LAKE FOREST ACADEMY

SUMMER PROGRAM FORMS

PLEASE COMPLETE THESE FORMS AND MAIL THEM TO THE SUMMER SESSION OFFICE BEFORE JULY 1, 2019

These forms must be completed and received at Lake Forest Academy before July 1, 2019. These forms can also be found at http://www.lfanet.org/esl

- ☐ General Permission
- ☐ School Guardian in the United States
- ☐ Medical Emergency Authorization (MEA)
- ☐ Student Medical Insurance – complete only if the student has his/her own medical insurance
- ☐ Immunization Checklist
- ☐ Additional Health Information
- ☐ DHS, State of Illinois, Certificate of Child Health Examination, Final page
  - ☐ Page One: Immunizations
  - ☐ Page Two: Health history and **physical exam**

For questions, please contact:

Paul Dunlop, Dean of Summer Session
Email: pdunlop@lfanet.org
Phone: 1-847-615-3239
Fax: 1-847-615-4841

PLEASE NOTE: STUDENTS MAY NOT ATTEND CLASSES OR PARTICIPATE IN ACTIVITIES UNTIL COMPLETED FORMS ARE RECORDED IN THE DEAN OF STUDENTS OFFICE.

GENERAL PERMISSION FORM

Name of Student _____
FAMILY NAME GIVEN NAME PREFERRED NAME

I. Campus Store

All transactions in the Campus Store during the Summer Program are cash, or credit card.

II. Student Bank

Boarding students are also permitted to create a student bank account with the Business Office. Once the account has been created, students may withdraw up to $150 per week. Students may take additional money with parents written permission (email)

Amount your child may withdraw per week (maximum $150): $_____ per week.

III. Leaving Campus (for boarding students only)

My child and I have discussed whether or not he/she may ride in a student-driven car.
He/she may _____ may not_____ (please check one) ride in a student-driven car.
(Please be aware that any changes to this permission must be sent in writing to the Dean of Students office and signed by the person who signed this form.)

IV. Information Services

I give Lake Forest Academy permission to include my child's name in press releases to the local newspapers.

_____ Yes _____ No

I give Lake Forest Academy permission to use my child's photograph in official school publications, including on the LFA website.

_____ Yes _____ No

Signature of Parent: _____ Date:_____

Signature of Student: _____ Date:_____

SCHOOL GUARDIAN IN THE UNITED STATES

International families must designate in writing an individual in the United States to act as a guardian ("School Guardian") for their child while the student is attending LFA. The school will regard such designated School Guardians to have the authorization to exercise parental authority over the student in the absence of the legal parent, unless the school is notified otherwise in writing. Such authority will include, but not be limited to, executing permission forms and approving a student's sign-out plans to leave campus. School Guardians will also receive copies of grades, bills, and other correspondence between the school and families.[1]

All international families must designate a School Guardian for their child by identifying the following information, and both a Parent and the designated School Guardian should sign where indicated below.

Parent:

I, _____ [parent], parent of _____ [student],

hereby designate _____ [school guardian] to act as a School Guardian, as described above, for my child for the Summer Program.

The contact information for the School Guardian is:

Name: _____

Address: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

E-mail: _____

Fax: _____

School Guardian:

I, _____ [school guardian], acknowledge and agree that I have been

designated to be the School Guardian, as described above, for _____ [student] for the Summer Program.

Signature of School Guardian: _____ Date: _____

Signature of Parent: _____ Date: _____

Signature of Student: _____ Date: _____

[1] *Please note that whenever the term "guardian" is used in LFA documents or correspondence, including but not limited to the Student Handbook, that term includes designated School Guardians.*

MEDICAL EMERGENCY AUTHORIZATION (MEA)

Student Information

Name of Student: _____ Cell Phone: _____
Date of Birth: _____ Social Security Number: _____
Allergies: _____
Chronic Medical Problems: _____
Current/Routine Medications: _____
Date of Last Diphtheria/Tetanus Immunization: _____

Parent Information

Father	Mother
Name _____	Name _____
Address _____	Address _____
_____	_____
Home Phone _____	Home Phone _____
Work Phone _____	Work Phone _____
Cell Phone _____	Cell Phone _____
Social Security #_____	Social Security # _____

Parent with Legal Custody: _____

Emergency Contacts

Name _____ This person may authorize medical care __ Yes __ No
Home Phone _____ Relationship to the student _____
Work Phone _____ Cell Phone _____

Family Physician

Name _____ Phone _____

Medical Authorization

1. During my child's attendance at Lake Forest Academy, I hereby give Lake Forest Academy permission and consent to make decisions to proceed with any emergency medical or surgical treatment required for my child's health and welfare.
2. Any community hospital or emergency center utilized by my child during his/her attendance at Lake Forest Academy has my permission to release my child's medical record to Lake Forest Academy for continuity of care.
3. We are attaching our insurance information which will be on record at LFA and Lake Forest Hospital. We agree to cover medical costs that are not met by our insurance carrier.
4. Please check **one** (1) of the following:

   _____ I hereby authorize the LFA Student Health Services personnel to administer to my son/daughter prescription medications as recommended by the Academy's licensed physician and non-prescription (over-the-counter) medications. I also allow the dorm staff to give my son/daughter over-the-counter medications (decongestants, analgesics, antihistamines, etc) as needed.

