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State of Illinois

# Certificate of Child Health Examination

| Student's Name (Last, First, Middle) | Birth Date (Mo/Day/Yr) | Sex | Race/Ethnicity | School/Grade Level/ID# |
|---|---|---|---|---|
| | | | | |

| Street Address, City, ZIP Code | Parent/Guardian | Telephone (home/work) |
|---|---|---|
| | | |

**HEALTH HISTORY: MUST 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 | | Hospitalization? When? What for? | ☐ Yes ☐ No | |
| Birth Defects? | ☐ Yes ☐ No | | Surgery? (List all) When? What for? | ☐ Yes ☐ No | |
| Developmental delay? | ☐ Yes ☐ No | | Serious injury or illness? | ☐ Yes ☐ No | |
| Blood disorder? Hemophilia, Sickle Cell, Other? Explain. | ☐ Yes ☐ No | | TB skin test positive (past/present)? | ☐ Yes* ☐ No | *If yes, refer to local health department |
| Diabetes? | ☐ Yes ☐ No | | TB disease (past or present)? | ☐ Yes* ☐ No | |
| Head injury/Concussion/Passed out? | ☐ Yes ☐ No | | Tobacco use (type, frequency)? | ☐ Yes ☐ No | |
| Seizures? What are they like? | ☐ Yes ☐ No | | Alcohol/Drug use? | ☐ Yes ☐ No | |
| Heart problem/Shortness of breath? | ☐ Yes ☐ No | | Family history of sudden death before age 50? (Cause?) | ☐ Yes ☐ No | |
| Heart murmur/High blood pressure? | ☐ Yes ☐ No | | | | |
| Dizziness or chest pain with exercise? | ☐ 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) _____

**Additional Information:**

Ear/Hearing problems? ☐ Yes ☐ No

Information may be shared with appropriate personnel for health and educational purposes.

Bone/Joint problem/injury/scoliosis? ☐ Yes ☐ No

**Parent/Guardian Signatures:** _____ **Date:** _____

**IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 (Check specific type) | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV |
| Hib Haemophiles Influenza Type B | | | | | | |
| Pneumococcal Conjugate | | | | | | |
| Hepatitis B | | | | | | |
| MMR Measles, Mumps, Rubella | | | | | | |
| Varicella (Chickenpox) | | | | | | |
| Meningococcal Conjugate | | | | | | |
| **RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose** | | | | | | |
| Hepatitis A | | | | | | |
| HPV | | | | | | |
| Influenza | | | | | | |
| Other: Specify Immunization Administered/Dates | | | | | | |

**Comments:** * indicates invalid dose

**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 _____

| Student's Name<br>Last First Middle | Birth Date (Mo/Day/Yr) | Sex | School | Grade Level/ID# |
|---|---|---|---|---|
| | | | | |

**Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.**

**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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

**Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:** _____

**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 aged 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 | SCREENINGS | Date | Results |
|---|---|---|---|---|---|
| Hemoglobin or Hematocrit | | | Developmental Screening | | ☐ Completed ☐ N/A |
| Urinalysis | | | Social and Emotional Screening | | ☐ Completed ☐ N/A |
| Sickle Cell (when indicated | | | Other: | | |

| 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:<br>☐ Quick-relief medication (e.g., Short Acting Beta Agonist)<br>☐ 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