# State of Illinois
# Certificate of Child Health Examination

| Student's Name<br>Last First Middle | Birth Date<br>Month Day Year | Sex | Race/Ethnicity | School /Grade Level/ID# |
|---|---|---|---|---|
| Address Street City Zip Code | Parent Guardian | Telephone # Home | | Work |

**IMMUNIZATIONS: To be completed by health care provider. The mo/da/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 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 | | | | | | |
| IIPV | | | | | | |
| 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.**

| Last | First | Middle | Birth Date (Month/Day/Year) | Sex | School | Grade Level/ ID |
|---|---|---|---|---|---|---|
| | | | | | | |

**HEALTH HISTORY** TO 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 | | | | | | |
| Birth defects? | Yes / No | | | Hospitalizations? When? What for? | Yes / No | | |
| Developmental delay? | Yes / No | | | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain | Yes / No | | | Surgery? (List all) When? What for? | Yes / No | | |
| Diabetes? | Yes / No | | | Serious injury or illness? | Yes / No | | |
| Head injury Concussion Passed out? | Yes / No | | | TB skin test positive (past present)? | Yes* / No | *If yes, refer to local health department | |
| Seizures? What are they like? | Yes / No | | | TB disease (past or present)? | Yes* / No | | |
| Heart problem Shortness of breath? | Yes / No | | | Tobacco use (type, frequency)? | Yes / No | | |
| Heart murmur High blood pressure? | Yes / No | | | Alcohol Drug use? | Yes / No | | |
| Dizziness or chest pain with exercise? | Yes / No | | | Family history of sudden death before age 50? (Cause?) | Yes / No | | |
| Eye Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) | | | | Dental ☐ Braces ☐ Bridge ☐ Plate Other | | | |
| 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 Signature | | Date | |

**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

**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**