

State of Illinois Certificate of Child Health Examination

Student's Name	Birth Date	Sex Race/Ethnicity			/Ethnicity	School /Grade Level/ID#					
Last	First	Middle									
Address Stre	eet City	Zip Code	Parent/Guardian	Telephone # Home				y	Work		
IMMINIZATIONS. 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	DOSE 1	DOSE 2	DOSE 3		DOSE 4		DOSE 5		DOSE 6		
Vaccine / Dose	MO DA YR	MO DA YR	MO DA YR	МО	DA	YR	MO DA	YR	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□D		DT	□Tdap□Td□DT		□Tdap□Td□DT		
Polio (Check specific type)	☐ IPV ☐ OPV								□ IPV □ OPV		
Hib Haemophilus influenza type b											
Pneumococcal Conjugate											
Hepatitis B											
MMR Measles Mumps. Rubella				Con	nments:		* indicates in	valid	dose		
Varicella (Chickenpox)				1							
Meningococcal		-		1							
conjugate (MCV4)	1			1							
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose											
Hepatitis A				1							
HPV											
Influenza											
Other: Specify											
Immunization Administered/Dates											
	er (MD, DO, APN, P	A sobool boolth mus	fossional hoolth offi	oiel\ v	ovifying	above	immunicatio	n histo	my must sign below		
	e above immunization					above		II HISTU	iry must sign below.		
Signature			Title				Da	te			
Signature	Title				Date						
ALTERNATIVE P	ROOF OF IMMUN	ITY									
1. Clinical diagnosi	s (measles, mumps, l	nepatitis B) is allowe	d when verified by a	physic	ian and s	suppo	rted with lab o	onfirm	nation. Attach		
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)											
*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.

						Birth Date		Sex	Scho	ol		Grade Level/ II		
Last		First			Middle		th/Day/ Year			C4 PT PP	OT TIPE D			
HEALTH HISTORY		A11	COMPLE	TED	AND SIGNED BY PARENT					CARE PRO	OVIDER			
ALLERGIES (Food, drug, insect, other)	Yes No	List:				taken on a regul	ON (Prescribed or as basis.)	Yes L No	ist:					
Diagnosis of asthma? Child wakes during ni	ght cougl	ning?	Yes Yes	No No			t on of one of pa /ear/kidney/testi)	čes No				
Birth defects?			Yes	No		Hospitalizat When? Wh			Y	čes No				
Developmental delay?		Yes	No											
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes	No		Surgery? (I When? Wh			Y	res No				
Diabetes?			Yes	No		Serious inju	or illness?		Y	čes No				
Head injury/Concussion/Passed out?			Yes	No		TB skin test	positive (past/pr	esent)?	Y	es* No	*If yes, ref departmen	er to local health		
Seizures? What are they like?			Yes	No						es* No	departmen			
Heart problem/Shortness of breath?			Yes	No			type, frequency	Open, mediaments.						
Heart murmur/High bl		sure?	Yes	No		Alcohol/Dru	1		_	es No				
Dizziness or chest pair exercise?	Dizziness or chest pain with exercise?			No		before age 5	0? (Cause?)			res No				
	Eye/Vision problems? Glasses Contacts Last exam by eye doctor Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)						Braces Bridge Plate Other							
Ear/Hearing problems		opang man,	Yes	No			be shared with appropriate personnel for health and educational purposes.							
Bone/Joint problem/in						— Parent/Gua Signature	Date							
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be comp														
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes No Ethnic Minority Yes No Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovari							And any two of the following: Family History Yes \(\Delta \) No \(\Delta \)							
LEAD DISK OUFST	IONNAT	Signs of a	rired for c	hildr	en age 6 months through 6 vi	a, polycystic ovai	licensed or public school operated day care, preschool, nursery school							
and/or kindergarten. (Blood tes	t required	if resides	in C	hicago or high risk zip code.)								
Questionnaire Admin	istered?	Yes 🗖 N	o 🔲 1		Test Indicated? Yes N		od Test Date Result							
TB SKIN OR BLOOI	TEST	Recommen	ided only f	or chi	ldren in high-risk groups includir sk categories. See CDC guidelin	ng children immu es http://www	obsuppressed due v cdc.gov/tb/pul	to HIV int olications	fection of s/facts	or other cond heets/testin	litions, frequ g/TB testin	ent travel to or born		
No test needed		rformed [Test: Date Read	V 5.	Result: Positive Negative mm							
			E	lood	Test: Date Reported		Result: Positiv	re 🗆 🛚 N	legativ		Value			
LAB TESTS (Recomme	1	Date	4	Results	9:11.0	1 (1 : 1)	. 0	+	Date	+-	Results			
Hemoglobin or Hematocrit				+			ell (when indicated in the control of the control o		+		+			
Urinalysis		Commen	-ts/Ealler		/Noods	Бечеюр	-	Normal	Comi	ments/Foll	ow-up/Nee	ds		
SYSTEM REVIEW	Normal	Commen	IUS/ F OHO	v-up/	Trecus	Endocr		101 224						
Skin		-		_		_								
Ears				_	Screening Result:		ntestinal		_		TAM			
Eyes					Screening Result:		Urinary		_		LMP			
Nose						Neurole	gical		_					
Throat						Muscul	skeletal							
Mouth/Dental						Spinal 1	xam							
Cardiovascular/HTN					1	Nutritio	nal status							
Respiratory					☐ Diagnosis of Asthma	Mental	Health							
Currently Prescribed Asthma Medication: Quick-relief medication (e.g. Short Acting Beta Agonist) Oth														
Controller medication (e.g. inhaled corticosteroid) NEEDS/MODIFICATIONS required in the school setting DIETAR						RY Needs/Restrictions								
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacer							maker, 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:						☐ Teacher ☐ Counselor ☐ Principal								
EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insec						-								
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.)							
On the basis of the examination of this day, 1 approve his clind's participation in PHYSICAL EDUCATION Yes No Modified INTERSCHOLASTIC														
Print Name (MD,DO, APN, PA) Signature							Date							
Address								Phone						