



STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name	Last	First	Middle	Birth Date	Sex	Grade Level	ID#
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Address	Street	City	ZIP code	Parent/Guardian	Telephone #	Home	Work
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IMMUNIZATIONS: 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	MO	1	DA	YR	MO	2	DA	YR	MO	3	DA	YR	MO	4	DA	YR	MO	5	DA	YR	MO	6	DA	YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																								
Diphtheria and Tetanus (Pediatric DT or Td)																								
Inactivated Polio (IPV)																								
Oral Polio (OPV)																								
Haemophilus influenzae type b (Hib)																								
Hepatitis B (HB)																								
Varicella (Chickenpox)																								
Combined Measles, Mumps and Rubella (MMR)																								
Measles (Rubeola)																								
Rubella (3-day measles)																								
Mumps																								
Pneumococcal (not required for school entry)																								
Check specific type (PCV7, PPV23)																								
Other (Specify hepatitis A, meningococcal, etc.)																								

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature	Title	Date
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(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)		
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(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)		

ALTERNATIVE PROOF OF IMMUNITY

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 (Rubeola) 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 report, if available.)

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

Date	Age/Grade	R	L	R	L	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/Contacts

Printed by Authority of the State of Illinois
(Complete Both Sides)

Student's Name				Birth Date		Sex	School	Grade Level/ ID #
Last		First		Middle		Month Day Year		
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER								
ALLERGIES (Food, drug, insect, other)					MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No	Indicate Severity		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during the night coughing?	Yes	No			Hospitalizations? When? What for?	Yes	No	
Birth complications/prematurity?	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 9 Braces 9 Bridge 9 Plate Other			
Dizziness or chest pain with exercise?	Yes	No			Other concerns?			
Eye/Vision problems? Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor					Information may be shared with appropriate personnel for health and educational purposes.			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					Parent/Guardian Signature			
Ear/Hearing problems?	Yes	No			Date			
Bone/Joint problem/injury/scoliosis?								

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

PHYSICAL EXAMINATION REQUIREMENTS		HEAD CIRCUMFERENCE		HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (Not required for daycare.) 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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date Blood Test Result (If child resides in Chicago, blood test is required.)							
TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. <input type="checkbox"/> No Test Needed <input type="checkbox"/> Test performed Date Read / / Result mm							
LAB TESTS (Recommended)		Date		Results		Date	
Hemoglobin or Hematocrit				Sickle Cell (when indicated)			
Urinalysis				Developmental Screening			
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs		
Skin				Endocrine			
Ears				Gastrointestinal			
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/>		Genito-Urinary	LMP		
Nose				Neurological			
Throat				Musculoskeletal			
Mouth/Dental				Spinal examination			
Cardiovascular/HTN				Nutritional status			
Respiratory				Mental Health			
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 (for one year) Yes ☐ No ☐ Limited ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature**

Date

Address **Phone**

(Complete both sides)