



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

Parents need to complete the top section on the back of this form....

Please Print

Student's Name			Birth Date	Sex	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. Note the mo/da/yr for every date administered. The day and month is required if you cannot determine if the vaccine was given after the minimum interval of 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)																			
Combined Measles, Mumps and Rubella (MMR)																			
Measles (Rubella)																			
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		
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.

Signature	Title	Date
Signature (If adding dates to the above immunization history section, put year initials by date(s) and sign here.)	Title	Date
Signature (If adding dates to the above immunization history section, put year initials by date(s) and sign here.)	Title	Date

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 (Rubella) 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. Form signing below is certifying that the prescriber'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																Code: P = Pass F = Fail U = Unable to Test R = Referred G/C = Glasses/Contact	
Age/Grade	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R		L
Vision																	
Hearing																	

Printed by Authority of the State of Illinois
(Complete Both Sides)

IL444-4737 (R-01-05)

Attention!!

Parents need to complete the top section on the back of this form....

Please Turn Over →

Student's Name <small>Last First Middle</small>			Birth Date <small>Month/Day/Year</small>		Sex	School	Grade Level/ID #
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HEALTH HISTORY ← TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

PARENTS	ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis)			
	Diagnosis of asthma? Child wakes during the night coughing	Yes No	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/heart/etc)	Yes	No
	Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No
	Developmental delay?	Yes	No		Surgery? (List all) When? What for?	Yes	No
	Blood disorders? Hemophilia, 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 before age 50? (Cause?)	Yes	No
Dizziness or chest pain with exercise?	Yes	No		Denial <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor				Other concerns? (trauma eye, drooping lids, squinting, difficulty reading)			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature _____ Date _____			
Bone/Joint problem/injury/ scoliosis?	Yes	No		Your signature required.			

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

PHYSICAL EXAMINATION REQUIREMENTS		HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING BMI > 85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/>		Signs of Insulin Resistance (obesity, acanthosis nigricans, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/>		At Risk	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date _____ Blood Test Result _____ (Blood test required in Chicago and other high risk zip codes.)					
TB SKIN TEST 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. Date Read ____/____/____ Result _____ mm					
LAB TESTS • INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES		Date	Results	Date	Results
Hemoglobin * or Hematocrit *				Sickle Cell * (as indicated)	
Urinalysis				Other	
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin				Endocrine	
Ears				Gastrointestinal	
Eyes Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> 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	
NEEDS/MODIFICATIONS required in the school setting			DIETARY Needs/Restrictions		
SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for anemia, 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <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.)		
PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>		
Physician/Advanced Practice Nurse/Physician Assistant performing examination					
Print Name		Signature		Date	
Address			Phone		

(Complete both sides)