



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 Street City Zip Code				Parent/Guardian Telephone # Home Work				
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> 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	
	MO	DA	YR	MO	DA	YR	MO	DA
DTP or DTaP								
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT	
Polio (Check specific type)	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Hib Haemophilus influenza type b								
Pneumococcal Conjugate								
Hepatitis B								
MMR Measles Mumps. Rubella								
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	Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes	No
Child wakes during night coughing?		Yes	No				
Birth defects?		Yes	No	Hospitalizations? When? What for?		Yes	No
Developmental delay?		Yes	No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes	No	Surgery? (List all.) When? What for?		Yes	No
Diabetes?		Yes	No	Serious injury or illness?		Yes	No
Head injury/Concussion/Passed out?		Yes	No	TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?		Yes	No	TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?		Yes	No	Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?		Yes	No	Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?		Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____				Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other _____			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Information may be shared with appropriate personnel for health and educational purposes.			
Ear/Hearing problems?		Yes	No	Parent/Guardian			
Bone/Joint problem/injury/scoliosis?		Yes	No	Signature Date			

PHYSICAL EXAMINATION REQUIREMENTS - Entire section below to be completed by MD/DO/PA/NP/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 ☐ No ☐ And any two of the following: Family History Yes ☐ No ☐ Ethnic Minority Yes ☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes ☐ No ☐ At Risk Yes ☐ No ☐								
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 ☐ No ☐		Blood Test Indicated? Yes ☐ No ☐		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 ☐		Test performed ☐		Skin Test: Date Read / / Result: Positive ☐ Negative ☐ mm _____ Blood Test: Date Reported / / Result: Positive ☐ Negative ☐ 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		☐ Diagnosis of Asthma			Mental Health			
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ 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: ☐ Nurse ☐ Teacher ☐ Counselor ☐ 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 ☐ 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.) PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐								
Print Name _____ (MD,DO, APN, PA)				Signature _____		Date _____		
Address _____				Phone _____				