



**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 | | Street | | City | | ZIP code | | Parent/ Guardian | | | Telephone # Home | | Work | | | | | | | | |
| IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for <i>every</i> dose administered. The day and month is required if you cannot determine if the vaccine was given <i>after</i> 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 D'TaP) | | | | | | | | | | | | | | | | | | | | | |
| 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 | | |
| 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) | | | | <input type="checkbox"/> Measles | | | <input type="checkbox"/> Mumps | | | <input type="checkbox"/> Rubella | | | <input type="checkbox"/> Hepatitis B | | | <input type="checkbox"/> 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 | | |
| 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 defects? | Yes | No | | Surgery? (List all.) When? What for? | Yes | No |
| Developmental delay? | Yes | No | | Serious injury or illness? | Yes | No |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes | No | | TB skin test positive (past/present)? | Yes* | No |
| Diabetes? | Yes | No | | TB disease (past or present)? | Yes* | No |
| Head injury/Concussion/Passed out? | Yes | No | | Tobacco use (type, frequency)? | Yes | No |
| Seizures? What are they like? | Yes | No | | Alcohol/Drug use? | 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 | | Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other | | |
| Dizziness or chest pain with exercise? | Yes | No | | Other concerns? | | |
| Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor | | | | Information may be shared with appropriate personnel for health and educational purposes. | | |
| Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) | | | | Parent/Cuardian Signature | Date | |
| Ear/Hearing problems? | Yes | No | | | | |
| 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 * | | | 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 <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)