

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

Student's Name										Birth Date				Sex School				Grade Level /ID#						
Last First Middle											Month/Day/ Year													
Address Street City ZIP code Parent/ Telephone # Guardian Home Work																								
IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for <u>every</u> dose administered. The day and month is required if you cannot determine if the vaccine was given <u>after</u> 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.																								
	VA	CCIN	E/DO	SE		N	10	1 DA	YR	МО	2 DA	YR	МО	3 DA	YR	МО	4 DA	YR	МО	5 DA	YR	МО	6 DA	YR
Diphtheria, (DTP or D		ıs and	l Pertus	ssis																				
Diphtheria and Tetanus (Pediatric DT or Td)																								
Inactivated																								
Oral Polio (	(OPV)																							
Haemophilus influenzae type b (Hib)																								
Hepatitis B	Hepatitis B (HB)																							
· ·	Varicella (Chickenpox)																							
Combined (MMR)	Measle	s, Mu	ımps ar	nd Rub	ella																			
Measles (R	ubeola	)																						
Rubella (3-	day me	easles	)																					
Mumps Pneumococcal (not required for school entry)																								
					or entry	, F	JI C V	/ / LI	V 23			11 123			III V 23		V / LI	1 123	ше		1 V 23	ше	V / LI	1 V23
Check specific type (PCV7, PPV23)																								
Other (Spec																								
Health ca	re pr	ovide	er (MI	), DO	, APN	, PA, s	cho	ol hea	alth pi	ofess	sional,	healt	h offic	cial) v	erifyin	g abov	e imm	unizat	tion hi	istory	must	sign b	elow.	
Signature	)															Ti	tle				Da	te		
Signature (If adding dates to the above immunization history section, put your initials by date(s) and sign here.)  Title  Date																								
Signature																								
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)  Title  Date																								
ALTERNATIVE PROOF OF IMMUNITY																								
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.													se.											
Date of Disease Signature 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						I										ı					П	P =	de: = Pass	
Age/Grade	R	L	R	L	R	L	R		L	R	L	R	L	R	L	R	L	R	L		R L		= Fail = Unal	ole to
Vision	1		- 10						_			1		"				"				_	test = Refe	rred
Hearing	1																					1	C = Gl ntacts	

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(Complete Both Sides)

