

## **Certificate of Child Health Examination**

Student's Name	tudent's Name					Birth Date (Mo/Day/Yr)		Race/Ethnicity		School/Grade Level/ID#				
Last	First		Middle											
Street Address	Address City			ZIP Code		Parent/Guardian				Telephone (hon			ne/work)	
HEALTH HISTOR	Y: MUST	BE COMPL	ETED AND	SIGNED	BY PA	RENT/G	UARI	OIAN AND	/ERIFIED	BY F	HEALTH C	CARE	PROVIDER	
	0Yes	st:				MEDIC	ATIO	N	0Yes	List:				
(Food, drug, insect,other)	□No					(Prescri regular		takenon <mark>a</mark>	□No			]		
Diagnosis of Asthma?			0Yes				s of function of one of paired			0Yes	No			
Child wakes duringnight coughir	ng?		0Yes 🗌				ans? (eye/ear/kidney/testicle)			0Yes	] <sub>No</sub>			
Birth Detects?			☐ Yes ☐				en? What for?			ores _	1110			
Developmental delay?			0Yes ⊔				gery? (List all)			☐Yes ☐	No			
Blood disorder? Hemophilia, Sic	kle Cell,Othe	er? Explain.	∐Yes ∐				en? What for? ous injury or illness?			0Yes	No No			
Diabetes?			☐Yes ☐							D Yes.				
Head injury/Concussion/Passed	out?		0Yes 🗌	No			TB skin test positive (past/pro				D Yes.		'If yes,refer to local health department	
Seizures? What are they like?						, , , , ,				Yes				
Heart problem/Shortness of breath?			Yes 📙		Tobacco use (type, frequence					□Yes □				
Heart murmur/High blood press	ure?		Yes 🔲			Alcohol/Drug use?  Family history of sudden death be								
Dizziness or chest pain with exer						age 50? (Cause?)				□ 163 □ 140				
Eye/Vision problems?	_ D	Glasses D Co	ontacts Last exam by eye docto				D Dental D Braces D Brid				idge D Plate D Other			
Other concerns? (Crossed eye	, drooping lie	ds, squinting, o	difficulty reading)				Additional Information:							
Ear/Hearing problems?			0Yes DNo				Information may be shared with appropriate personnel for health an						d educational purposes.	
Bone/Joint problem/injury/scolios	is?		D Yes D No				Parent/Guardian Signatures:				Date:			
IMMUNIZATIONS: To be of contraindicated, a separate explaining the medical re	must be att													
REQUIRED Vaccine/Dose		OSE1 DA YR	DOSE2 MO DA YR		DOSE3 MO DA YF		R	DOSE4 MO DA YR		DOSES MO DA YR		R	DOSE6 MO DA YR	
DTP or DTaP														
Tdap; Td or Pediatric OT (Check specific type)	0 Tdap	TO O bT C	0 Tdap O	dap O Td O OT 0		) Tdap O Td O (		OT 0 Tdap O Td O OT		0 Tdap O Td O OT		) OT	0 Tdap O Td O OT	
Polio (Check specific type)	0 IP\	/ 00PV	OIPV OOPV		0 IPV 00PV		/	OIPV 00PV		OIPV 00PV		<b>V</b>	OIPV 00PV	
Hib Haemophiles Influenza TypeB														
Pneumococcal Conjugate														
Hepatitis B														
MMR Measles, Mumps, Rubella								Comments	s: • ir	ndicate	s invalid dos	se		
Varicella (Chickenpox)														
Meningococcal Conjugate														
RECOMMENDED, BUT NOT REC	QUIRED Vac	cine/Dose												
Hepatitis A														
HPV														
Influenza														
Other: Specify Immunization Administered/Dates														
			•	-				mmunization	history mi	ust sig	n below.			
