¡ATENCIÓN!
El padre o tutor debe completar el sección de Historial de Salud en esta página

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)

HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.

ALERGIAS (Alimentos, drogas, insectos, otro) ☐ Sí ☐ No — **Anote todas las alergias:**

MEDICAMENTOS (Recetados o tomados con regularidad) ☐ Sí ☐ No — **Anote todos los medicamentos:**

¿Tiene diagnóstico de asthma?	☐ Sí ☐ No	
¿Despierta el niño tosiendo en la noche?	☐ Sí ☐ No	
¿Tiene defectos de nacimiento?	☐ Sí ☐ No	
¿Tiene retrasos del desarrollo?	☐ Sí ☐ No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique.	☐ Sí ☐ No	
¿Tiene diabetes?	☐ Sí ☐ No	
¿Tiene heridas en la cabeza/golpe/desmayo?	☐ Sí ☐ No	
¿Tiene convulsiones? Cómo se manifiestan?	☐ Sí ☐ No	
¿Tiene problemas cardiacos/Dificultad para respirar?	☐ Sí ☐ No	
¿Tiene soplo en el corazón/presión arterial alta?	☐ Sí ☐ No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?	☐ Sí ☐ No	
¿Problemas con los ojos/visión? _____ ☐ Lentes ☐ Lentes de Contacto Último examen _____		
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee) _____		
¿Tiene problemas de los oídos/no oye bien?	☐ Sí ☐ No	
¿Tiene problemas de los huesos/articulaciones/heridas/ escoliosis?	☐ Sí ☐ No	

¿Tiene pérdida de funciones en uno de los órganos?(Ojos/Oídos/Riñones/Testículos)	☐ Sí ☐ No	
¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	☐ Sí ☐ No	
¿Ha tenido heridas graves o enfermedades?	☐ Sí ☐ No	
¿Prueba positiva de TB (Pasado o Presente)?	☐ Si* ☐ No	*Si contestó sí, refiera al departamento de salud local
¿Enfermedad de TB (Pasado o Presente)?	☐ Si* ☐ No	
¿Usa tabaco (tipo, frecuencia)?	☐ Sí ☐ No	
¿Toma alcohol/drogas?	☐ Sí ☐ No	
¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	☐ Sí ☐ No	

☐ Dental ☐ Frenos ☐ Puente ☐ Placas ☐ Otro

Información Adicional:

La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.

Firma del Padre/ Tutor: _____ **Fecha:** _____

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 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: ☐ 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