



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

NOTE PARENTS:
Parents responsible for
Health History on back!

Please Print

Student's Name			Birth Date			Sex	School	Grade Level /ID#				
Last	First	Middle	Month/Day/ Year									
Address Street		City	ZIP code	Parent/ Guardian		Telephone # Home		Work				
IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for <u>every</u> dose administered. The day and month is required if you cannot determine if the vaccine was given <u>after</u> 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
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)												
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	R	L	R		L
Vision																			
Hearing																			

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

HEALTH HISTORY, PARENT SIGNATURE and DIABETES SCREENING REQUIRED

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

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"/> Referred to Ophthalmologist/Optomtrist 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** (If No or Modified, please attach explanation.)
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)