Administered/Dates  Health care provider (MD, DO			•	-				mmunization	history mu	ust sig	n below.	Date		

12/23

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and Maintained by the School Authority.  ALTERNATIVE PROOF OF IMMUNITY  1. Cillinical diagnosis (measles, mumps, hepatitis §) is allowed when verified by physician and supported with size confirmation. Attach copy of lab result.  1. Cillinical diagnosis (measles, mumps, hepatitis §) is allowed when verified by physician and supported with size confirmation. Attach copy of lab result.  2. History of varicals (chickenpox) disease is acceptable if verified by health care provider; school health professional or health official. Orenos signing below verified by providers and is accepted guident advantage of various diseases history is indicated of pare infection and is accepted, such health professional or health official. Orenos signing below verified and providers of the infection and is accepted, such health professional or health official. Orenos signing below verified by diseases a cases diagnosed on or an after July 1, 2002, most be confirmed by listocality evidence.  2. History of Varicella (chickenpox) disease is acceptable if verified by most providence.  2. Physicalized Science of July 1, 2002, most be confirmed by listocality evidence.  2. Physicalized Science diagnosed on or an after July 1, 2002, most be confirmed by listocality evidence.  2. Physicalized Science of July 1, 2002, most be confirmed by listocality evidence.  2. Physicalized Science of July 1, 2002, most be confirmed by listocality evidence.  2. Physicalized Science of July 1, 2002, most be confirmed by listocality evidence.  2. Physicalized Science of Confirmed by listocality evidence of the firm and providence.  2. Physicalized Science of Confirmed by listocality evidence of the firm and providence.  2. Physicalized Science of Confirmed by listocality evidence of the firm and providence.  2. Physicalized Science of Confirmed by listocalized by listocalized by listocalized by listocalized by listocalized by listocal				1		_						_		
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ALTERNATIVE PROOF OF MANUFACT  1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.  1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.  1. MEASLES (fluxeded) (MOCAYN)  1. VINENDE, SECONTROLL (VINENDE, MOCAYN)  1. VINENDE, SECONTROLL (VINENDE, MO	Last		First	Middle										
A.TERNATIVE PROOF OF MAMUNITY  1. Clinical diagnosis (measies, mump, hepatitis B) is allowed when verified by physician and supported with isb confirmation. Attach copy of lab result.  1. AREA & B3 (Alleader) (MCDANY)  2. History of varicals (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Present systing tows verified by the provider, school health professional or health official. Present systing tows verified by the provider, school health professional or health official. Present systing tows verified by the provider, school health professional or health official. Present systing tows verified by the provider, school health professional or health official. Present systing tows verified by the provider of participation and sucception school health professional or health official. Present systing tows verified by the provider, school health professional or health official. Present systing tows verified by the provider, school health professional or health official. Present systing tows verified by the provider, school health professional or health official. Present systing tows verified by the provider, school health professional or health official. Present systing tows verified by the present school present system of the supplementation of the supplement school present system of the supplement supplement school present system of the supplement school present system of the supplement school pr														
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Date of Disease  Signature  Tale  All control processes adaptored or varieties disease history is indicative of past infection and is accepting such history as occumentation of disease.  All menatives causes diagnosed on or after study 1, 2002, must be confirmed by laboratory evidence.  "All manages causes diagnosed on or after study 1, 2002, must be confirmed by laboratory evidence.  "All manages causes diagnosed on or after study 1, 2002, must be confirmed by laboratory evidence.  "All manages causes diagnosed on or after study 1, 2013, must be confirmed by laboratory evidence.  "All manages causes diagnosed on or after study 1, 2013, must be confirmed by laboratory evidence.  "All manages causes diagnosed on or after study 1, 2013, must be confirmed by laboratory evidence.  "All manages causes diagnosed on or after study 1, 2013, must be confirmed by laboratory evidence.  "All manages causes diagnosed on or after study 1, 2013, must be confirmed by laboratory evidence.  "All manages causes diagnosed on or after study 1, 2013, must be confirmed by laboratory evidence.  "Physician Stateman for through 1000 IDPN for responsible of the study study in the study study study in the study study in the study study study in the study study study study in	*MEASLES (Rubeola) (	MO/DA/	YR)	**MUMPS (MO/DA/YR)		HEF	PATITIS E	B (MO/DA/YR)	)	VA	ARICELLA (MO/DA/YR)			
3. Laboratory Evidence of Immunity (check one)	2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below													
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IEAD RISK QUESTIONNAIRE: Required for exiderin aged 5 months through 6 years enrolled in licensed or public-school operated day care, preschool, numery school and/or kindergarten. (Blood test required if residue in Chicago or high risk sp poole).	DIABETES SCREENING	3: {NOTR	EQUIRED FOR DAY CARE	BM1>8S% age/sex D	Yes D	No	And any	two of the	following:	Family Histo	ory D Yes D No			
Questionnaire Administered? D vs D No Blood Test Indicated? D vs D No Blood Test Date Result  Test SKIN OR BLOOD TEST: Recommended only for children in high-risk categories see CDC guidelines. http://www.dcdoi.gov/bib/bublications/fact-sheets/festinos/TB testinos/TB. testino	Ethnic Minority D Y	es D ı	No Signs of Ir	sulin Resistance (hypertension, dy	yslipidemia,	polycystic o	varian synd	Irome, acanthosi	s nlgricans)	0 Yes O 1	No At Risk O	Yes 0 No		
TESKIN 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-providence countlines of those exposed to adults in high-risk categories. See CDC guidelines http://www.cdc.gov/bipoublications/factstees/testers/artstees/testino/TEStestino.htm.  No lest needed					enrolled in	n licensed	or public-	-school operat	ed day ca	re, preschool, n	ursery school and/or ki	ndergarten.		
