



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	Work	
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																		
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Comments:

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

- 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
- 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 _____
- 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 _____ <small>Month Day Year</small>	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 <small>(Food, drug, insect, other)</small>	Yes	No	List:	MEDICATION <small>(Prescribed or taken on a regular basis.)</small>	Yes	No	List:
Diagnosis of asthma? Child wakes during night coughing?	Yes	No		Loss of function of one of paired organs? <small>(eye/ear/kidney/testicle)</small>	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No		Surgery? <small>(List all)</small> When? What for?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Serious injury or illness?	Yes	No	
Diabetes?	Yes	No		TB skin test positive <small>(past/present)</small> ?	Yes*	No	*If yes, refer to local health department.
Head injury/Concussion/Passed out?	Yes	No		TB disease <small>(past or present)</small> ?	Yes*	No	
Seizures? What are they like?	Yes	No		Tobacco use <small>(type, frequency)</small> ?	Yes	No	
Heart problem/Shortness of breath?	Yes	No		Alcohol/Drug use?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Family history of sudden death before age 50? <small>(Cause?)</small>	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____			
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? <small>(crossed eye, drooping lids, squinting, difficulty reading)</small>				Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?	Yes	No		Parent/Guardian Signature _____ Date _____			
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 _____	B/P _____
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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

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

LAB TESTS <small>(Recommended)</small>	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell <small>(when indicated)</small>
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:
 Quick-relief medication (e.g. Short Acting Beta Agonist)
 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 _____