



State of Illinois Certificate of Child Health Examination

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

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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	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		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										Comments: * indicates invalid dose								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
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	Child wakes during night coughing?				Loss of function of one of paired organs? (eye/ear/kidney/testicle)				Yes	No				
Birth defects?		Yes	No					Hospitalizations? When? What for?				Yes	No				
Developmental delay?		Yes	No					Surgery? (List all.) When? What for?				Yes	No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes	No					Serious injury or illness?				Yes	No				
Diabetes?		Yes	No					TB skin test positive (past/present)?				Yes*	No	*If yes, refer to local health department.			
Head injury/Concussion/Passed out?		Yes	No					TB disease (past or present)?				Yes*	No				
Seizures? What are they like?		Yes	No					Tobacco use (type, frequency)?				Yes	No				
Heart problem/Shortness of breath?		Yes	No					Alcohol/Drug use?				Yes	No				
Heart murmur/High blood pressure?		Yes	No					Family history of sudden death before age 50? (Cause?)				Yes	No				
Dizziness or chest pain with exercise?		Yes	No					Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other									
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____																	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																	
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			BMI PERCENTILE			B/P		
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>																	
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 <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read _____ Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported _____ Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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		<input type="checkbox"/> Diagnosis of Asthma						Mental Health									
Currently Prescribed Asthma Medication: <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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> INTERSCHOLASTIC SPORTS Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>																	
Print Name						(MD,DO, APN, PA) Signature						Date					
Address						Phone											