructions For Completing Family Income Information Form

IF YOUR HOUSEHOLD RECEIVES BENEFITS FROM SNAP/TANF, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students). (Attach another application if necessary.)

Part 2: List the DHS case number (SNAP or TANF) of any household member that corresponds with their name in Part 1. Do not use your Medicare card number.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A HOMELESS, RUNAWAY, OR HEAD START CHILD, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students).

Skip to Part 3: Check the appropriate box; obtain date and signature of Homeless, or Runaway Liaison/Coordinator.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

IF YOU ARE APPLYING FOR A FOSTER CHILD, FOLLOW THESE INSTRUCTIONS:

If all children in the household are foster children:

Part 1: List student's name, date of birth and check the box for "Foster Child" to the left of your foster child's name.

Skip to Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

IF SOME CHILDREN IN THE HOUSEHOLD ARE FOSTER CHILDREN:

Part 1: List student's name, date of birth and check the box for "Foster Child" to the left of your foster child's name.

Skip to Part 4: Follow the instructions under ALL OTHER HOUSEHOLDS INSTRUCTIONS (Part 4) below.

Part 5: If you are interested in sharing application information with All Kids or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

ALL OTHER HOUSEHOLDS, FOLLOW THESE INSTRUCTIONS:

Part 1: List all of the household members and date of birth (for students).

Skip to Part 4: Follow these instructions to report total household income:

Column 1: Name
List the first and last name of each person in your household who receives income, related or not (such as grandparents, other relatives, or friends. Attach another sheet of paper if necessary.).

Columns 2 & 3: Gross Income Amounts and Frequency
The Gross Income is the amount earned before taxes and other deductions. It should be noted on pay stubs. This is not the same as take-home pay. List the amount each person receives from these sources. Round to the nearest dollar. All other sources of income should also be noted on this application. Next to each amount fill in the circle that indicates how often the person receives their stated income (weekly, every other week, twice a month, monthly, or annually). If you do not wish to disclose your income, please note "decline to answer" in this section. Be aware that if you are low-income, failure to share household income information could reduce the funds your school may otherwise receive.

Part 5: If you are interested in sharing application information with Medicaid or SNAP agencies, check the box and sign.

Part 6: Sign the Form.

Part 7: Check the appropriate box to indicate your racial and ethnic identities.

SCHOOL USE ONLY

Initial Determination: ELIGIBLE (Free or Reduced) INELIGIBLE (Denied, N/A or ?)

CONFIRMATION *(Only for those applications selected for verification)*

Signature of Confirming Official (Required) _____ Date _____

RETAIN IN FBF FOLDER FOR 4 YEARS