



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 <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 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)																			
Combined Measles, Mumps and Rubella (MMR)																			
Measles (Rubeola)																			
Rubella (3-day measles)																			
Mumps																			
Pneumococcal (not required for school entry)		☐ PCV7 ☐ PPV23			☐ PCV7 ☐ PPV23			☐ PCV7 ☐ PPV23			☐ PCV7 ☐ PPV23			☐ PCV7 ☐ PPV23			☐ PCV7 ☐ 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	
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(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)					
Signature		Title		Date	
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)					

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All <u>measles</u> 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																			

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(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							
Developmental delay?		Yes	No							
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes	No			Surgery? (List all.) When? What for?		Yes	No	
Diabetes?		Yes	No			Serious injury or illness?		Yes	No	
Head injury/Concussion/Passed out?		Yes	No			TB skin test positive (past/present)?		Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?		Yes	No			TB disease (past or present)?		Yes*	No	
Heart problem/Shortness of breath?		Yes	No			Tobacco use (type, frequency)?		Yes	No	
Heart murmur/High blood pressure?		Yes	No			Alcohol/Drug use?		Yes	No	
Dizziness or chest pain with exercise?		Yes	No			Family history of sudden death before age 50? (Cause?)		Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____						Dental ☐ Braces ☐ Bridge ☐ 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?		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 ☐ No ☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes ☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ At Risk Yes ☐ No ☐										
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 ☐ No ☐ Amblyopia Yes ☐ No ☐	Objective screening Yes ☐ No ☐ Referred to Ophthalmologist/Optometrist Yes ☐ No ☐		Result _____		Genito-Urinary		LMP	
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)										