



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#		Work												
Street		City		ZIP code				Home												
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 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)																				
Check specific type (PCV7, 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		
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
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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
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? Child wakes during the night coughing	Yes	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes	No	
Diabetes?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Head injury/Concussion/Passed out?	Yes	No		TB disease (past or present)?	Yes*	No	
Seizures? What are they like?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart problem/Shortness of breath?	Yes	No		Alcohol/Drug use?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Family history of sudden death before age 50? (Cause?)	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)			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis?	Yes	No		Parent/Guardian Signature	Date		

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 <input type="checkbox"/> No <input type="checkbox"/>		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"/>	Genito-Urinary	LMP
	Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Referred to Ophthalmologist/Optomtrist	Yes <input type="checkbox"/> No <input type="checkbox"/>	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)