Please complete all forms and return to the Our Saviour School Office as soon as possible.

All new students, please send a copy of the certified copy of your child's birth certificate.

This is important information to complete the registration process.

Thank you!

Our Saviour School Office

Our Saviour School
Verification of School Information-2025-2026

Please Print**Family Information** (Please complete all boxes)

Family Name & Address	**Father's Name:** **Cell:** **email:** **Address- if Different:**	**Religion:**
	Mother's Name: **Maiden Name:** **Cell:** **email:** **Address- if Different:**	**Religion:**

Please √ all that apply:

___ Parents are married **___ Mother deceased**

___ Parents are separated **___ Father deceased**

___ Parents divorced

Student resides with:

___ Mother **___ Father**

___ Step-Mother **___ Step-Father**

___ Guardian **___ Other:**

In instances of divorce, statement about child custody must be on file in the school office.

Father's Employer: **Address:** **Phone:**	**Mother's Employer:** **Address:** **Phone:**	**Emergency Contact when parents can not be reached** **Name:** **Relationship:** **Phone:**

Guardian if other than parent: (In instances of Guardianship -copy of legal papers required)
Name:

Address:
Relationship:

Full Name of Student	**Grade**	**Soc. Sec. No.**	**Birthdate**	**Birthplace**	***ISP/ IEP? Y/N**	**Catholic/ Non-Catholic**

***ISP/IEP = Educational Service Plan, including speech**

Please turn over to complete more information

School Messenger (Phone Numbers to call to receive important messages from the school)
Please list 3 numbers:

1. _____ 2. _____

3. _____

For Catholic Families only
Baptism Information:

Child's Name _____ **Baptismal Date** _____
Church _____

Child's Name _____ **Baptismal Date** _____
Church _____

Child's Name _____ **Baptismal Date** _____
Church _____

Child's Name _____ **Baptismal Date** _____
Church _____

School physical complete with immunizations required for PreK, Kindergarten and 6th grade

Dental form required for Kindergarten, 2nd and 6th Grades

Eye Exam required for Kindergarten,

Certified copy of Birth Certificate

Baptismal Certificate

Home Language Survey

The state requires the district to collect a Home Language Survey for each student. This information is used to count the students whose families speak a language other than English at home. It also helps to identify the students who need to be assessed for English language proficiency.

Please answer the questions below and return this survey to your child's school.

Student's Name: _____

1. Is a language other than English spoken in your home?

   Yes _____ No _____

   What language? _____

2. Does your child speak a language other than English?

   Yes _____ No _____

   What language? _____

3. The following information is used for State forms that must be filled out annually. Please mark the correct designation for your child to help assure that our information is accurate.

Race/Ethnic Designation:

Native American/Native Alaskan _____
Asian _____
Black/African American _____
Native Hawiian/Pacific Islander _____
Middle Eastern/North African
Hispanic or Latino _____
White _____
Two or more Races _____
Unknown _____

Parent/Legal Guardian Signature

Date

Rev. 2/28/25

It has been brought to our attention that many students' various allergies have not been listed on their physical forms. This has caused us some concern. Therefore, the need to ask for this information. Please provide a list of all known allergies that your child(ren) have.

Student Name	Food allergy (list food)	Other Allergy (grass, mold, latex etc.)	No known allergies

Our Saviour School must follow Illinois law requirements for:

A. Health Examination Requirements

All children must receive health examinations before

- entering kindergarten
- entering grade 6, or
- into any grade if the student has not been previously examined

B. Immunization Requirements

- All children in PreK-grade 8 must provide proof of immunization against polio, measles, mumps, rubella, and Varicella/Chickenpox.
- All children in PreK and grades 6-8 must provide proof of immunization against hepatitis B.
- All children in PreK must provide proof of immunization against Hib.
- All children in grades PreK-8 must provide proof of immunization against DTP/DTaP/Td .
- All children in grades 6-8 must provide proof of immunization against Tdap.
- All children in PreK must provide proof of immunization against Pneumococcal.
- All children in grade 6 or grade 7 must provide proof of immunization against Meningococcal.

C. Eye Examination Requirements

- All children entering kindergarten are required to have an eye examination.
- Children entering grades 1-8 in an Illinois school for the first time are required to have an eye examination.

D. Dental Examination Requirements

- All children in kindergarten and grades 2 and 6 are required to have a dental examination.

