



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

Please Print

Student's Name Last			First			Middle			Birth Date			Sex			Grade Level			ID#		
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Address Street				City				ZIP code				Parent/Guardian				Telephone # Home				Work			
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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)																			
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			
Check specific type (PCV7, PPV23) Date																			
Other (Specify hepatitis A, meningococcal, etc.)																			

Comments

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

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		Hospitalizations? When? What for?	Yes	No
Birth complications/prematurity?	Yes	No	Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Diabetes?	Serious injury or illness?	Yes	No
Head injury/Concussion/Passed out?	Yes	No	Head injury/Concussion/Passed out?	TB skin test positive (past/present)?	Yes*	No
Seizures? What are they like?	Yes	No	Seizures? What are they like?	TB disease (past or present)?	Yes*	No
Heart problem/Shortness of breath?	Yes	No	Heart problem/Shortness of breath?	Tobacco use (type, frequency)?	Yes	No
Heart murmur/High blood pressure?	Yes	No	Heart murmur/High blood pressure?	Alcohol/Drug use?	Yes	No
Dizziness or chest pain with exercise?	Yes	No	Dizziness or chest pain with exercise?	Family history of sudden death before age 50? (Cause?)	Yes	No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental 9 Braces 9 Bridge 9 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.			
Bone/Joint problem/injury/scoliosis?				Parent/Guardian Signature	Date	

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

PHYSICAL EXAMINATION REQUIREMENTS		HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (Not required for daycare.) 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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (If child resides in Chicago, blood test is required.)						
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. <input type="checkbox"/> No Test Needed <input type="checkbox"/> Test performed Date Read / / Result mm						
LAB TESTS (Recommended)	Date	Results	Date	Results		
Hemoglobin or Hematocrit			Sickle Cell (when indicated)			
Urinalysis			Developmental Screening			
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs	
Skin				Endocrine		
Ears				Gastrointestinal		
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening	Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____	Genito-Urinary	LMP	
Nose		Referred to Ophthalmologist/Optomtrist Yes <input type="checkbox"/> No <input type="checkbox"/>		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 _____ (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)