



**State of Illinois  
Certificate of Child Health Examination**

<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>						
Last	First	Middle	Month/Day/Year									
<b>Address</b>			<b>Parent/Guardian</b>		<b>Telephone # Home Work</b>							
Street			City		Zip Code							
<b>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.</b>												
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>		<b>DOSE 2</b>		<b>DOSE 3</b>		<b>DOSE 4</b>		<b>DOSE 5</b>		<b>DOSE 6</b>	
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
<b>DTP or DTaP</b>												
<b>Tdap; Td or Pediatric DT</b> (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	
<b>Polio</b> (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	
<b>Hib</b> Haemophilus influenza type b												
<b>Pneumococcal Conjugate</b>												
<b>Hepatitis B</b>												
<b>MMR</b> Measles Mumps, Rubella							<b>Comments:</b> * indicates invalid dose					
<b>Varicella</b> (Chickenpox)												
<b>Meningococcal conjugate (MCV4)</b>												
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>												
<b>Hepatitis A</b>												
<b>HPV</b>												
<b>Influenza</b>												
<b>Other: Specify Immunization Administered/Dates</b>												
<b>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.</b>												
<b>Signature</b>				<b>Title</b>				<b>Date</b>				
<b>Signature</b>				<b>Title</b>				<b>Date</b>				
<b>ALTERNATIVE PROOF OF IMMUNITY</b>												
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> <b>*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR</b>												
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> 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. <b>Date of Disease</b> _____ <b>Signature</b> _____ <b>Title</b> _____												
<b>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.</b> *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.												
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b> 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
<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)	Yes No	List:	<b>MEDICATION</b> (Prescribed or taken on a regular basis.)	Yes No	List:	
Diagnosis of asthma? Child wakes during night coughing?	Yes No	Yes No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No		
Developmental delay?	Yes No		Surgery? (List all.) 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 (past/present)?	Yes* No		*If yes, refer to local health department.
Head injury/Concussion/Passed out?	Yes No		TB disease (past or present)?	Yes* No		
Seizures? What are they like?	Yes No		Tobacco use (type, frequency)?	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? (Cause?)	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? (crossed eye, drooping lids, squinting, difficulty reading)			Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?	Yes No		<b>Parent/Guardian</b>			
Bone/Joint problem/injury/scoliosis?	Yes No		<b>Signature</b>		<b>Date</b>	
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>						
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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> .						
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: <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 _____		