



State of Illinois  
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES  
CFS 600  
Rev 2/2013



Student's Name			Birth Date		Sex	Race/Ethnicity	School /Grade Level/ID#					
Last First Middle			Month/Day/Year									
Address Street City Zip Code			Parent/Guardian		Telephone # Home		Work					
<b>IMMUNIZATIONS:</b> To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given after the minimum interval or age. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.												
Vaccine / Dose	1 MO DA YR		2 MO DA YR		3 MO DA YR		4 MO DA YR		5 MO DA YR		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												
Hepatitis B (HB)												
Varicella (Chickenpox)												
MMR Combined Measles Mumps Rubella												
Single Antigen Vaccines	Measles		Rubella		Mumps							
Pneumococcal Conjugate												
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza												
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				
<b>ALTERNATIVE PROOF OF IMMUNITY</b>												
1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)												
*MEASLES (Rubella) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature												
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below is verifying 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				Date
3. Laboratory confirmation (check one)				<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Varicella								
Lab Results				Date MO DA YR				(Attach copy of lab result)				

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN												
Date												
Age/Grade												
	R	L	R	L	R	L	R	L	R	L	R	L
Vision												
Hearing												
Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contact												

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)									<b>MEDICATION</b> (List all prescribed or taken on a regular basis)								
Diagnosis of asthma? Yes <input type="checkbox"/> No <input type="checkbox"/>									Loss of function of one of paired organs? (eye/ear/kidney/testicle) Yes <input type="checkbox"/> No <input type="checkbox"/>								
Child wakes during night coughing? Yes <input type="checkbox"/> No <input type="checkbox"/>									Hospitalizations? When? What for? Yes <input type="checkbox"/> No <input type="checkbox"/>								
Birth defects? Yes <input type="checkbox"/> No <input type="checkbox"/>									Surgery? (List all.) When? What for? Yes <input type="checkbox"/> No <input type="checkbox"/>								
Developmental delay? Yes <input type="checkbox"/> No <input type="checkbox"/>									Serious injury or illness? Yes <input type="checkbox"/> No <input type="checkbox"/>								
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.									TB skin test positive (past/present)? Yes* <input type="checkbox"/> No <input type="checkbox"/> *If yes, refer to local health department.								
Diabetes? Yes <input type="checkbox"/> No <input type="checkbox"/>									TB disease (past or present)? Yes* <input type="checkbox"/> No <input type="checkbox"/>								
Head injury/Concussion/Passed out? Yes <input type="checkbox"/> No <input type="checkbox"/>									Tobacco use (type, frequency)? Yes <input type="checkbox"/> No <input type="checkbox"/>								
Seizures? What are they like? Yes <input type="checkbox"/> No <input type="checkbox"/>									Alcohol/Drug use? Yes <input type="checkbox"/> No <input type="checkbox"/>								
Heart problems/Shortness of breath? Yes <input type="checkbox"/> No <input type="checkbox"/>									Family history of sudden death before age 50? (Cause?) Yes <input type="checkbox"/> No <input type="checkbox"/>								
Heart murmur/High blood pressure? Yes <input type="checkbox"/> No <input type="checkbox"/>									Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other								
Dizziness or chest pain with exercise? Yes <input type="checkbox"/> No <input type="checkbox"/>									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 _____									<b>Parent/Guardian Signature</b>								
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)									<b>Date</b>								
Ear/Hearing problems? Yes <input type="checkbox"/> No <input type="checkbox"/>																	
Bone/Joint problem/injury/scoliosis? Yes <input type="checkbox"/> No <input type="checkbox"/>																	
<b>PHYSICAL EXAMINATION REQUIREMENTS</b> 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 <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 (hypercholesterolemia, 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, nurseries, 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. 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		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		Normal		Comments/Follow-up/Needs					
Skin						Endocrine											
Ears						Gastrointestinal											
Eyes				Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>		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)																	
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 table: <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"/> Limited <input type="checkbox"/>																	
Print Name				(MD, DO, APN, PA) Signature				Date									
Address				Phone													

(Complete Both Sides)





## PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
				/ /
Address:	Street	City	ZIP Code	Telephone:
Name of School:			Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:			Address (of parent/guardian):	

To be completed by dentist:

### Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1<sup>st</sup> molars.

☐ Yes ☐ No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

### Treatment Needs (check all that apply)

☐ **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date of Exam \_\_\_\_\_

Address \_\_\_\_\_  
Street City ZIP Code

Telephone \_\_\_\_\_



## DENTAL EXAMINATION WAIVER FORM

Please print:

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
				/ /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender:	
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Address (of parent/guardian):			

I am unable to obtain the required dental examination because:

- ☐ My child is enrolled in the free and reduced lunch program and is not covered by private or public dental insurance (Medicaid/All Kids).
- ☐ My child is enrolled in the free and reduced lunch program and is ineligible for public insurance (Medicaid/All Kids).
- ☐ My child is enrolled in Medicaid/All Kids, but we are unable to find a dentist or dental clinic in our community that is able to see my child and will accept Medicaid/All Kids.
- ☐ My child does not have any type of dental insurance, and there are no low-cost dental clinics in our community that will see my child.

Signature \_\_\_\_\_

Date \_\_\_\_\_



## State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name \_\_\_\_\_  
(Last) (First) (Middle Initial)  
Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
(Month/Day/Year)  
Parent or Guardian \_\_\_\_\_  
(Last) (First)  
Phone \_\_\_\_\_  
(Area Code)  
Address \_\_\_\_\_  
(Number) (Street) (City) (ZIP Code)  
County \_\_\_\_\_

### To Be Completed By Examining Doctor

#### Case History

Date of exam \_\_\_\_\_  
Ocular history: ☐ Normal or Positive for \_\_\_\_\_  
Medical history: ☐ Normal or Positive for \_\_\_\_\_  
Drug allergies: ☐ NKDA or Allergic to \_\_\_\_\_  
Other information \_\_\_\_\_

#### Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

#### Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other \_\_\_\_\_



## State of Illinois Eye Examination Report

### Recommendations

1. Corrective lenses: ☐ No ☐ Yes, glasses or contacts should be worn for:  
☐ Constant wear ☐ Near vision ☐ Far vision  
☐ May be removed for physical education

2. Preferential seating recommended: ☐ No ☐ Yes

Comments \_\_\_\_\_

3. Recommend re-examination: ☐ 3 months ☐ 6 months ☐ 12 months

☐ Other \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Print name \_\_\_\_\_

Optometrist or physician (such as an ophthalmologist)  
who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

### Consent of Parent or Guardian

I agree to release the above information on my child  
or ward to appropriate school or health authorities.

\_\_\_\_\_  
(Parent or Guardian's Signature)

\_\_\_\_\_  
(Date)

(Source: Amended at 32 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)