No test needed   Dest performed   Skin Test:   Date Read   Result:   Positive   Negative   Value	Questionnaire Admin	nistered	? D Yes D No	Blood Test Indicated?	D Yes I	D No	В	Blood Test D	ate		Result			
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LAB TESTS (Recommended)  Date  Results  SCREENINGS  Developmental Screening  Developmental Scree														
Developmental Screening   Developments/Follow-up/Needs   Developments/Follow-up/Needs   Developmental Screening   Develo														
Urinalysis   Social and Emotional Screening   D Completed   N/A   Sickle Cell (when indicated   Other:      SYSTEM REVIEW   rmal   Comments/Follow-up/Needs   Endocrine     Ears   Screening Result:   Gastrointestinal     Eyes   Screening Result:   Ganito-Urinary   LMP:   Nose   Neurological     Throat   Musculoskeletal     Musculoskeletal   Spinal Exam     Musculoskeletal     Cardiovascular/HTN   Nutritional Status     Cardiovascular/HTN   Nutritional Status     Currently Prescribed Asthma Medication:   Other   Other     O Culcive-relief medication (e.g., inhaled corticosteroid)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., inhaled corticosteroid)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., inhaled corticosteroid)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., short Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Beta Agonist)   Other     O Controller medication (e.g., short) Acting Be	,		Date	Results	D					Date	_			
System Review Normal Comments/Follow-up/Needs Endocrine Ears Screening Result: Gastrointestinal Eyes Screening Result: Genito-Urinary LMP:  Nose Screening Result: Genito-Urinary LMP:  Nose Nourlogical Musculoskoletal Muscu		Crit									- '			
SYSTEM REVIEW N mal Comments/Follow-up/Needs  Skin						ŭ l					<b>D</b> completed	O N/A		
Skin	SICKIE CEII (WHEN HIGHERE													
Ears Screening Result: Gastrointestinal  Eyes Screening Result: Genito-Urinary LMP:  Nose Neurological  Throat Musculoskeletal  Mouth/Dental Spinal Exam Nutritional Status  Cardiovascular/HTN Nutritional Status  Respiratory O Diagnosis of Asthma Medication:  O Quick-relief medication (e.g., Short Acting Beta Agonist) O 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 idscuss thissuldent's health with school or school health personnel, check title O Nurse O Teacher O Counselor O 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)?  D Yes D No If yes, please describe:  On the basis of the examination on this day, I approve this child'sparticipation in (If No or Modified please attach explanation.)  PHYSICAL EDUCATION Peeds Plass of the examination on this day, I approve this child'sparticipation in INTERSCHOLASTICSPORTS D Yes D No D Modified  Date	SYSTEM REVIEW	rmal	Comments/Follow				Norma	Normal Comments/Follow-up/Needs						
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Nose  Neurological  Throat  Musculoskeletal  Mouth/Dental  Spinal Exam  Nutritional Status  Respiratory  Diagnosis of Asthma  Currently Prescribed Asthma Medication: O Quick-relief medication (e.g., Short Acting Beta Agonist) O Controller medication (e.g., seigured in the school should know about this student? If you would like to discuss thisstudent's health with school or school health personnel, check title O Nurse O Teacher O Counselor O 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)? O Yes D No If yes, please describe: On the basis of the examination on this day, I approve this child'sparticipation in (If No or Modified please attach explanation.) PHYSICAL EDUCATION D Yes D No D Modified INTERSCHOLASTICSPORTS D Yes D No D Modified  Print Name  O MD O DO APN O PA Signature  Date	Ears			,	Gastroir	ntestinal	I							
Throat  Musculoskeletal  Spinal Exam  Nutritional Status  Respiratory  O Diagnosis of Asthma Mental Health  Currently Prescribed Asthma Medication: O Quick-relief medication (e.g., Short Acting Beta Agonist) O 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 thisstudent's health with school or school health personnel, check title.  Murse O Teacher O Counselor O 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)?  D Yes D No If yes, please describe:  Onthe basis of the examination on this day, I approve this child'sparticipation in (If No or Modified please attach explanation.)  PHYSICAL EDUCATION D Yes D No D Modified  INTERSCHOLASTICSPORTS D Yes D No D Modified  Print Name  D MD O DO APN O PA Signature  Date	Eyes				Genito-U	rinary								
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