



State of Illinois

Parent/Guardian Must Complete ALL Highlighted Information
9th Grade Physicals Are Due July 1st

Certificate of Child Health Examination

Student's Name			Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Last	First	Middle				
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		☐ Yes ☐ No		List:		☐ Yes ☐ No
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
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	
DTP or DTaP	☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT	
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT	
Polio (Check specific type)	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Hib Haemophiles Influenza Type B	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Pneumococcal Conjugate	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Hepatitis B	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
MMR Measles, Mumps, Rubella	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Varicella (Chickenpox)	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Meningococcal Conjugate	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
HPV	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Influenza	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Other: Specify Immunization Administered/Dates	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
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 _____	

Completed forms must be submitted to Lori Balsamo @ lbalsamo@csd99.org or Faxed to: (630) 795-7192
Please call (630) 795-8528 if you have any questions or concerns.

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

**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 _____