



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								
Address Street City Zip Code				Parent/Guardian Telephone # Home		Work						
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> 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.</b>												
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>		<b>DOSE 2</b>		<b>DOSE 3</b>		<b>DOSE 4</b>		<b>DOSE 5</b>		<b>DOSE 6</b>	
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
<b>DTP or DTaP</b>												
<b>Tdap; Td or Pediatric DT (Check specific type)</b>	<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	
<b>Polio (Check specific type)</b>	<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	
<b>Hib Haemophilus influenza type b</b>												
<b>Pneumococcal Conjugate</b>												
<b>Hepatitis B</b>												
<b>MMR Measles Mumps Rubella</b>												
<b>Varicella (Chickenpox)</b>												
<b>Meningococcal conjugate (MCV4)</b>												
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>												
<b>Hepatitis A</b>												
<b>HPV</b>												
<b>Influenza</b>												
<b>Other: Specify Immunization Administered/Dates</b>												
<b>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>												
<b>Signature</b>				<b>Title</b>				<b>Date</b>				
<b>Signature</b>				<b>Title</b>				<b>Date</b>				
<b>ALTERNATIVE PROOF OF IMMUNITY</b>												
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b>												
*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR												
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b>												
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>						
<b>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.</b>												
*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.												
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b>												
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
<b>HEALTH HISTORY                      TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes <input type="checkbox"/> No <input type="checkbox"/>	List:		<b>MEDICATION</b> (Prescribed or taken on a regular basis.)		Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosis of asthma?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Child wakes during night coughing?		Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes <input type="checkbox"/> No <input type="checkbox"/>
Birth defects?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Developmental delay?		Hospitalizations? When? What for?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes?		Surgery? (List all.) When? What for?		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?		Serious injury or illness?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart problem/Shortness of breath?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart murmur/High blood pressure?		TB skin test positive (past/present)?		Yes* <input type="checkbox"/> No <input type="checkbox"/>
Dizziness or chest pain with exercise?		Yes <input type="checkbox"/> No <input type="checkbox"/>			TB disease (past or present)?		Yes* <input type="checkbox"/> No <input type="checkbox"/>
Eye/Vision problems?      Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate      Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Bone/Joint problem/injury/scoliosis?		Parent/Guardian Signature		Date
<b>PHYSICAL EXAMINATION REQUIREMENTS                      Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI	B/P
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE)</b> BMI>85% age/sex      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. (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	
<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> .							
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			
<b>LAB TESTS (Recommended)</b>		Date	Results			Date	Results
Hemoglobin or Hematocrit					Sickle Cell (when indicated)		
Urinalysis					Developmental Screening Tool		
<b>SYSTEM REVIEW</b>	Normal <input type="checkbox"/>	Comments/Follow-up/Needs			Normal <input type="checkbox"/>	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			
<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> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			
Print Name		(MD,DO, APN, PA)		Signature		Date	
Address		Phone					