



## State of Illinois Certificate of Child Health Examination

<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>
Last	First	Middle	Month/Day/Year			
<b>Address</b>			<b>Parent/Guardian</b>		<b>Telephone # Home Work</b>	
Street	City	Zip Code				

**IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every 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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	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		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps, Rubella										<b>Comments:</b> * indicates invalid dose								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																		
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.**

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**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.**

<b>Date of Disease</b>	<b>Signature</b>	<b>Title</b>
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**3. Laboratory Evidence of Immunity (check one)    Measles\*    Mumps\*\*    Rubella    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 Month/Day/ Year	Sex	School	Grade Level/ ID
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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)	Yes No	List:	<b>MEDICATION</b> (Prescribed or taken on a regular basis.)	Yes No	List:
Diagnosis of asthma?	Yes No	Yes No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Child wakes during night coughing?	Yes No		Hospitalizations? When? What for?	Yes No	
Birth defects?	Yes No		Surgery? (List all.) When? What for?	Yes No	
Developmental delay?	Yes No		Serious injury or illness?	Yes No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.
Diabetes?	Yes No		TB disease (past or present)?	Yes* No	
Head injury/Concussion/Passed out?	Yes No		Tobacco use (type, frequency)?	Yes No	
Seizures? What are they like?	Yes No		Alcohol/Drug use?	Yes No	
Heart problem/Shortness of breath?	Yes No		Family history of sudden death before age 50? (Cause?)	Yes No	
Heart murmur/High blood pressure?	Yes No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Dizziness or chest pain with exercise?	Yes No		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)		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	Yes No		<b>Parent/Guardian Signature</b>	<b>Date</b>	

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

<b>HEAD CIRCUMFERENCE</b> if < 2-3 years old	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>BMI PERCENTILE</b>	<b>B/P</b>
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI &gt; 85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>And any two of the following:</b> <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. (Blood test required if resides in Chicago or high risk zip code.)					
<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>Result</b> _____					
<b>TB SKIN OR BLOOD TEST</b> 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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a>					
<b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____					

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: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> Needs/Restrictions
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**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** Yes  No  Modified

Print Name \_\_\_\_\_ (MD,DO, APN, PA) Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_