



State of Illinois Certificate of Child Health Examination

Student's Name Last First Middle			Birth Date Month/Day/Year		Sex	Race/Ethnicity	School /Grade Level/ID#					
Address Street City Zip Code			Parent/Guardian		Telephone # Home		Work					
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> 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 MO DA YR		DOSE 2 MO DA YR		DOSE 3 MO DA YR		DOSE 4 MO DA YR		DOSE 5 MO DA YR		DOSE 6 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		
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	*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				Information may be shared with appropriate personnel for health and educational purposes										
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____									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:								Other										
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																		
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																		
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <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.)																		
PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>																		
Print Name _____								(MD,DO, APN, PA) Signature _____				Date _____						
Address _____												Phone _____						