   _____ I do **not** want the school nurse or faculty to administer non-emergency medications to my child. I will allow attending physicians to prescribe and administer medications as needed in emergency situations.
5. Please note any medical conditions or allergies that may affect the dispensing of medication :

   _____

Signature of parent: _____ Date: _____

STUDENT MEDICAL INSURANCE

Medical insurance is included in the tuition for the Summer Program. However, Lake Forest Academy will give a $270 refund to students who can prove that they have their own insurance coverage. This coverage must be with an insurance company with offices and a telephone contact in the United States. All other students will be enrolled automatically through LFA's recognized insurance company, United Healthcare Insurance Company.

Please note: payment for medical bills and other charges not covered through the insurance policy are the responsibility of the student, not the responsibility of Lake Forest Academy. LFA assumes no burden of medical expenses.

1. If your child does not have insurance, an insurance policy will be purchased for him or her automatically.

OR

2. If your child has medical insurance, and the insurance company has offices in the United States, please complete the following to apply for a $270 tuition refund. Please attach a **photocopy of both the front and back of your child's insurance card.**

   [ ] Please do not enroll _____ in an insurance plan.
   Student Name

   In making this selection, I accept full responsibility for all medical costs incurred by my child. My current, active plan is with:

   _____

   Insurance Company Name **Policy Number & Phone Number**

   _____

   Insurance Company Address **City, State & Zip Code**

   I understand that medical insurance for the student identified above is a condition of admission to the Lake Forest Academy Summer Program, and that LFA assumes no burden of any medical expenses.

   _____

   Signature of Parent/Guardian **Date**

DHS FORM AND IMMUNIZATION CHECKLIST

All students must complete the DHS (State of Illinois, Department of Human Services, and Certificate of Child Health Examination) form.

Front side of DHS form:

I ____ Complete personal information on the top two lines
II ____ Immunizations (**ALL** shots from the day you were born until today)
1.____ **TDAP** (Diphtheria, Pertussis, Tetanus) (**TD does NOT meet the requirement!**)
ALL shots from birth must be on your record (**3** or **4** dates required)
Last date must be within 10 years of today
2.____ **Oral Polio**
3 dates required
3.____ **Hepatitis B**
3 dates required
4.____ **Varicella** or **Chicken Pox**
2 dates required (or the date of disease at the bottom of the form)
5.____ **MMR** (Measles, Mumps, Rubella)
2 dates required
III ____ Signature and date by the doctor

Back side of DHS form:

I ____ Health History completed by the parent

II ___ Physical Examination

- S**igned and dated** by your doctor **before** you come to Lake Forest Academy

1.____**Diabetes** screening question

2.____**TB Test**

- *If this test is positive, a chest X-ray is required*

Please note:

1. The DHS form must be filled **completely** before your child arrives at LFA.
2. All dates of all immunizations are required.
3. Bring an additional photocopy of the DHS form with you when you arrive at LFA.
4. Do **not** bring medications from your country. All medications you use at LFA must come from the school nurse. If you take medications daily, you must report this to the school nurse.

ADDITIONAL HEALTH INFORMATION

Please have your physician review and complete this as part of your child's examination.

Students sometimes complain about chronic conditions of which we have no medical record (some examples include migraines, asthma, depression, excessive menstrual cramps, diabetes, an orthopedic condition, Crohn's disease, ADD, etc.). Please use the space below to indicate any medical treatments which are being administered to this student and any prescription drugs which will be taken during the school year.

Name of Student _____

Name of Physician _____

Signature of Physician _____ Date _____

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	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
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)				Comments		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23
Check specific type (PCV7, PPV23)						
Other (Specify hepatitis A, meningococcal, etc.)						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **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 report, if available.)**

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date																								
Age/Grade																								
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																								
Hearing																								

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/ Contacts

Printed by Authority of the State of Illinois
(Complete Both Sides)

IL444-4737 (R-01-05)

Student's Name (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?	Yes	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the 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 _____				Dental ☐Braces ☐Bridge ☐Plate Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Other concerns?			
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					

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS HEIGHT WEIGHT BMI B/P

DIABETES SCREENING 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 Indicated? Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** **mm**

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

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 ☐**

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)