



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 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 influenzae 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																		

Comments:

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
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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.

Student's Name	Birth Date	Sex	School	Grade Level/ID
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)		MEDICATION (Prescribed or taken on a regular basis.)		
Diagnosis of asthma?		Loss of function of one of paired organs? (eye/ear/kidney/testicle)		
Child wakes during the night coughing?		Hospitalizations? When? What for?		
Developmental delay?		Birth Defects?		
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Surgery? (List all.) When? What for?		
Diabetes?		Serious injury or illness?		
Head Injury/Concussion/Passed out?		TB skin test positive (past/present)?		*If yes, refer to local health department
Seizures? What are they like?		TB disease (past or present)?		
Heart problem/Shortness of breath?		Tobacco use (type, frequency)?		
Heart murmur/High blood pressure?		Alcohol/Drug use?		
Dizziness or chest pain with exercise?		Family history of sudden death before age 50? (Cause?)		
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)		Information may be shared with appropriate personnel for health and educational purposes.		
Ear/Hearing problems?		Parent/Guardian Signature _____ Date _____		
Bone/Joint problem/injury/scoliosis?				

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if <2-3 years old

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex: And any two of the following: Family History: Ethnic Minority: Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans): At Risk:

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? Blood Test Indicated? 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 Test Needed: Test Performed: Skin Test: Date Read: Result: Mm: Blood Test: Date Reported: Result: Value:

LAB TESTS (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)	
Urinalysis			Developmental Screening Tool	
SYSTEM REVIEW	Comments/Follow-up/Needs	Comments/Follow-up/Needs	Comments/Follow-up/Needs	Comments/Follow-up/Needs
Skin		Endocrine		
Ears	Screening Result:	Gastrointestinal		
Eyes	Screening Result: Amblyopia:	Genito-Urinary		
Nose		Neurological		
Throat		Musculoskeletal		
Mouth/Dental		Spinal Exam		
Cardiovascular/HTN		Nutritional status		
Respiratory		Mental Health		
Diagnosis of Asthma		Other		

Currently Prescribed Asthma Medications:

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 professional, check title:

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)? If yes, please describe:

On the basis of the examination of this day, I approve the child's participation in: (If No or Modified, please attach explanation)

PHYSICAL EDUCATION: yes INTERSCHOLASTIC SPORTS:

Print Name _____ Signature _____ Date _____
Address/Phone _____