



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 | |
| Street | City | Zip Code | | | | Work |

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