



State of Illinois Certificate of Child Health Examination

Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#												
Last	First	Middle	Month/Day/Year															
Address			Parent/Guardian			Telephone # Home												
Street	City	Zip Code			Work													
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																Comments: * indicates invalid dose		
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 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

ALLERGIES (Food, drug, insect, other)	Yes	No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes	No	List:
Diagnosis of asthma?			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
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	Information may be shared with appropriate personnel for health and educational purposes.			
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)				Parent/Guardian Signature _____ Date _____			
Ear/Hearing problems?			Yes No				
Bone/Joint problem/injury/scoliosis?			Yes No				

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

HEAD CIRCUMFERENCE if <2-3 years old	HEIGHT	WEIGHT	BMI	BMI PERCENTILE	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: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)			Other	

NEEDS/MODIFICATIONS required in the school setting	DIETARY 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** _____