



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 Street City Zip Code				Parent/Guardian Telephone # Home		Work		
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> 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	DOSE 1		DOSE 2		DOSE 3		DOSE 4	
Vaccine / Dose	MO	DA	YR	MO	DA	YR	MO	DA
DTP or DTaP								
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT	
Polio (Check specific type)	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ 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) ☐ 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			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?			Yes		No				
Birth defects?			Yes		No					When? What for?									
Developmental delay?			Yes		No					Surgery? (List all.)			Yes		No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes		No					When? What for?									
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 _____									Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other _____										
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)									Information may be shared with appropriate personnel for health and educational purposes.										
Ear/Hearing problems?			Yes		No					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																			
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 ☐ 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 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 ☐ 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				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/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: ☐ 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																