State of Illinois  
Certificate of Child Health Examination  

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>School /Grade Level/ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>Middle</td>
<td>Month/Day/Year</td>
<td>Parent/Guardian</td>
</tr>
<tr>
<td>Address</td>
<td>Street</td>
<td>City</td>
<td>Zip Code</td>
<td></td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Vaccine / Dose</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Tdap, Td or Pediatric DT (Check specific type)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Polio (Check specific type)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hib Haemophilus influenza type b</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hepatitis B (HB)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>MMR Combined Measles Mumps. Rubella</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Single Antigen Vaccines</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pneumococcal Conjugate</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other/Specify Meningococcal, Hepatitis A, HPV, Influenza</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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.

**COMMENTS:**

[Table for vision and hearing screening]

**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.

<table>
<thead>
<tr>
<th>Date of Disease</th>
<th>Signature</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

3. Laboratory confirmation (check one) ☐Measles ☐Mumps ☐Rubella ☐Hepatitis B ☐Varicella

<table>
<thead>
<tr>
<th>Lab Results</th>
<th>Date MO DA YR</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

[Table for vision and hearing screening]

**VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN**

<table>
<thead>
<tr>
<th>Date</th>
<th>Code:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age/ Grade</td>
<td>P = Pass</td>
</tr>
<tr>
<td>R L R L R L R L R L R L R L R L</td>
<td>F = Fail</td>
</tr>
<tr>
<td>Vision</td>
<td>U = Unable to test</td>
</tr>
<tr>
<td>Hearing</td>
<td>R = Referred</td>
</tr>
<tr>
<td></td>
<td>Glasses/Contacts</td>
</tr>
</tbody>
</table>
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

**ALLERGIES** (Food, drug, insect, other)  
**MEDICATION** (List all prescribed or taken on a regular basis.)

<table>
<thead>
<tr>
<th>Diagnosis of asthma?</th>
<th>Yes</th>
<th>No</th>
<th>Loss of function of one of paired organs? (eye/ear/kidney/testicle)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child wakes during night coughing?</td>
<td>Yes</td>
<td>No</td>
<td>Hospitalizations?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Birth defects?</td>
<td>Yes</td>
<td>No</td>
<td>When? What for?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Developmental delay?</td>
<td>Yes</td>
<td>No</td>
<td>Surgery? (List all.)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood disorders? Hemophilia, Sickle Cell, Other? Explain.</td>
<td>Yes</td>
<td>No</td>
<td>Serious injury or illness?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes?</td>
<td>Yes</td>
<td>No</td>
<td>TB skin test positive (past/present)?</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>Head injury/Concussion/Passed out?</td>
<td>Yes</td>
<td>No</td>
<td>TB disease (past or present)?</td>
<td>Yes*</td>
<td>No</td>
</tr>
<tr>
<td>Seizures? What are they like?</td>
<td>Yes</td>
<td>No</td>
<td>Tobacco use (type, frequency)?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart problem/Shortness of breath?</td>
<td>Yes</td>
<td>No</td>
<td>Alcohol/Drug use?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart murmur/High blood pressure?</td>
<td>Yes</td>
<td>No</td>
<td>Family history of sudden death before age 50? (Cause?)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dizziness or chest pain with exercise?</td>
<td>Yes</td>
<td>No</td>
<td>Information may be shared with appropriate personnel for health and educational purposes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye/Vision problems?</td>
<td>Glasses</td>
<td>Contacts</td>
<td>Last exam by eye doctor</td>
<td>Dental</td>
<td>Braces</td>
</tr>
<tr>
<td>Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SYSTEM REVIEW**  
**Normal Comments/Follow-up/Needs**

<table>
<thead>
<tr>
<th>Head Circumference</th>
<th>If &lt; 2-3 years old</th>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
<th>B/P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Screening</td>
<td>(Not Required for Day Care)</td>
<td>BMI&lt;85% age/sex</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Ethnic Minority</td>
<td>Yes</td>
<td>No</td>
<td>Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**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.)

**PHYSICAL EXAMINATION REQUIREMENTS**  
**Entire section below to be completed by MD/DO/APN/PA**

**HEAD CIRCUMFERENCE**

**HEIGHT**

**WEIGHT**

**BMI**

**B/P**

**DIABETES SCREENING**  
**BMIB<85% age/sex**

**Ethnic Minority**  
**Yes**

**No**

| Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) | Yes | No | At Risk |

**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.

**Skin Test:**  
Date Read | / | Result | Positive | Negative | mm

**Blood Test:**  
Date Reported | / | Result | Positive | Negative | Value

**LAB TESTS** (Recommended)

| Hemoglobin or Hematocrit
| Urinalysis
| | Developmental Screening Tool

**SYSTEM REVIEW**  
**Normal Comments/Follow-up/Needs**

| Skin
| Endocrine
| Gastrointestinal
| Amblyopia | Genito-Urinary | LMP
| Nose
| Neurological
| Throat
| Musculoskeletal
| Mouth/Dental
| Spinal Exam
| Cardiovascular/HTN
| Nutritional status
| Respiratory
| Diagnosis of Asthma | Mental Health |
| | 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

**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 | Limited

| Print Name
| (MD, DO, APN, PA) | Signature
| Address
| Phone

(Complete Both Sides)