

Certificate of Child Health Examination

Student's Name			1	Birth Date (Mo/Day/Yr) Sex Race/Ethnicity		hnicity	School/Grade Level/ID#							
Last	First		Middle											
Street Address		City		ZIP Code	Parent/0	Guardian					Tele	ohone (ho	ome/work)	
HEALTH HISTORY	r: MUS	T BE COMPL	ETED AND	SIGNED	BY PA	RENT/	GUAR	DIAN AND	VERIFIE	D BY	HEALT	H CAR	E PROVIDER	
ALLERGIES	Yes	List:				MEDIC	OITA	N	Yes	List:				
(Food, drug, insect, other)	□ □ No					(Prescrik regular l		aken on a	□ No					
Diagnosis of Asthma?			Yes 🔲	No			Loss o	f function of o	ne of paired	,	Yes	No		
Child wakes during night coughin	g?		Yes 🔲 I	No				talization?	iney/testicie		☐ Yes	ا _{۱۸} ۸		
Birth Defects?			Yes 🔲 I	No				? What for?			☐ 163			
Developmental delay?			Yes 🔲	No				ry? (List all)			Yes	□No		
Blood disorder? Hemophilia, Sick	le Cell, Ot	ther? Explain.	Yes 🔲	No			-	? What for?			□ voc I	ا _{۱۱۵} -		
Diabetes?			Yes 🔲 I	No			-	is injury or illn			∐ Yes			
Head injury/Concussion/Passed out?			Yes 🔲 I				n test positive		Yes*		*If yes, refer to local health department			
Seizures? What are they like?			Yes No					ease (past or p		Yes*		neath department		
Heart problem/Shortness of breath?			Yes No					co use (type, f		∐ Yes				
Heart murmur/High blood pressure?			Yes No				Alcohol/Drug use?				Yes			
Dizziness or chest pain with exercise?			Yes No					/ history of sud)? (Cause?)	petore	Yes	No			
Eye/Vision problems?	ntacts Last ex	octor		+	ental Bra	idge] Plate [Other	r					
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading)						Additional Information:								
Ear/Hearing problems?			Yes No				Information may be shared with appropriate personnel for health and educational purposes.							
Bone/Joint problem/injury/scolic	sis?		Yes No				Parent/Guardian Signatures: Dat							
IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for <i>every</i> dose administered is required. If a specific vaccine is medicontraindicated, 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	М	DOSE 1 D DA YR	DOS MO D		1	DOSE 3 DDA \	/R	DOS MO D		N	DOSE 5		DOSE 6 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	☐ Tda	p 🗌 Td	☐ DT	☐ Tdap ☐ Td ☐ DT	
Polio (Check specific type)	I	PV OPV	☐ IPV	☐ OPV	☐ IF	PV 🗆 O	PV	☐ IPV	☐ OPV		IPV 🗌	OPV	☐ IPV ☐ OPV	
Hib Haemophiles Influenza Type B														
Pneumococcal Conjugate														
Hepatitis B														
MMR Measles, Mumps, Rubella								Comment	s: * ir	ndicates	invalid	dose		
Varicella (Chickenpox)														
Meningococcal Conjugate														
RECOMMENDED, BUT NOT REC	QUIRED \	Vaccine/Dose												
Hepatitis A														
HPV														
Influenza														
Other: Specify Immunization Administered/Dates														
Health care provider (MD, DO								immunizati	on history	l must si	gn belov	v.	<u> </u>	
If adding dates to the above immunization history section, put your initials by date(s) and sign here.														
Signature				Title								Date	e	

