



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

Please Print

<b>Student's Name</b> Last First Middle			<b>Birth Date</b>			<b>Sex</b>			<b>Grade Level</b>			<b>ID#</b>								
<b>Address</b> Street City ZIP code						Parent/ Guardian			Telephone # Home			Work								
<b>IMMUNIZATIONS:</b> 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. <b>If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.</b>																				
<b>VACCINE/DOSE</b>			1 MO DA YR			2 MO DA YR			3 MO DA YR			4 MO DA YR			5 MO DA YR			6 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		
Check specific type (PCV7, PPV23)			Date																	
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.**

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b> (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	<b>Title</b>	<b>Date</b>
<b>Signature</b> (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)	<b>Title</b>	<b>Date</b>

**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	
Vision																	
Hearing																	

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

<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
Last	First	Middle	Month/Day/ Year			

**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during the night coughing?	Yes Yes	No No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	No
Birth complications/prematurity?	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
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 9 Braces 9 Bridge 9 Plate Other		
Eye/Vision problems? _____ 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.		
Bone/Joint problem/injury/scoliosis?				<b>Parent/Guardian Signature</b>		<b>Date</b>

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

<b>PHYSICAL EXAMINATION REQUIREMENTS</b>	<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (Not required for daycare.) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>					
<b>LEAD RISK QUESTIONNAIRE</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Blood Test Result</b> _____ (If child resides in Chicago, blood test is required.)					
<b>TB SKIN TEST</b> 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 <b>Date Read</b> / / <b>Result</b> mm					
<b>LAB TESTS (Recommended)</b>	Date	Results	Date	Results	
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening		
<b>SYSTEM REVIEW</b>	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/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		
<b>NEEDS/MODIFICATIONS</b> required in the school setting			<b>DIETARY</b> 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

<b>Print Name</b>	<b>Signature</b>	<b>Date</b>
<b>Address</b>	<b>Phone</b>	

(Complete both sides)