RAUNER COLLEGE PREP

(Español al reverso)

Emergency Contact Form 2016-2017

1337 W. Ohio St.
Chicago, IL 60642

p: 312.226.5345
f: 312.226.3552

Class of: ☐ 2017 ☐ 2018 ☐ 2019 ☐ 2020

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

STUDENT'S NAME:	*FIRST* *LAST* *MIDDLE*	
DATE OF BIRTH	*MONTH* / *DAY* / *YEAR*	**GENDER:** ☐ MALE ☐ FEMALE
HOME ADDRESS:	**Please include Apt, Unit or Floor*	*CITY* *STATE* *ZIPCODE*
HOME PHONE NUMBER:	(__ ___)____-_____	**Note: Student must reside with his/her legal guardian in the city of Chicago in order to enroll at a Noble campus; proof of residency will be requested.*

PRIMARY GUARDIAN: (This will be the first point of contact.)	*FIRST* *LAST*	
WORK PHONE: (__ ___)____-_____	**CELL PHONE:** (__ ___)____-_____	**PREFERED LANGUAGE FOR CONTACT** ☐ SPANISH ENGLISH
EMAIL:		
SECONDARY GUARDIAN: (this person will be contacted when primary guardian is not reachable)	*FIRST* *LAST*	
WORK PHONE: (__ ___)____-_____	**CELL PHONE:** (__ ___)____-_____	**PREFERED LANGUAGE FOR CONTACT** ☐ SPANISH ENGLISH
EMAIL:		

LEGAL GUARDIANSHIP: ***Below***

The student's legal guardian is:	Relationship to student:
The student lives with:	Relationship to student:

The following person(s) **MAY NOT** pick up the student (In the case of a parent, legal documentation is required):

EMERGENCY CONTACTS (other than guardians):

The persons listed below are authorized to pick up the student in case of an emergency and in the absence of a guardian.
Note: All students must be picked up by an adult, age 21 years or older.

1. NAME: [illegible]	*LAST*	**RELATIONSHIP TO STUDENT**
PHONE #1: (__ ___)____-_____	**PHONE # 2:** (__ ___)____-_____	**Over 21?** ☐ YES
2. NAME: *FIRST*	*LAST*	**RELATIONSHIP TO STUDENT**
PHONE #1: (__ ___)____-_____	**PHONE # 2:** (__ ___)____-_____	**Over 21?** ☐ YES

I certify that the information on this form is correct:

Parent/ Guardian Signature: ________________ ***Date:*** __________

(*OPTIONAL*) HOMELESS EDUCATION PROGRAM (STLS) POLICY: ***Confidential Information***

Complete this box only if it reflects (1) your child's current living situation; or (2) your living situation if you are a youth not living with a parent or guardian.

Check one box if you are living:

- ☐ Awaiting foster care placement
- ☐ In a car/park/other public place
- ☐ In a hotel/motel
- ☐ In a shelter
- ☐ Doubled-up
- ☐ In transitional housing

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Medical Form
2016-2017

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In order to ensure the safety of your child during the school day, extracurricular activities, on any field trip, and other school sponsored events, we are asking you to please complete this section. For confidentiality purposes, this information will only be shared with relevant staff. Thank you for your cooperation in this important matter.

MEDICAL OR ALLERGY CONDITIONS:

If your child is **currently receiving** treatment for any of the conditions listed below, please indicate this with a check (✓).

☐ My child has NO allergies, medical conditions and/or does not take any medications during school hours. (Skip to next section.)

☐ Asthma ☐ Seizures ☐ Diabetes (circle type): Type 1 Type 2

☐ Food Allergies and reactions/severity: ____________________

☐ Non-Food Allergies and reactions: (type) ____________________

☐ Other Medical Condition: ____________________

Note: If you made a selection above, we will need further information so our clinicians and teachers can provide your child with any necessary accommodations. Please check (✓) one of the options below:

☐ I have read the above and have attached information to this form for the school to use for a 504 plan (school accommodations) or an emergency action plan for my child due to his/her medical or allergy conditions.

☐ I have read the above, and I **DO NOT** feel that the school needs to implement any accommodations or write an emergency action plan for my child's allergy or medical condition.

______ ______
INITIAL **DATE**

MEDICATION POLICY:

- If a student requires medication during school hours, the monitoring of the medications will be supervised by the Office Manager or School Nurse. Students are not allowed to have medication in their possession or in their locker (except for asthma inhaler or epi pen). In order to monitor any student's self administration of prescribed medication **(including asthma inhalers)**, we must have a Physician Request for Self-Administration form on file (form available in Main Office). For over the counter medication, we must have a Parent-Self-Administration form on file (form available in Main Office).
- Students are responsible for coming to the main office to take their medications at the appropriate time.
  Please see the school office for Medication Administration forms.

