



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

Please Print

Student's Name			Birth Date	Sex	School	Grade Level /ID#
Last	First	Middle	Month/Day/ Year			
Address			Parent/ Guardian	Telephone #		
Street	City	ZIP code		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			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	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)	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> 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															Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/ Contacts
Age/Grade															
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision															
Hearing															

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

Student's Name <small>Last First Middle</small>	Birth Date <small>Month/Day/ Year</small>	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 the night coughing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Birth defects?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Hospitalizations? When? What for?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Developmental delay?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Surgery? (List all) When? What for?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes <input type="checkbox"/> No <input type="checkbox"/>		Serious injury or illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>		TB skin test positive (past/present)?	Yes* <input type="checkbox"/> No <input type="checkbox"/>	*If yes, refer to local health department.
Head injury/Concussion/Passed out?	Yes <input type="checkbox"/> No <input type="checkbox"/>		TB disease (past or present)?	Yes* <input type="checkbox"/> No <input type="checkbox"/>	
Seizures? What are they like?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Tobacco use (type, frequency)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Heart problem/Shortness of breath?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Alcohol/Drug use?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Heart murmur/High blood pressure?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Family history of sudden death before age 50? (Cause?)	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Dizziness or chest pain with exercise?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Eye/Vision problems? Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Other concerns?		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Information may be shared with appropriate personnel for health and educational purposes.		
Ear/Hearing problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>		Parent/Guardian Signature	Date	
Bone/Joint problem/injury/scoliosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>				

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 <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/>	Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>			

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 <input type="checkbox"/>	Comments/Follow-up/Needs	Normal <input type="checkbox"/>	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____ Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optomestrist Yes <input type="checkbox"/> No <input type="checkbox"/>			Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	

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 **PHYSICAL EDUCATION** Yes No Modified **INTERSCHOLASTIC SPORTS** (for one year) Yes No Limited (If No or Modified, please attach explanation.)

Physician/Advanced Practice Nurse/Physician Assistant performing examination _____

Print Name	Signature	Date
Address	Phone	

(Complete both sides)