



State of Illinois
Certificate of Child Health Examination

Student's Name, Birth Date, Sex, Race/Ethnicity, School /Grade Level/ID#, Address, Street, City, Zip Code, Parent/Guardian, Telephone # Home, Work

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.

Table with columns for DOSE 1 through DOSE 6 and rows for various vaccines: DTP or DTaP, Tdap, Polio, Hib, Pneumococcal Conjugate, Hepatitis B, MMR, Varicella, Meningococcal conjugate (MCV4), Hepatitis A, HPV, Influenza, Other: Specify Immunization Administered/Dates.

Comments: (Large empty box for handwritten notes)

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 (Two rows for provider and parent/guardian)

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 (Form for alternative 2)

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.

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.
----------	--------	---------	--	------	---------	----------------------

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 <input type="checkbox"/> No <input type="checkbox"/>	Anótelas todas:	MEDICINAS (Anote todas las recetadas o tomadas con regularidad)	Sí <input type="checkbox"/> No <input type="checkbox"/>
¿Tiene diagnóstico de asthma? ¿Despierta el niño tosiendo en la noche?	Sí No		¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí No
¿Tiene defectos de nacimiento?	Sí No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	Sí No
¿Tiene retrasos del desarrollo?	Sí No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	Sí No
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí No		¿Ha tenido heridas graves o enfermedades?	Sí No
¿Tiene diabetes?	Sí No		¿Prueba positiva de TB (Pasado o Presente)?	Sí No
¿Tiene heridas en la cabeza/golpe/desmayo?	Sí No		¿Enfermedad de TB (Pasado o Presente)?	Sí No
¿Tiene convulsiones? Cómo se manifiestan?	Sí No		¿Usa tabaco (tipo, frecuencia)?	Sí No
¿Tiene problemas cardiacos/No respira bien?	Sí No		¿Toma alcohol/drogas?	Sí No
¿Tiene soplo en el corazón/presión arterial alta?	Sí No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	Sí No
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí No			
¿Problemas con los ojos/visión? <input type="checkbox"/> 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? (bizco, 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

PHYSICAL EXAMINATION REQUIREMENTS 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 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		<input type="checkbox"/> Diagnosis of Asthma	Mental Health	

Currently Prescribed Asthma Medication:
 Quick-relief medication (e.g. Short Acting Beta Agonist)
 Controller medication (e.g. inhaled corticosteroid)

NEEDS/MODIFICATIONS required in the school setting **Other**

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** _____