State of Illinois

Certificate of Child Health Examination

Student's Name Last / First / Middle	**Birth Date** (Mo/Day/Yr)	**Sex**	**Race/Ethnicity**	**School/Grade Level/ID#**
Street Address / City / ZIP Code	Parent/Guardian / Telephone (home/work)			

HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	0Yes ☐No	List:	**MEDICATION** (Prescribed or taken on a regular basis)	0Yes ☐No	List:

Diagnosis of Asthma?	0Yes No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)?	0Yes No	
Child wakes during night coughing?	0Yes ☐No		Hospitalization? When? What for?	0Yes ☐No	
Birth Defects?	☐ Yes ☐No				
Developmental delay?	0Yes ☐No		Surgery? (List all) When? What for?	☐Yes ☐No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐Yes ☐No				
Diabetes?	☐Yes ☐No		Serious injury or illness?	0Yes ☐No	
Head injury/Concussion/Passed out?	0Yes ☐No		TB skin test positive (past/present)?	D Yes• ☐No	'If yes, refer to local health department
Seizures? What are they like?	☐		TB disease (past or present)?	D 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?	☐		Family history of sudden death before age 50? (Cause?)	☐Yes ☐No	
Eye/Vision problems? _ D Glasses D Contacts Last exam by eye doctor			D Dental D Braces D Bridge D Plate D Other		
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading)			**Additional Information:**		
Ear/Hearing problems?	0Yes DNo		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	D Yes D No		**Parent/Guardian Signatures:**	**Date:**	

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSES** MO DA YR	**DOSE 6** MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric **OT** (Check specific type)	0 Tdap O Td O OT	0 Tdap O Td O OT	0 Tdap O Td O OT	0 Tdap O Td O OT	0 Tdap O Td O OT	0 Tdap O Td O OT
Polio (Check specific type)	0 IPV 00PV	OIPV OOPV	0 IPV 00PV	OIPV 00PV	OIPV 00PV	OIPV 00PV
Hib Haemophiles Influenza TypeB						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				**Comments:** • indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal Conjugate						
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

Student's Name Last First Middle	**Birth Date** (Mo/Day/Yr)	**Sex**	**School**	**Grade Level/ID#**

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. 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) D Measles* D Mumps** D Rubella D 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.

Physician Statements of Immunity MUST be submitted to IDPH for review.
Completion of Alternatives 1 or 3 MUST be accompanied by labs & Physician Signature:

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 8/P

DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) **BM1>8S% age/sex** D Yes D No And any two of the following: **Family History** D Yes D No
Ethnic Minority D Yes D No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nlgricans) 0 Yes O No **At Risk** O Yes 0 No

LEAD RISK QUESTIONNAIRE: Required for children aged 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? D Yes D No **Blood Test Indicated?** D Yes D No **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**.
D No test needed D Test performed **Skin Test:** Date Read ___ Result: D Positive D Negative mm ___
Blood Test: Date Reported Result: D Positive D Negative Value

LAB TESTS (Recommended)	**Date**	**Results**	**SCREENINGS**	**Date**	**Results**
Hemoglobin or Hematocrit			Developmental Screening		D Completed 0 N/A
Urinalysis			Social and Emotional Screening		D Completed 0 N/A
Sickle Cell (when indicated			Other:		

SYSTEM REVIEW	**N rmal**	**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		0 Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: 0 Quick-relief medication (e.g., Short Acting Beta Agonist) 0 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 thisstudent's health with school or school health personnel, check title: 0 Nurse 0 Teacher O Counselor 0 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 D Yes D No D Modified **INTERSCHOLASTICSPORTS** D Yes D No D Modified

Print Name 0 MD O DO O APN O PA Signature Date

Address Phone