State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School/Grade Level/ID#**
Address Street City ZIP Code	Parent/Guardian Telephone# Home 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** Month Day Year	**DOSE 2** Month Day Year	**DOSE 3** Month Day Year	**DOSE 4** Month Day Year	**DOSE 5** Month Day Year	**DOSE 6** Month Day Year
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				Comments:		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify any immunizations administered and 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)** Month Day Year	****MUMPS** Month Day Year	**HEPATITIS B** Month Day Year	**VARICELLA** Month Day Year

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) ☐ **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.

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** (List all 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				
Birth defects?	☐ Yes ☐ No		Hospitalizations? When? What for?	☐ Yes ☐ No	
Developmental delay?	☐ Yes ☐ No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	☐ Yes ☐ No		Surgery? (List all.) When? What for?	☐ Yes ☐ No	
Diabetes?	☐ Yes ☐ No		Serious injury or illness?	☐ Yes ☐ No	
Head injury/Concussion/Passed out?	☐ Yes ☐ No		TB skin test positive (past/present)? *	☐ Yes ☐ No	*If yes, refer to local health department.
Seizures? What are they like?	☐ Yes ☐ No		TB disease (past or present)? *	☐ 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?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ Yes ☐ No	
Eye/Vision problems? ☐ No ☐ Glasses ☐ Contacts Last exam by eye doctor Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other		
Ear/Hearing problems?	☐ Yes ☐ No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian**		
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No		**Signature**		**Date**

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

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **(NOT REQUIRED FOR DAY CARE)** **BMI>85%age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

Ethnic Minority ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

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 ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST ☐ **No test needed** ☐ **Test performed**

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.

Skin Test: Date Read / / **Result:** ☐ **Positive** ☐ **Negative** **mm** _____

Blood Test: Date Reported / / **Result:** ☐ **Positive** ☐ **Negative** **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		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restriction

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: ☐ Nurse ☐ Teacher ☐ Counselor ☐ 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 ☐ No 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** ☐ **No** ☐ **Modified** **INTERSCHOLASTIC SPORTS** ☐ **Yes** ☐ **No** ☐ **Modified**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

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