



**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> Month/Day/ Year		<b>Sex</b>	<b>School</b>	<b>Grade Level /ID#</b>
<b>Address</b> Street                      City                      ZIP code				<b>Parent/ Guardian</b>		<b>Telephone #</b> Home                      Work	

**IMMUNIZATIONS:** To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* 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)	<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)       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	R		L		R		L		R		L		R		L		Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/ Contacts
Age/Grade																	
Vision																	
Hearing																	

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

<b>Student's Name</b> Last First Middle	<b>Birth Date</b> Month/Day/Year	Sex	School	<b>Grade Level/ ID #</b>
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**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 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? _____ 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. Parent/Guardian Signature _____ Date _____		
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)**

<b>PHYSICAL EXAMINATION REQUIREMENTS</b>					<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> 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"/>								
<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. 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.)								
<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. Date Read / / Result mm								
<b>LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES</b>		Date	Results	Date	Results			
Hemoglobin * or Hematocrit *				Sickle Cell * (as indicated)				
Urinalysis				Other				
<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"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optomtrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Result		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			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup								
<b>MENTAL HEALTH/OTHER</b> 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								
<b>EMERGENCY ACTION</b> 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.) <b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>								
Physician/Advanced Practice Nurse/Physician Assistant performing examination								
Print Name			Signature			Date		
Address					Phone			

(Complete both sides)