



State of Illinois Certificate of Child Health Examination

Student's Name Last First Middle				Birth Date Month/Day/Year			Sex	Race/Ethnicity		School /Grade Level/ID#								
Address Street City Zip Code				Parent/Guardian			Telephone # Home		Work									
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.																		
REQUIRED Vaccine / Dose	DOSE 1 MO DA YR			DOSE 2 MO DA YR			DOSE 3 MO DA YR			DOSE 4 MO DA YR			DOSE 5 MO DA YR			DOSE 6 MO DA YR		
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps Rubella																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.																		
Signature						Title			Date									
Signature						Title			Date									
ALTERNATIVE PROOF OF IMMUNITY																		
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR																		
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies 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																		
3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/>Measles* <input type="checkbox"/>Mumps** <input type="checkbox"/>Rubella <input type="checkbox"/>Varicella Attach copy of lab result. *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.																		
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____ Physician Statements of Immunity MUST be submitted to IDPH for review.																		

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last _____ First _____ Middle _____			Birth Date ____/____/____ <small>Month/Day/Year</small>		Sex	School	Grade Level/ ID
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER							
ALLERGIES (Food, drug, insect, other) Yes <input type="checkbox"/> No <input type="checkbox"/> List: _____			MEDICATION (Prescribed or taken on a regular basis.) Yes <input type="checkbox"/> No <input type="checkbox"/> List: _____				
Diagnosis of asthma? Yes <input type="checkbox"/> No <input type="checkbox"/>			Loss of function of one of paired organs? (eye/ear/kidney/testicle) Yes <input type="checkbox"/> No <input type="checkbox"/>		Child wakes during night coughing? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Birth defects? Yes <input type="checkbox"/> No <input type="checkbox"/>			Hospitalizations? When? What for? Yes <input type="checkbox"/> No <input type="checkbox"/>		Developmental delay? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Blood disorders? Hemophilia, Sickle Cell, Other? Explain. Yes <input type="checkbox"/> No <input type="checkbox"/>			Surgery? (List all.) When? What for? Yes <input type="checkbox"/> No <input type="checkbox"/>		Diabetes? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Head injury/Concussion/Passed out? Yes <input type="checkbox"/> No <input type="checkbox"/>			Serious injury or illness? Yes <input type="checkbox"/> No <input type="checkbox"/>		Head injury/Concussion/Passed out? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Seizures? What are they like? Yes <input type="checkbox"/> No <input type="checkbox"/>			TB skin test positive (past/present)? Yes* <input type="checkbox"/> No <input type="checkbox"/>		*If yes, refer to local health department.		
Heart problem/Shortness of breath? Yes <input type="checkbox"/> No <input type="checkbox"/>			TB disease (past or present)? Yes* <input type="checkbox"/> No <input type="checkbox"/>		Heart murmur/High blood pressure? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Dizziness or chest pain with exercise? Yes <input type="checkbox"/> No <input type="checkbox"/>			Tobacco use (type, frequency)? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dizziness or chest pain with exercise? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Alcohol/Drug use? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Family history of sudden death before age 50? (Cause?) Yes <input type="checkbox"/> No <input type="checkbox"/>		Ear/Hearing problems? Yes <input type="checkbox"/> No <input type="checkbox"/>		
Bone/Joint problem/injury/scoliosis? Yes <input type="checkbox"/> No <input type="checkbox"/>			Information may be shared with appropriate personnel for health and educational purposes.		Parent/Guardian Signature _____ Date _____		
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI B/P	
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) 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 required if resides in Chicago or high risk zip code.)							
Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/>		Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/>		Blood Test Date		Result	
TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm .							
No test needed <input type="checkbox"/>		Test performed <input type="checkbox"/>		Skin Test: Date Read / /		Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____	
		Blood Test: Date Reported / /		Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		Value _____	
LAB TESTS (Recommended)		Date	Results		Date	Results	
Hemoglobin or Hematocrit			Sickle Cell (when indicated)				
Urinalysis			Developmental Screening Tool				
SYSTEM REVIEW		Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs	
Skin					Endocrine		
Ears			Screening Result:		Gastrointestinal		
Eyes			Screening Result:		Genito-Urinary		LMP
Nose					Neurological		
Throat					Musculoskeletal		
Mouth/Dental					Spinal Exam		
Cardiovascular/HTN					Nutritional status		
Respiratory			<input type="checkbox"/> Diagnosis of Asthma		Mental Health		
Currently Prescribed Asthma Medication:				Other			
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)							
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)							
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>				INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			
Print Name _____		(MD,DO, APN, PA) Signature _____				Date _____	
Address _____				Phone _____			