State of Illinois
Illinois Department of Public Health

Eye Examination Waiver Form

Please print:

Student Name _____ Birth Date _____
(Last) (First) (Middle Initial) (Month/Day/Year)

School Name _____ Grade Level _____ Gender: ❑ Male ❑ Female

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

Phone _____
(Area Code)

Parent or Guardian _____
(Last) (First)

Address of Parent or Guardian _____
(Number) (Street) (City) (ZIP Code)

I am unable to obtain the required vision examination because:

❑ My child is enrolled in medical assistance/ALL KIDS, but we are unable to find a medical doctor who performs eye examinations or an optometrist in the community who is able to examine my child and accepts medical assistance/ ALL KIDS.

❑ My child does not have any type of medical or vision/eye care coverage, my child does not qualify for medical assistance/ ALL KIDS, there are no low-cost vision/eye clinics in our community that will see my child, and I have exhausted all other means and do not have sufficient income to provide my child with an eye examination.

❑ Other undue burden or a lack of access to an optometrist or to a physician who provides eye examinations:

_____

_____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois

IOCI 13-378

State of Illinois
Illinois Department of Public Health

DENTAL EXAMINATION WAIVER FORM

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

I am unable to obtain the required dental examination because:

☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid / All Kids).

☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid / All Kids.

☐ My child is enrolled Medicaid / All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid / All Kids.

☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Parent or Guardian Signature _____ Date:_____

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

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Revised 07/2021

Decatur Memorial Hospital

HEALTH HISTORY

Dear Parent/Guardian: *Please complete the information below for your child's health record. This information is strictly confidential and allows the nursing staff to ensure the health safety of your child. If an emergency does arise and your child needs to be sent to the hospital, a copy of this form may accompany them. It is important that the information is complete and up-to-date. Thank you for filling out this form. Please return the completed form to the school nurse.*

Student's Name: _____ Grade/Teacher: _____ Birth Date: _____

Please indicate if your child has had or now has any of the following:	YES	NO
Chicken Pox	☐	☐
TB Explosure	☐	☐
Diabetes	☐	☐
Asthma	☐	☐
name of inhaler: _____		
Blood Disorder	☐	☐
Serious Injury	☐	☐
describe: _____		
Birth Defect	☐	☐
describe: _____		
Allergies	☐	☐
food: _____ medications: _____ bee sting: _____		
History of head injury	☐	☐
Eye/Vision Defect	☐	☐
Ear/Hearing Defect	☐	☐
Heart Defect	☐	☐
Seizures	☐	☐
Bone/Joint Disorder	☐	☐
Developmental Delay	☐	☐
Hospitalization	☐	☐
describe: _____		
Surgery	☐	☐
describe: _____		
Medications	☐	☐
list current medications and dosage: _____		

From the "yes" answers above, please describe in detail: _____

_____

List other health concerns not listed above: _____

_____

Emergency Contact: _____ Phone: _____

Physician's Name: _____ Phone: _____

Hospital Preference: _____

I, _____, give permission for the school nurse to treat my child if/when an emergency arises and to provide the necessary information to school personnel and emergency personnel.

_____

Parent/Guardian Signature Phone Number Date