



**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			
<b>Address</b>				<b>Parent/Guardian</b>	<b>Telephone # Home</b>	<b>Work</b>	
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
<b>DTP or DTaP</b>																		
<b>Tdap: Td or Pediatric DT</b> (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
<b>Polio</b> (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	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV		
<b>Hib Haemophilus influenzae type b</b>																		
<b>Pneumococcal Conjugate</b>																		
<b>Hepatitis B</b>																		
<b>MMR Measles Mumps Rubella</b>																		
<b>Varicella (Chickenpox)</b>																		
<b>Meningococcal conjugate (MCV4)</b>																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																		
<b>Hepatitis A</b>																		
<b>HPV</b>																		
<b>Influenza</b>																		
<b>Other: Specify Immunization Administered/Dates</b>																		

**Comments:**

**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>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**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	
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>																	
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes	No	List:				<b>MEDICATION</b> (Prescribed or taken on a regular basis.)			Yes	No	List:				
Diagnosis of asthma?				Yes	No	Child wakes during night coughing?				Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)			Yes	No	
Birth defects?				Yes	No	Developmental delay?				Yes	No	Hospitalizations? When? What for?			Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.				Yes	No	Diabetes?				Yes	No	Surgery? (List all.) When? What for?			Yes	No	
Head injury/Concussion/Passed out?				Yes	No	Seizures? What are they like?				Yes	No	Serious injury or illness?			Yes	No	
Heart problem/Shortness of breath?				Yes	No	Heart murmur/High blood pressure?				Yes	No	TB skin test positive (past/present)?			Yes*	No	
Dizziness or chest pain with exercise?				Yes	No	Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Yes	No	TB disease (past or present)?			Yes*	No	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Yes	No	Ear/Hearing problems?				Yes	No	Tobacco use (type, frequency)?			Yes	No	
Bone/Joint problem/injury/scoliosis?				Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____				Yes	No	Alcohol/Drug use?			Yes	No	
Information may be shared with appropriate personnel for health and educational purposes.																	
Parent/Guardian Signature												Date					
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>																	
HEAD CIRCUMFERENCE if < 2-3 years old				HEIGHT				WEIGHT				BMI		B/P			
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI &gt; 85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>																	
<b>LEAD RISK QUESTIONNAIRE:</b> 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.) <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Result</b> _____																	
<b>TB SKIN OR BLOOD TEST</b> 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> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____																	
<b>LAB TESTS (Recommended)</b>		Date		Results				Date		Results							
Hemoglobin or Hematocrit				Sickle Cell (when indicated)													
Urinalysis				Developmental Screening Tool													
<b>SYSTEM REVIEW</b>	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:							Other										
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																	
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																	
<b>NEEDS/MODIFICATIONS</b> required in the school setting							<b>DIETARY</b> Needs/Restrictions										
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																	
<b>MENTAL HEALTH/OTHER</b> 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																	
<b>EMERGENCY ACTION</b> 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.)																	
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>																	
Print Name				(MD, DO, APN, PA) Signature				Date									
Address										Phone							