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	Pare nt/G ua rd ia n	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 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
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 (Checkspecific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza typeb						
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) verifyingaboveimmunization history must sign below. Ifaddingdates totheaboveimmunizationhistorysection,put your initialsbydate(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. Personsigning belowverifiesthattheparent/guardian'sdescriptionofvaricelladiseasehistoryisindicativeofpastinfectionandisacceptingsuchhistoryas documentation ofdisease.

Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (checkone) **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 ofImmunityMUSTbesubmitted to IDPHfor 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 BYHEALTH 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						
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? _____ Glasses Contacts Last exam by eye doctor _____ Other concerns? (crossedeye,droopinglids, squinting, difficultyreading)				Dental Braces Bridge Plate Other			
Ear/Hearing problems?	Yes No			Informationmaybesharedwithappropriatepersonnelforhealthandeducational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes No						

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

HEADCIRCUMFERENCEif <2-3yearsold **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **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: Requiredforchildrenage6monthsthrough 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/orkindergarten. (Bloodtestrequiredifresidesin Chicagoorhighriskzipcode.)

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

TB SKIN OR BLOOD TEST Recommendedonlyforchildreninhigh-riskgroupsincluding children immunosuppressed due to HIV infection or other conditions, frequent travelto or born inhighprevalencecountriesorthoseexposedtoadultsinhigh-riskcategories.SeeCDCguidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

No test needed **Test performed** **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 Nose Throat		Screening Result:	**Genito-Urinary**		LMP
Mouth/Dental			**Neurological**		
Cardiovascular/HTN			**Musculoskeletal**		
Respiratory			**Spinal Exam**		
			Nutritional status		
		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed AsthmaMedication: ☐ Quick-relief medication(e.g. Short Acting Beta Agonist) ☐ Controllermedication(e.g.inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS requiredintheschool 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 Isthereanything else the school should know about this student?
Ifyouwouldliketodiscussthisstudent'shealthwith school or school health personnel, check title: Nurse Teacher Counselor Principal

EMERGENCY ACTION neededwhileatschool due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes **No** Ifyes, please describe.

Onthebasisoftheexaminationonthisday,Iapprovethischild'sparticipationin (IfNoorModifiedpleaseattachexplanation.)

PHYSICAL EDUCATION **Yes** **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified**

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

Address **Phone**