



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

Please Print

|                       |       |        |                   |            |               |                         |
|-----------------------|-------|--------|-------------------|------------|---------------|-------------------------|
| <b>Student's Name</b> |       |        | <b>Birth Date</b> | <b>Sex</b> | <b>School</b> | <b>Grade Level /ID#</b> |
| Last                  | First | Middle | Month/Day/Year    |            |               |                         |

|                |               |             |                 |                        |                         |             |
|----------------|---------------|-------------|-----------------|------------------------|-------------------------|-------------|
| <b>Address</b> | <b>Street</b> | <b>City</b> | <b>ZIP code</b> | <b>Parent/Guardian</b> | <b>Telephone # Home</b> | <b>Work</b> |
|----------------|---------------|-------------|-----------------|------------------------|-------------------------|-------------|

**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 on 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.

| 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)                           |  |    |    |  |    |    |  |    |    |  |    |    |  |    |    |  |    | Comments |
| Combined Measles, Mumps and Rubella (MMR)        |  |    |    |  |    |    |  |    |    |  |    |    |  |    |    |  |    |          |
| Measles (Rubeola)                                |  |    |    |  |    |    |  |    |    |  |    |    |  |    |    |  |    |          |
| 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.

|  |              |             |
|--|--------------|-------------|
| <b>Signature</b>   | <b>Title</b> | <b>Date</b> |
| <b>Signature</b><br>(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) | <b>Title</b> | <b>Date</b> |
| <b>Signature</b><br>(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) | <b>Title</b> | <b>Date</b> |

**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.

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:    |          |                    |                        |
| Age/Grade  |   |   |   |   |   |   |   |   |   |   |   |   |   |   | P = Pass | F = Fail | U = Unable to test |                        |
|  | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R        | L        | R = Referred       | G/C = Glasses/Contacts |
| Vision   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |          |          |                    |                        |
| Hearing  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |          |          |                    |                        |

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|  |  |  |                                     |  |            |               |                          |
|--|--|--|-------------------------------------|--|------------|---------------|--------------------------|
| <b>Student's Name</b><br>Last First Middle |  |  | <b>Birth Date</b><br>Month/Day/Year |  | <b>Sex</b> | <b>School</b> | <b>Grade Level/ ID #</b> |
|--|--|--|-------------------------------------|--|------------|---------------|--------------------------|

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

**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                      |
|--|---|--|-----------------------------------|--|--------------------------|
| <b>DIABETES SCREENING</b> BMD-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"/><br>Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/> |   |  |                                   |  |                          |
| <b>LEAD RISK QUESTIONNAIRE</b> * Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.<br>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.)  |   |  |                                   |  |                          |
| <b>TB SKIN TEST</b> 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  |   |  |                                   |  |                          |
| <b>LAB TESTS</b> *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES  |   | Date   | Results                           | Date   | Results                  |
| Hemoglobin * or Hematocrit *   |   |  |                                   | Sickle Cell * (as indicated)   |                          |
| Urinalysis   |   |  |                                   | Other  |                          |
| <b>SYSTEM REVIEW</b>   | 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"/>                      | Result   |                                   | Genito-Urinary   | LMP                      |
| Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>   | Referred to Ophthalmologist/Optomestrist Yes <input type="checkbox"/> No <input type="checkbox"/> |  |                                   | Neurological   |                          |
| Nose   |   |  |                                   | Musculoskeletal  |                          |
| Throat   |   |  |                                   | Spinal examination   |                          |
| Mouth/Dental   |   |  |                                   | Nutritional status   |                          |
| Cardiovascular/HTN   |   |  |                                   | Mental Health  |                          |
| Respiratory  |   |  |                                   |  |                          |
| <b>NEEDS/MODIFICATIONS</b> required in the school setting  |   |  | <b>DIETARY</b> Needs/Restrictions |  |                          |
| <b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup   |   |  |                                   |  |                          |
| <b>MENTAL HEALTH/OTHER</b> Is there anything else the school should know about this student?<br>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  |   |  |                                   |  |                          |
| <b>EMERGENCY ACTION</b> needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?<br>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.)   |   |  |                                   |  |                          |
| <b>PHYSICAL EDUCATION</b>  |   | Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> |                                   | <b>INTERSCHOLASTIC SPORTS</b> (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)

CD-11-09 1070-0001