# 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#**

<table>
<thead>
<tr>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

**Parent/Guardian**
- Telephone #
  - Home
  - Work

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### IMMUNIZATIONS

**REQUIRED Vaccine / Dose**

<table>
<thead>
<tr>
<th>REQUIRED Vaccine / Dose</th>
<th>DOSE 1</th>
<th>DOSE 2</th>
<th>DOSE 3</th>
<th>DOSE 4</th>
<th>DOSE 5</th>
<th>DOSE 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
<td>MO</td>
<td>DA</td>
<td>YR</td>
<td>MO</td>
<td>DA</td>
<td>YR</td>
</tr>
<tr>
<td>Tdap, Td or Pediatric DT (Check specific type)</td>
<td>MO</td>
<td>DA</td>
<td>YR</td>
<td>MO</td>
<td>DA</td>
<td>YR</td>
</tr>
</tbody>
</table>

**Polio**
- (Check specific type)
  - □ IPV
  - □ 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**

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**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

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### 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
- Date

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.

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11/2015

(COMPLETE BOTH SIDES)

Printed by Authority of the State of Illinois
HEALTH HISTORY

Allergies

Diagnosis of asthma? Yes No
Child wakes during night coughing? Yes No

Diabetes? Yes No

Ear, Nose, Throat

Mouth/Dental Screen

Eye/Vision problems? Yes No

Health History

TB Skin Test

DIABETES SCREENING

LEAD RISK QUESTIONNAIRE

Physical Examination Requirements

Blood Pressure

Urinalysis

Laboratory Tests

System Review

Respiratory

Special Instructions/Devices

Mental Health/Other

Emergency Action

Print Name

Address