



## 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				Parent/Guardian		Telephone # Home						
Street				City		Zip Code						
Work				Work		Work						
<b>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.</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>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Tdap; Td or Pediatric DT (Check specific type)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Polio (Check specific type)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IPV	OPV		IPV	OPV		IPV	OPV		IPV	OPV	
<b>Hib Haemophilus influenza type b</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pneumococcal Conjugate</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hepatitis B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MMR Measles Mumps. Rubella</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Varicella (Chickenpox)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Meningococcal conjugate (MCV4)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>												
<b>Hepatitis A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HPV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Influenza</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other: Specify Immunization Administered/Dates</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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> <b>*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR</b>												
<b>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> <b>Date of Disease Signature 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> <b>*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.</b> <b>**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.</b>												
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b> <b>Physician Statements of Immunity MUST be submitted to IDPH for review.</b>												

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

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.
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**HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD**

ALERGIAS (Alimentos, drogas, insectos, otro)	Sí No	Anótelas todas:	MEDICINAS (Anoté todas las recetadas o tomadas con regularidad)	Sí No	
¿Tiene diagnóstico de asma?	Sí No	¿Despierta el niño tosiendo en la noche?	¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí No	
¿Tiene defectos de nacimiento?	Sí No	¿Tiene retrasos del desarrollo?	¿Ha sido hospitalizado?	Sí No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí No	¿Tiene diabetes?	¿Cuándo? ¿Para qué?	Sí No	
¿Tiene heridas en la cabeza/golpe/desmayo?	Sí No	¿Tiene convulsiones? Cómo se manifiestan?	¿Ha tenido alguna cirugía?(anótelas todas)	Sí No	
¿Tiene problemas cardíacos/No respira bien?	Sí No	¿Tiene problemas de los ojos/visión? Lentes <input type="checkbox"/> Lentes de Contacto <input type="checkbox"/> Último examen <input type="checkbox"/>	¿Cuándo? ¿Para qué?	Sí No	
¿Tiene soplo en el corazón/presión arterial alta?	Sí No	¿Tiene problemas de los oídos/no oye bien?	¿Ha tenido heridas graves o enfermedades?	Sí No	
¿Tiene marcos o dolor de pecho al hacer ejercicios?	Sí No	¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	¿Prueba positiva de TB (Pasado o Presente)?	Sí No	*Si contestó sí, refiera al departamento de salud local
¿Problemas con los ojos/visión? Lentes <input type="checkbox"/> Lentes de Contacto <input type="checkbox"/> Último examen <input type="checkbox"/>		¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)	¿Enfermedad de TB (Pasado o Presente)?	Sí No	
¿Tiene problemas de los oídos/no oye bien?	Sí No	¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	¿Usa tabaco (tipo, frecuencia)?	Sí No	
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	Sí No		¿Toma alcohol/drogas?	Sí No	
			¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	Sí No	
			Dental <input type="checkbox"/> Ganchos <input type="checkbox"/> Puente <input type="checkbox"/> Placas <input type="checkbox"/> Otro		
			La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
			Firma del Padre/Tutor		Fecha

**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  No  And any two of the following: Family History Yes  No   
 Ethnic Minority Yes  No  Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes  No  At Risk Yes  No

**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  No  Blood Test Indicated? Yes  No  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](http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm).

No test needed  Test performed  Skin Test: Date Read / / Result: Positive  Negative  mm \_\_\_\_\_  
 Blood Test: Date Reported / / Result: Positive  Negative  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

**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