



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												
Street				City		Zip Code												
Work																		
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 influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps Rubella																Comments: * indicates invalid dose		
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 Month/Day/ Year			Sex	School		Grade Level/ ID
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? When? What for?			Yes	No					
Birth defects?			Yes	No		Surgery? (List all.) When? What for?			Yes	No					
Developmental delay?			Yes	No		Serious injury or illness?			Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes	No		TB skin test positive (past/present)?			Yes*	No		*If yes, refer to local health department.			
Diabetes?			Yes	No		TB disease (past or present)?			Yes*	No					
Head injury/Concussion/Passed out?			Yes	No		Tobacco use (type, frequency)?			Yes	No					
Seizures? What are they like?			Yes	No		Alcohol/Drug use?			Yes	No					
Heart problem/Shortness of breath?			Yes	No		Family history of sudden death before age 50? (Cause?)			Yes	No					
Heart murmur/High blood pressure?			Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other									
Dizziness or chest pain with exercise?			Yes	No		Information may be shared with appropriate personnel for health and educational purposes.									
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)						Parent/Guardian Signature						Date			
Ear/Hearing problems?			Yes	No											
Bone/Joint problem/injury/scoliosis?			Yes	No											
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					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:						Other									
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)															
<input type="checkbox"/> 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 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							