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Student's Name				Birth (Mo/Da		Sex		Scho	ool		Grade Level/ID#
Last		First	Middle								
	s of Re		nption to Immunization							of Med	ical Contraindication
			are reviewed and Main	ntaine	ed by t	the Sc	hool <i>P</i>	۱uth	ority.		
ALTERNATIVE PRO											
1	•		patitis B) is allowed when verif **MUMPS (MO/DA/YR)	•			• •				• •
2. History of varice	ella (chic	kenpox) diseas	e is acceptable if verified by he n of varicella disease history is indi	ealth ca	re prov	ider, sch	hool he	alth p	rofessio	al or hea	Ith official. Person signing bel
Date of Disease		Signatur	k one)						Title		attach copy of lab result.
									Varicella	Α	attach copy of lab result.
			July 1, 2002, must be confirm r July 1, 2013, must be confirn								
Physician Stateme	ents of I	mmunity MUST	be submitted to IDPH for rev	view.							
Completion of Alter	natives 1	1 or 3 MUST be a	ccompanied by Labs & Physician	Signatu	ure:						
PHYSICAL EXAMI	NATION	REQUIREMEN	TS Entire section below	to be	comple	eted by	MD/D	O/AP	N/PA		
HEAD CIRCUMFEREN	NCE if < 2	2-3 years old	HEIGHT	WEIGHT	т	_ BI	MI		BMI PE	CENTILE	B/P
DIABETES SCREENIN				Yes 🗌	No	And any	two of	the fo	llowing: F	amily Hist	ory No No
Ethnic Minority 🗌	Yes 🔲 I	No Signs of I	nsulin Resistance (hypertension, dyslip								
LEAD RISK QUESTIO (Blood test required if			ren aged 6 months through 6 years en c zip code.)	rolled in	licensed	or public-s	school op	erate	d day care,	oreschool, r	ursery school and/or kindergarter
Questionnaire Adm	inistered	I? 🗌 Yes 🗌 N	O Blood Test Indicated?	Yes	☐ No	В	lood Te	st Da	te		Result
			or children in high-risk groups includin nigh-risk categories. See CDC guideline	g childre	n immuno	suppress	ed due to	HIV ii	nfection or	other condi	tions, frequent travel to or born in
			kin Test: Date Read							m	
	_		lood Test: Date Reported						Negative	Value	
LAB TESTS (Recommo	andad)	Date	Results			SCREENIN		<u> </u>	-	Date	Results
		Date	Results	Dovol					<u> </u>	Jale	Completed N/A
	bin or Hematocrit Developmental Screening						Completed N/A				
· ·											Completed N/A
Sickle Cell (when indi	cated			Other	r:						
SYSTEM REVIEW	Normal	Comments/Follo	ow-up/Needs				Nor	rmal	Comment	/Follow-u	p/Needs
Skin					Endocrin	ie					
Ears			Screening Result:		Gastroin	testinal					
Eyes			Screening Result:		Genito-l	Jrinary		7			LMP:
Nose			-		Neurolo	gical		7 1			
Throat					Musculo			7			
Mouth/Dental				+	Spinal Ex		17	7			
Cardiovascular/HTN					Nutritio		s	7			
Respiratory			Diagnosis of A				+ -	7			
Currently Prescribed	Asthma N	I Medication:			Other						
Quick-relief me	dication ((e.g., Short Acting	• ,				[
Controller med	ication (e	.g., inhaled cortic	osteroid)								
NEEDS/MODIFICATION	ONS requi	red in the school set	ting		DIETARY	Needs/Re	estrictions	;			
SPECIAL INSTRUCTIO	NS/DEVI	CES (e.g., safety glas	sses, glass eye, chest protector for arrhy	thmia, pa	acemaker,	prosthetic	c device, o	dental	bridge, false	teeth, athle	tic support/cup)
MENTAL HEALTH/OT	THER Is th	here anything else th	ne school should know about this studer	nt?							
1		, •	chool or school health personnel, check	_	Nurse	Teach	ner 🗆 C	Counse	lor Pri	ncipal	
-			o child's health condition (e.g., seizures,			_				-	s, heart problem)?
☐ Yes ☐ No If y			, 5,,	,		, ,					
On the basis of the exan	nination or	n this day, I approve	this child's participation in			((If No or N	/lodifie	d please att	ach explanat	tion.)
PHYSICAL EDUCATIO	N N	es 🗌 No 🗌 M	odified INTERSCHOLASTIC S	SPORTS	☐ Yes	☐ No	□ Мо	dified	<u> </u>		
Print Name				APN	PA Si	gnature					Date
Address											Phone