



**STATE OF ILLINOIS  
DEPARTMENT OF HUMAN SERVICES  
CERTIFICATE OF CHILD HEALTH EXAMINATION**

Please Print

|                       |       |        |                   |            |               |                         |
|-----------------------|-------|--------|-------------------|------------|---------------|-------------------------|
| <b>Student's Name</b> |       |        | <b>Birth Date</b> | <b>Sex</b> | <b>School</b> | <b>Grade Level /ID#</b> |
| Last                  | First | Middle | Month/Day/ Year   |            |               |                         |

|                |      |          |                             |                             |             |
|----------------|------|----------|-----------------------------|-----------------------------|-------------|
| <b>Address</b> |      |          | <b>Parent/<br/>Guardian</b> | <b>Telephone #<br/>Home</b> | <b>Work</b> |
| Street         | City | ZIP code |                             |                             |             |

**IMMUNIZATIONS:** To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

| VACCINE/DOSE                                     | 1                             |                                |                               | 2                              |                               |                                | 3                             |                                |                               | 4                              |                               |                                | 5                             |                                |                               | 6                              |                               |                                |
|--|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|-------------------------------|--------------------------------|
|  | MO                            | DA                             | YR                            | MO                             | DA                            | YR                             | MO                            | DA                             | YR                            | MO                             | DA                            | YR                             | MO                            | DA                             | YR                            | MO                             | DA                            | YR                             |
| Diphtheria, Tetanus and Pertussis (DTP or DTaP)  |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Diphtheria and Tetanus (Pediatric DT or Td)      |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Inactivated Polio (IPV)                          |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Oral Polio (OPV)                                 |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Haemophilus influenzae type b (Hib)              |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Hepatitis B (HB)                                 |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Varicella (Chickenpox)                           |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               | Comments                       |
| Combined Measles, Mumps and Rubella (MMR)        |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Measles (Rubeola)                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Rubella (3-day measles)                          |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Mumps  |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Pneumococcal (not required for school entry)     | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 | <input type="checkbox"/> PCV7 | <input type="checkbox"/> PPV23 |
| Check specific type (PCV7, PPV23)                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |
| Other (Specify hepatitis A, meningococcal, etc.) |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |                               |                                |

**Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.**

|  |              |             |
|--|--------------|-------------|
| <b>Signature</b>   | <b>Title</b> | <b>Date</b> |
| <b>Signature</b><br>(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) | <b>Title</b> | <b>Date</b> |
| <b>Signature</b><br>(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) | <b>Title</b> | <b>Date</b> |

**ALTERNATIVE PROOF OF IMMUNITY**

1. **Clinical diagnosis is acceptable if verified by physician.** \*(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

\*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

2. **History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.**  
Person signing below is verifying 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 | Date |
|-----------------|-----------|-------|------|

3. **Laboratory confirmation (check one)**  Measles  Mumps  Rubella  Hepatitis B  Varicella  
**Lab Results** Date MO DA YR (Attach copy of lab report, if available.)

**VISION AND HEARING SCREENING DATA**

| Pre-school – annually beginning at age 3; School age – during school year at required grade levels |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
|--|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Age/Grade  | R | L | R | L | R | L | R | L | R | L | R | L | R | L |
| Vision   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| Hearing  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

**Code:**  
**P = Pass**  
**F = Fail**  
**U = Unable to test**  
**R = Referred**  
**G/C = Glasses/Contacts**

|  |                                      |            |               |                          |
|--|--------------------------------------|------------|---------------|--------------------------|
| <b>Student's Name</b><br>Last First Middle | <b>Birth Date</b><br>Month/Day/ Year | <b>Sex</b> | <b>School</b> | <b>Grade Level/ ID #</b> |
|--|--------------------------------------|------------|---------------|--------------------------|

**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

|  |            |          |  |   |             |
|--|------------|----------|--|---|-------------|
| <b>ALLERGIES</b> (Food, drug, insect, other)   |            |          | <b>MEDICATION</b> (List all prescribed or taken on a regular basis.) |   |             |
| Diagnosis of asthma?<br>Child wakes during the night coughing  | Yes<br>Yes | No<br>No | Indicate Severity  | Loss of function of one of paired organs? (eye/ear/kidney/testicle)   | Yes No      |
| Birth defects?   | Yes        | No       |  | Hospitalizations?<br>When? What for?  | Yes No      |
| Developmental delay?   | Yes        | No       |  | Surgery? (List all.)<br>When? What for?   | Yes No      |
| Blood disorders? Hemophilia,<br>Sickle Cell, Other? Explain.   | Yes        | No       |  | Serious injury or illness?  | Yes No      |
| Diabetes?  | Yes        | No       |  | TB skin test positive (past/present)?   | Yes* No     |
| 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<br>before age 50? (Cause?)   | Yes No      |
| Dizziness or chest pain with<br>exercise?  | Yes        | No       |  | Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate Other |             |
| Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____<br>Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) |            |          |  | Other concerns?   |             |
| Ear/Hearing problems?  | Yes        | No       |  | Information may be shared with appropriate personnel for health and educational purposes.                   |             |
| Bone/Joint problem/injury/scoliosis?   | Yes        | No       |  | <b>Parent/Guardian<br/>Signature</b>  | <b>Date</b> |

**Entire section below to be completed by MD/DO/APN/PA (\*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)**

|   |                  |   |                                   |                              |
|---|------------------|---|-----------------------------------|------------------------------|
| <b>PHYSICAL EXAMINATION REQUIREMENTS</b>  | <b>HEIGHT</b>    | <b>WEIGHT</b>   | <b>BMI</b>                        | <b>B/P</b>                   |
| <b>DIABETES SCREENING 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"/><br><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.<br><b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> <b>Blood Test Result</b> (Blood test required in Chicago and other high risk zip codes.)   |                  |   |                                   |                              |
| <b>TB SKIN TEST</b> Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. <b>Date Read</b> / / <b>Result</b> mm   |                  |   |                                   |                              |
| <b>LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES</b>   | Date             | Results   | Date                              | Results                      |
| Hemoglobin * or Hematocrit *  |                  |   |                                   | Sickle Cell * (as indicated) |
| Urinalysis  |                  |   |                                   | Other                        |
| <b>SYSTEM REVIEW</b>  | Normal           | Comments/Follow-up/Needs  | Normal                            | Comments/Follow-up/Needs     |
| Skin  |                  |   | Endocrine                         |                              |
| Ears  |                  |   | Gastrointestinal                  |                              |
| Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/><br>Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>  |                  | Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Result _____<br>Referred to Ophthalmologist/Optometrist Yes <input type="checkbox"/> No <input type="checkbox"/> | Genito-Urinary                    | LMP                          |
| Nose  |                  |   | Neurological                      |                              |
| Throat  |                  |   | Musculoskeletal                   |                              |
| Mouth/Dental  |                  |   | Spinal examination                |                              |
| Cardiovascular/HTN  |                  |   | Nutritional status                |                              |
| Respiratory   |                  |   | Mental Health                     |                              |
| <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?<br>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)?<br>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> (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>  |                                   |                              |
| Physician/Advanced Practice Nurse/Physician Assistant performing examination  |                  |   |                                   |                              |
| <b>Print Name</b>   | <b>Signature</b> |   |                                   | <b>Date</b>                  |
| <b>Address</b>  | <b>Phone</b>     |   |                                   |                              |

(Complete both sides)