



## State of Illinois Certificate of Child Health Examination

<b>Student's Name</b>				<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>													
Last		First		Middle		Month/Day/Year														
Address				Parent/Guardian		Telephone # Home														
Street				City		Zip Code														
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> 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.</b>																				
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		
<b>DTP or DTaP</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
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
Hib Haemophilus influenza type b																				
Pneumococcal Conjugate																				
Hepatitis B																				
MMR Measles Mumps, Rubella																				
Varicella (Chickenpox)																				
Meningococcal conjugate (MCV4)																				
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																				
Hepatitis A																				
HPV																				
Influenza																				
Other: Specify Immunization Administered/Dates																				
<b>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.</b>																				
<b>Signature</b>										<b>Title</b>					<b>Date</b>					
<b>Signature</b>										<b>Title</b>					<b>Date</b>					
<b>ALTERNATIVE PROOF OF IMMUNITY</b>																				
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> *MEASLES (Rubeola) MO DA YR    **MUMPS MO DA YR    HEPATITIS B MO DA YR    VARICELLA MO DA YR																				
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> 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.																				
<b>Date of Disease</b>					<b>Signature</b>										<b>Title</b>					
<b>3. Laboratory Evidence of Immunity (check one)    <input type="checkbox"/>Measles*    <input type="checkbox"/>Mumps**    <input type="checkbox"/>Rubella    <input type="checkbox"/>Varicella    Attach copy of lab result.</b>																				
*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.																				
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b> <b>Physician Statements of Immunity MUST be submitted to IDPH for review.</b>																				

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Apellido		Nombre		Inicial	Fecha de Nacimiento	Sexo	Escuela	Grado/Núm. de Ident.
					Mes / Día / Año			
HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD								
ALERGIAS (Alimentos, drogas, insectos, otro)		Sí No	Anótelas todas:		MEDICINAS (Anoté todas las recetas o tomadas con regularidad)		Sí No	
¿Tiene diagnóstico de asma?		Sí No			¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)		Sí No	
¿Despierta el niño tosiendo en la noche?		Sí No			¿Ha sido hospitalizado?		Sí No	
¿Tiene defectos de nacimiento?		Sí No			¿Cuándo? ¿Para qué?		Sí No	
¿Tiene retrasos del desarrollo?		Sí No			¿Ha tenido alguna cirugía?(anótelas todas)		Sí No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro		Sí No			¿Cuándo? ¿Para qué?		Sí No	
¿Tiene diabetes?		Sí No			¿Ha tenido heridas graves o enfermedades?		Sí No	
¿Tiene heridas en la cabeza/golpe/desmayo?		Sí No			¿Prueba positiva de TB (Pasado o Presente)?		Sí No	*Si contestó sí, refiera al departamento de salud local
¿Tiene convulsiones? Cómo se manifiestan?		Sí No			¿Enfermedad de TB (Pasado o Presente)?		Sí No	
¿Tiene problemas cardiacos/No respira bien?		Sí No			¿Usa tabaco (tipo, frecuencia)?		Sí No	
¿Tiene soplo en el corazón/presión arterial alta?		Sí No			¿Toma alcohol/drogas?		Sí No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?		Sí No			¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?		Sí No	
¿Problemas con los ojos/visión? Lentes <input type="checkbox"/> Lentes de Contacto <input type="checkbox"/> Último examen <input type="checkbox"/>					Dental <input type="checkbox"/> Ganchos <input type="checkbox"/> Puente <input type="checkbox"/> Placas <input type="checkbox"/> Otro			
¿Otras Preocupaciones? (bizo, párpados caídos, parpadear, dificultad cuando lee)								
¿Tiene problemas de los oídos/no oye bien?		Sí No			La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.			
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?		Sí No			Firma del Padre/Tutor		Fecha	
<b>PHYSICAL EXAMINATION REQUIREMENTS</b> 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 <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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> .								
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)					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: <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			