______ ______
INITIAL **DATE**

EMERGENCY FIRST AID:

In the event of an emergency, I hereby give permission to any campus of Noble Street Charter High School to perform emergency first aid or any other medical procedure immediately necessary. Furthermore, I give permission for the school to make a plan for my child to be taken to an emergency room in the event of an emergency. The school will attempt to contact the guardian(s) first. It is the guardian(s) responsibility to ensure that the school always has a current phone number.

I have read the above information and accept responsibility for following the school's policies regarding notification of: address/phone changes, emergency contact, medical conditions, and medication policy.

______ ______
INITIAL **DATE**

I certify that the information on this form is correct:

Parent/Guardian Signature: ____________________ Date: __________

Print Parent/Guardian's Name: ____________________

Student's Name: ____________________

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PHOTO RELEASE

Pictures of Unnamed Students

Students may occasionally appear in photographs and video recordings taken by school staff members, other students, or other individuals authorized by the building principal, and the school may use these pictures, without identifying the student, in various publications, including school yearbooks, school newspapers, and the school website. If such sound, still, or moving images do not identify a student individually, no consent or notice for such a release is needed or will be given.

Pictures of Named Students

Sometimes the school also may want to identify a student in a school picture. For example, the school may wish to acknowledge students who participate in a school activity or deserve special recognition, including in a news release or a school sponsored material, publication, video recording or website. By signing below, I give permission to record my child's name, image, voice, statements and /or writing to The Noble Network of Charter Schools (NNCS). I further irrevocably grant to NNCS, its advertisers, agents, successors and partners, unrestricted rights to use the above mentioned sound, still, or moving images in any medium for educational, promotional, advertising, or other purposes without limitation consistent with the mission of the school. I agree that all rights to the sound, still, or moving images belong to NNCS. By signing below, I voluntarily waive the right to inspect or approve such images. I understand that this release constitutes a waiver of my privacy rights under The Federal Educational Rights and Privacy Act and the Illinois School Student Records Act. This consent is effective on the date written below and will remain in effect indefinitely.

Pictures Taken By Non-School Agencies

While the school limits access to school buildings by outside photographers, it has no control over outside parties that may publish a picture of a named or unnamed student.

Student's Name: ____
Please Print

Parent/Guardian's Name: ____
Please Print

Parent/Guardian's Signature: _____________________________________

Date: ____

CPS

ENGLISH

Race and Ethnicity Survey

Student's Name:
Gender:
Birth Date:

School Name:
School ID:

INSTRUCTIONS: Please answer the questions below. Both questions must be answered. Part A asks about the student's ethnicity and Part B asks about the student's race. If you decline to respond to either question, the school district is required to provide the missing information by observer identification.

Part A. Is this student Hispanic/Latino? (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.) Choose only one.

☐ No, not Hispanic/Latino

☐ Yes, Hispanic/Latino

The question above is about ethnicity, not race. No matter which answer you selected, continue and respond to the question below by marking one or more boxes to indicate what you consider this student's race to be.

Part B. What is the student's race? Choose one or more.

☐ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)

☐ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)

☐ **Black or African American** (A person having origins in any of the black racial groups of Africa.)

☐ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)

☐ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian Telephone # Home Work			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	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 Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)				COMMENTS:		
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

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**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying 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** **Date**

3. Laboratory confirmation (check one) ☐Measles ☐Mumps ☐Rubella ☐Hepatitis B ☐Varicella
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																			Code:
Age/ Grade																			P = Pass F = Fail
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	U = Unable to test R = Referred
Vision																			G/C =
Hearing																			Glasses/Contacts

Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

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

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)		
Diagnosis of asthma? Child wakes during night coughing?	Yes No Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?	Yes No	
Diabetes?	Yes No		Serious injury or illness?	Yes No	
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or present)?	Yes* No	
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequency)?	Yes No	
Heart murmur/High blood pressure?	Yes No		Alcohol/Drug use?	Yes No	
Dizziness or chest pain with exercise?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ • Bridge ☐ • Plate Other		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature Date		
Bone/Joint problem/injury/scoliosis?	Yes No				

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

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

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** (Blood test required if resides in Chicago.)

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. **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		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes		Amblyopia Yes☐ No☐	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 Antagonist) ☐ 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 (for one year)** **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)