



**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	
	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	
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	
Hib Haemophilus influenza 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						
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 <input type="checkbox"/> No <input type="checkbox"/>		List:			MEDICATION (Prescribed or taken on a regular basis)			Yes <input type="checkbox"/> No <input type="checkbox"/>		List:				
Diagnosis of asthma?			Yes <input type="checkbox"/> No <input type="checkbox"/>		Child wakes during night coughing?			Loss of function of one of paired organs? (eye/ear/kidney/testicle)			Yes <input type="checkbox"/> No <input type="checkbox"/>						
Birth defects?			Yes <input type="checkbox"/> No <input type="checkbox"/>		Developmental delay?			Hospitalizations? When? What for?			Yes <input type="checkbox"/> No <input type="checkbox"/>						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes <input type="checkbox"/> No <input type="checkbox"/>		Diabetes?			Surgery? (List all.) When? What for?			Yes <input type="checkbox"/> No <input type="checkbox"/>						
Head injury/Concussion/Passed out?			Yes <input type="checkbox"/> No <input type="checkbox"/>		Seizures? What are they like?			Serious injury or illness?			Yes <input type="checkbox"/> No <input type="checkbox"/>						
Heart problem/Shortness of breath?			Yes <input type="checkbox"/> No <input type="checkbox"/>		Heart murmur/High blood pressure?			TB skin test positive (past/present)?			Yes* <input type="checkbox"/> No <input type="checkbox"/>		*If yes, refer to local health department.				
Dizziness or chest pain with exercise?			Yes <input type="checkbox"/> No <input type="checkbox"/>		Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			TB disease (past or present)?			Yes* <input type="checkbox"/> No <input type="checkbox"/>						
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 _____												
Ear/Hearing problems?			Yes <input type="checkbox"/> No <input type="checkbox"/>		Bone/Joint problem/injury/scoliosis?			Information may be shared with appropriate personnel for health and educational purposes.			Parent/Guardian 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) BMD>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:			<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)			<input type="checkbox"/> 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 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			Phone								
Address																	