ILLINOIS DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION
(Information on this form may be shared with appropriate personnel for health and educational purposes.)

Please Print

Student's Name	**Birth Date**	Sex	Grade Level	ID#

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* 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.**

VACCINE/DOSE	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 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: **Corrected copy of immunizations**		
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumonococcal (not required for school entry) ☐ PCV7 ☐ PPV23	☐ PCV7 ☐ PPV23	☐ PCV7 ☐ PPV23	☐ PCV7 ☐ PPV23	☐ PCV7 ☐ PPV23	☐ PCV7 ☐ PPV23	☐ PCV7 ☐ PPV23
Check specific type (PCV7, PPV23) Date						
Other (Specify: Hepatitis A, meningoccal, etc)						

Health care provider (MD, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

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

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

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician *(All measles 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

This section to be completed by IDPH certified screening personnel, if pre-existing approved IDPH for is not available.
Pre-school – annually beginning at age 3; School age – during school year at required grade levels.

Date																				
Age/Grade																				
	R	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**
Vision																				
Hearing																				

Code:
P=Pass
F=Fail
U=Unable to test
R=Referred
G/C=Glasses/ Contacts

Printed by Authority of the State of Illinois (over)

IL 444-4737 (N-11-02)

Student's **Name** 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**

	Circle one	Comments		Circle one	Comments
Diagnosis of Asthma? Wheeze/Cough During or After Play?	Yes○ No ○ Yes○ No ○	**Indicate Severity:**	Loss of Function of One of Paired Organs? (Eye/Ear/Kidney/Testicle)	Yes○ No ○	
Birth Defects?	Yes○ No ○		Hospitalizations? When? What for?	Yes○ No ○	
Developmental Delay?	Yes○ No ○				
Blood Disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes○ No ○		Surgery? (List All) 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 or Present)?	Yes○ No ○	*Refer positive response to the 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 or Sudden Death Before Age 50? (Cause?)	Yes○ No ○	
Bone/Joint Problems/Injury? Scoliosis?	Yes○ No ○		Dental •Braces •Bridge •Plate Other		
			Other Concerns?		
Ear/Hearing Problems?	Yes○ No ○		**Information on this form may be shared with appropriate personnel for health And educational purposes.**		
Eye/Vision Problems? Glasses Contacts Last Exam_____ Other Concerns?			**Parent/Guardian Signature** **Date**		

TO BE COMPLETED BY MD/APN/PA **(*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES OR SELECTED SCHOOLS AND PROGRAMS)**

Strongly Recommended Tests	**Date**	**Results**		**Date**	**Results**
Hemoglobin * or			**Urinalysis**		
Hematocrit *			**Sickle Cell * (as needed)**		

Lead Questionnaire* Completed? Yes ◯ No ◯ Date Blood Test Indicated? Yes ◯ No ◯ Blood Test Performed? Yes ◯ No ◯

TB Skin Test Recommended only for children in high-risk groups: Includes 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**

PHYSICAL EXAMINATION REQUIREMENTS **HEIGHT** **WEIGHT** **B/P** **HEART RATE**

	Normal	Comments/Follow-up/Needs		Normal	
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes			Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Examination		
Cardiovascular/HTN			Nutritional Status		
Respiratory			Mental Health		

ALLERGIES (Food, drug, insect, other)

MEDICATION (List all prescribed or taken on a regular basis)

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 supporter/cup**

MENTAL HEALTH/OTHER: **Is there anything else that you think 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 die 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 (for one year) Yes☐ No☐ Limited ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**