



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 <u>every</u> 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			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	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 (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 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.

Apellido			Nombre			Inicial			Fecha de Nacimiento			Sexo			Escuela			Grado/Núm. de Ident.					
Mes / Día / Año																							
HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD																							
ALERGIAS (Alimentos, drogas, insectos, otro)			Sí No			Anótelas todas:						MEDICINAS (Anote todas las recetas o tomadas con regularidad)			Sí No								
¿Tiene diagnóstico de asthma?						Sí No						¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)						Sí No					
¿Despierta el niño tosiendo en la noche?																							
¿Tiene defectos de nacimiento?						Sí No						¿Ha sido hospitalizado?						Sí No					
¿Tiene retrasos del desarrollo?						Sí No						¿Cuándo? ¿Para qué?											
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro						Sí No						¿Ha tenido alguna cirugía?(anótelas todas)						Sí No					
¿Tiene diabetes?						Sí No						¿Cuándo? ¿Para qué?											
¿Tiene heridas en la cabeza/golpe/desmayo?						Sí No						¿Ha tenido heridas graves o enfermedades?						Sí No					
¿Tiene convulsiones? Cómo se manifiestan?						Sí No						¿Prueba positiva de TB (Pasado o Presente)?						Sí No					
¿Tiene problemas cardiacos/No respira bien?						Sí No						¿Enfermedad de TB (Pasado o Presente)?						Sí No					
¿Tiene soplo en el corazón/presión arterial alta?						Sí No						¿Usa tabaco (tipo, frecuencia)?						Sí No					
¿Tiene mareos o dolor de pecho al hacer ejercicios?						Sí No						¿Toma alcohol/drogas?						Sí No					
¿Tiene historial de familiares de muerte repentina antes de los 50 años? ¿Causa?						Sí No																	
¿Problemas con los ojos/visión? _____ Lentes ☐ Lentes de Contacto ☐ Último examen _____ ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)												Dental ☐ Ganchos ☐ Puente ☐ Placas Otro											
¿Tiene problemas de los oídos/no oye bien?						Sí No						La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.											
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?						Sí No						Firma del Padre/Tutor											
												Fecha											
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 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													