



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 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
DTP or DTaP																		
Tdap, Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT			☐ Tdap ☐ Td ☐ DT			☐ Tdap ☐ Td ☐ DT			☐ Tdap ☐ Td ☐ DT			☐ Tdap ☐ Td ☐ DT			☐ Tdap ☐ Td ☐ DT		
Polio (Check specific type)	☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV			☐ IPV ☐ OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps, Rubella										Comments:								
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					Hospitalizations?			Yes No						
Birth defects?			Yes No					When? What for?			Yes No						
Developmental delay?			Yes No					Surgery? (List all.)			Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes No					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)																	
Ear/Hearing problems?			Yes No					Information may be shared with appropriate personnel for health and educational purposes.									
Bone/Joint problem/injury/scoliosis?			Yes No					Parent/Guardian Signature			Date						
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				☐ Diagnosis of Asthma			Mental Health										
Currently Prescribed Asthma Medication:								Other									
☐ Quick-relief medication (e.g. Short Acting Beta Agonist)																	
☐ Controller medication (e.g. inhaled corticosteroid)																	
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									