State of Illinois
Certificate of Child Health Examination

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

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				Comments:		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

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 (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola) MO DA YR** ****MUMPS MO DA YR** **HEPATITIS B MO DA YR** **VARICELLA MO DA YR**

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

Date of Disease **Signature** **Title**

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

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

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

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

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)	Yes / No	List:		**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	List:	
Diagnosis of asthma?	Yes / No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes / No		
Child wakes during night coughing?	Yes / No						
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. (Blood test required if resides in Chicago or high risk zip code.)

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

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

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

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		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		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		
NEEDS/MODIFICATIONS required in the school setting			**DIETARY** Needs/Restrictions		

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

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

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

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

Yes ☐ **No** ☐ If yes, please describe.

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

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

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

Address **Phone**

State of Illinois
Illinois Department of Public Health

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

Parent or Guardian _____
(Last) (First)

Phone _____
(Area Code)

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

County _____

To Be Completed By Examining Doctor

Case History

Date of exam _____

Ocular history: ❑ Normal or Positive for _____

Medical history: ❑ Normal or Positive for _____

Drug allergies: ❑ NKDA or Allergic to _____

Other information _____

Examination

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

Was refraction performed with dilation? ❑ Yes ❑ No

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

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

Diagnosis

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

Other _____

Continued on back

State of Illinois
Illinois Department of Public Health

State of Illinois
Eye Examination Report

Recommendations

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

2. Preferential seating recommended: ❑ No ❑ Yes
   Comments

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

4. _____

5. _____

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

License Number _____

Address

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)

Phone _____

Signature _____ Date _____

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

Printed by Authority of the State of Illinois

IOCI 15-391

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, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

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

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

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

Student's Race/Ethnicity:

☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ Asian
☐ Native American ☐ Native Hawaiian/Pacific Islander ☐ Multi-racial ☐ Unknown
☐ Other_____

To be completed by dentist:

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

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

Oral Health Status (check all that apply)

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

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

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

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

Additional comments: _____

Signature of Dentist _____ License #:_____ Date:_____

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

IOCI 0600-10 Printed by Authority of the State of Illinois

Grades 1 - 8 only

Transfer of Records Request

FROM: School Name _____

Street Address _____

City/State/Zip _____

To: Our Saviour School
455 East State Street
Jacksonville, IL 62650
217-243-8621
Fax: 217- 408- 7636

Student(s) Name:

_____ Grade _____ D/O/B_____

_____ Grade _____ D/O/B _____

_____ Grade _____ D/O/B _____

We request your school to forward student cumulative records, copy of birth certificate, health and immunization history, academic test scores, social/psychological referrals and evaluations, current IEP's, and reports of special services the student(s) has received or been enrolled in, the ISBE student transfer form, or any other information deemed helpful in the proper placement of this student(s).

Should any of these records be stored in a separate building other than the building receiving this request, PLEASE FORWARD this release of information to that building. The Illinois Student School Records Act and the School Code (ch 122.par 50-8.1B) requires that a request for student records shall be honored within 15 days after the request is received. Thank you for your assistance in helping us place this student appropriately.

RELEASE OF RECORDS AUTHORIZATION

Today's Date: _____

I hereby authorize _____ to release all school records including all Special Education information, reports for any special services the student(s) has received or been enrolled in as well as school health/immunization records.

Parent(s)/Guardian(s) Signature _____

Address: _____

City/State/Zip code: _____

Our Saviour Catholic Church

453 E. State • Jacksonville, Illinois 62650 • (217)245-6184
office@ospchurch.com www.oursaviourparish.org

Please complete this form and return it as soon as possible.

Parent Name: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Please check one option below:

_____ My family is practicing Catholic. I understand that our family's Mass attendance needs to be 51% or more at weekend Masses to qualify for the parish scholarship. I will turn in the Mass attendance sheets to the priest to track our attendance.

Member of what parish? _____

_____ My family is not Catholic and is interested in learning about becoming Catholic.

_____ My family is practicing another faith or non-practicing.

Please indicate (with an "X") whether each family member is Catholic "C" or practicing Other Faiths "O/F":

	First & Last Name	C	If Catholic, Approximate Date/Place of Baptism	O/F
Father/Guardian				
Mother/Guardian				
OSS Students				

****Please submit a baptism certificate if your student(s) was not baptized at Our Saviour Parish.**