



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)	<input type="checkbox"/> Yes	List:	MEDICATION (Prescribed or taken on a regular basis)	<input type="checkbox"/> Yes	List:
	<input type="checkbox"/> No			<input type="checkbox"/> No	
Diagnosis of Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Child wakes during night coughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hospitalization? When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Birth Defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Surgery? (List all) When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Developmental delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Serious injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB skin test positive (past/present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	*If yes, refer to local health department
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB disease (past or present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
Head injury/Concussion/Passed out?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tobacco use (type, frequency)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures? What are they like?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alcohol/Drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart problem/Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Family history of sudden death before age 50? (Cause?)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart murmur/High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Dizziness or chest pain with exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Eye/Vision problems? _____ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Last exam by eye doctor _____			<input type="checkbox"/> Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____			Additional Information:		
Ear/Hearing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No			Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis? <input type="checkbox"/> Yes <input type="checkbox"/> 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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR															
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> 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 _____

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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, pre school, 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		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Sickle Cell (when indicated)			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	Screening Result:	Gastrointestinal	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	Screening Result:	Genito-Urinary	<input type="checkbox"/>	LMP:
Nose	<input type="checkbox"/>		Neurological	<input type="checkbox"/>	
Throat	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	
Mouth/Dental	<input type="checkbox"/>		Spinal Exam	<input type="checkbox"/>	
Cardiovascular/HTN	<input type="checkbox"/>		Nutritional Status	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis of Asthma	Mental Health	<input type="checkbox"/>	
Currently Prescribed Asthma Medication:			Other	<input type="checkbox"/>	
<input type="checkbox"/> Quick-relief medication (e.g., Short Acting Beta Agonist)					
<input type="checkbox"/> Controller medication (e.g., inhaled corticosteroid)					
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 _____