



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 <u>every</u> 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	
	MO	DA	YR	MO	DA	YR	MO	DA
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	<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	<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								
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			Sex		School			Grade Level/ ID				
Month/Day/ Year																					
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?			Yes		No									
Birth defects?			Yes		No		When? What for?			Yes		No									
Developmental delay?			Yes		No		Surgery? (List all.)			Yes		No									
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes		No		When? What for?			Yes		No									
Diabetes?			Yes		No		Serious injury or illness?			Yes		No									
Head injury/Concussion/Passed out?			Yes		No		TB skin test positive (past/present)?			Yes*		No									
Seizures? What are they like?			Yes		No		TB disease (past or present)?			Yes*		No									
Heart problem/Shortness of breath?			Yes		No		Tobacco use (type, frequency)?			Yes		No									
Heart murmur/High blood pressure?			Yes		No		Alcohol/Drug use?			Yes		No									
Dizziness or chest pain with exercise?			Yes		No		Family history of sudden death before age 50? (Cause?)			Yes		No									
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____						Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____															
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																					
Ear/Hearing problems?			Yes		No		Information may be shared with appropriate personnel for health and educational purposes.														
Bone/Joint problem/injury/scoliosis?			Yes		No		Parent/Guardian Signature			Date											
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																	
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: <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 _____											