



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				Parent/Guardian								
Street	City	Zip Code		Telephone #		Home	Work					
IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> 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
DTP or DTaP												
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap	☐ Td	☐ DT	☐ Tdap	☐ Td	☐ DT	☐ Tdap	☐ Td	☐ DT	☐ Tdap	☐ Td	☐ DT
Polio (Check specific type)	☐ IPV	☐ OPV		☐ IPV	☐ OPV		☐ IPV	☐ OPV		☐ IPV	☐ OPV	
Hib Haemophilus influenza type b												
Pneumococcal Conjugate												
Hepatitis B												
MMR Measles Mumps Rubella												
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? When? What for?			Yes		No					
Birth defects?			Yes		No		Surgery? (List all.) When? What for?			Yes		No					
Developmental delay?			Yes		No		Serious injury or illness?			Yes		No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes		No		TB skin test positive (past/present)?			Yes*		No		*If yes, refer to local health department.			
Diabetes?			Yes		No		TB disease (past or present)?			Yes*		No					
Head injury/Concussion/Passed out?			Yes		No		Tobacco use (type, frequency)?			Yes		No					
Seizures? What are they like?			Yes		No		Alcohol/Drug use?			Yes		No					
Heart problem/Shortness of breath?			Yes		No		Family history of sudden death before age 50? (Cause?)			Yes		No					
Heart murmur/High blood pressure?			Yes		No		Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other										
Dizziness or chest pain with exercise?			Yes		No		Information may be shared with appropriate personnel for health and educational purposes.										
Eye/Vision problems? ☐ Glasses ☐ Contacts ☐ Last exam by eye doctor							Parent/Guardian Signature							Date			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																	
Ear/Hearing problems?			Yes		No												
Bone/Joint problem/injury/scoliosis?			Yes		No												
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: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)								Other									
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.																	
(If No or Modified please attach explanation.)																	
On the basis of the examination on this day, I approve this child's participation in PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS Yes ☐ No ☐ Modified ☐																	
Print Name								(MD,DO, APN, PA) Signature		Date							
Address								Phone									