Child wakes during the night coughing   No	Student's Name			Birt	h Date	Sex	Sch	ool			Grade Level/ ID #	
MALERGES (Trough generations)  Palageous of authors?  Ver No   Indicate Severity   Loss of function of one of pared organic (special chapter)   Ver No   Child voices during the right coupling Ver No   Selfet deficies?  Ver No   Hospitalizations?  Developmental delay?  Ver No   Wand Wand for   Ver No   Child voices during the right coupling Ver No   Ver No   Child voices during the right coupling Ver No   Ver No   Child voices during the right coupling Ver No   Ver No   Child voices during the right coupling Ver No   Ver No   Child voices during the right coupling Ver No   Ver No   Child voices during the right coupling Ver No   Ver No   Child voices during the right coupling Ver No   Ver	Last First		Middle		Month/Day/ Year							
Diagrams of adminit? Child saked starring the night ecoughing Yes No   Indicated Severity   Uses of function of cos of puriod   Uses of function of cos of function of cos of function of cos of puriod   Uses of function of cos of function of function of function of cos of function of cos of function of function of function of function of cos of function of function of cos of function of cos of function of cos of function of function of cos of f		COMPLETE		BY PARENT/G		IFIED BY H	EAL	TH CA	RE PI	ROVIDER		
Child wakes furing the might coughing Yes No   urganot (eyesearchimeysteintee)   Yes No	ALLERGIES (Food, drug, insect, other)				MEDICATION (List a	ll prescribed or	taken o	n a regular	basis.)			
Discretion and delay?  Ves No   Where Where for Ves No   Sections injury or illinear?  Part Head injury Concession Passed out? Ves No   This skin test positive (pass/person). Ves No   Sections injury or illinear?  Need injury Concession Passed out? Ves No   This skin test positive (pass/person). Ves No   This skin te	Diagnosis of asthma? Child wakes during the night coughing		Indicate Severity	7				Yes	No			
Developmental delay?   Yes   No     Surgery? (List all.)   Yes   No     Soften improve all the properties of the properties   Yes   No     Yes   No     The street (passed out?   Yes   No   The street (passed out?   Yes   No   The street (passed out.)   Yes   No	Birth defects?	Yes No						Vec	No			
Sische Cell, Other? Pisphann.   150   No   Whee? What for?   150   No   Datebers?   Ves No   Serious narpy or dimens?   Ves No   Head nippyConcusion/Passed out?   Ves No   Head history or dimens?   Ves No   Head nippyConcusion/Passed out?   Ves No   Head history or dimens?   Ves No   Head nippyConcusion/Passed out?   Ves No   Head history of souther death.   Ves No   Head nippyConcusion/Passed out?   Ves No   Head history of souther death.   Ves No   Head nippyConcusion/Passed out?   Ves No   Tebracon sea (type, frequency)?   Ves No   Head nippyConcusion/Passed out.   Ves No   AbdoubtDrug use?   Ves No   Destal   Head nippyConcusion/Passed   Ves No   Passed   P	1 ,	Yes No						103	140			
Head injuny/Concussion/Passed out?   Yes   No     Head injuny/Concussion/Passed out.   Head injuny/Concussion/Passed out.   Yes   No     Head injuny/Concussion/Passed out.   Head injuny/Concu	Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No			When? What for?			Yes	No			
Sciences What are they like?   No   This disease (past or present)?   Yes   No   Apartment.	Diabetes?	Yes No						Yes	No			
Secure   S	Head injury/Concussion/Passed out?			?	Yes*	No						
Heart murmur/High blood pressure?   Yes   No	Seizures? What are they like?	Yes No			* *			Yes*	No			
Public Plant   Publ	*	Yes No			``*	quency)'?						
Secretics     Ve   No	<u> </u>	Yes No				1 1 1		Y es	No			
Part   Dental   Brances   Bridge   Plate Other Other Concerns? (crossed eye, dropping like, squinting, difficulty reading)   Other concerns? (crossed eye, dropping like, squinting, difficulty reading)   Other Concerns?   Other Concerns		Yes No						Yes	No			
Parent/Garatha   Pare	Eye/Vision problems? Glasses			e doctor		es 🗆 Bridg	ge 🗆	Plate	Other			
Parent/Garatha   Pare	Far/Hearing problems?	Vag Na			Information may be share	d with appropri	iate per	sonnel fo	r healt	h and education	nal purposes.	
DIABETES SCREENING   BMI>85% age/sex   Ves   No   And any two of the following: Family History   Ves   No   Rhine Minority   Ves   No   Signs of Insulin Resistance (hypertension, dystyndemia, polycystic ovarian syndrome, acarthosis nigrcans)   Ves   No   At Risk   Ves   No   Commentation   Ves   No   Code   Ves   Ves   No   Code   Ves   Ves   No   Code   Ves   Ves   No   Code   Ves   Ves   Ves   No   Code   Ves   Ves   No   Code   Ves   V	Bone/Joint problem/injury/scoliosis?				Parent/Guardian							
DIABETES SCREENING BMB85% 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 ingicians) 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 Result (Blood test required in Chicago and other high risk zip codes.)  The SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high minum to the problems. The problems of the problems. The problems of the	Entire section below to be con	npleted by	MD/DO/APN	N/PA (*IND	DICATES TESTING MAND	ATED FOR ST	TATE I	ICENSE	D CHI	LD CARE FAC	CILITIES)	
LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated use quere, preschool, numery school and/or kindregarten. Blood Test Result (Blood test required in Chicago and other high risk zip codes.)    The SKIN TEST   Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high min min learned countries, or those exposed to solute in high-risk categories. See CDC guidelines.   Date   Result   Date   Result	PHYSICAL EXAMINATION REQU	UIREMENTS		HEIGHT	WEIGHT			BMI			B/P	
LEAD RISK QUESTIONNAIRE* Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nunsery school and/or kindergarten. Blood Test Indicated? Yes   No   Blood Test Date   Blood Test Date		_		•	_		Yes					
Date   Results   Date	LEAD RISK QUESTIONNAIRE* Re	quired for childre	en age 6 months thr	ough 6 years enrol	led in licensed or public s							
MANDATE POR STATE LICENSED CHILD  Date  Results    Comments   Sickle Cell * (as indicated)									ndition	ns, recent imm		
Urinalysis	LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	;	Results				D	ate		Results	
SYSTEM REVIEW Normal   Comments/Follow-up/Needs   Endocrine    Ears   Gastrointestinal    Eyes Normal   Yes   No   Objective screening Yes   No   Result   Genito-Urinary   LMP    Nose   Musculoskeletal    Throat   Spinal examination    Mouth/Dental   Outside   Musculoskeletal    Cardiovascular/HTN   Method   Nutritional status    Cardiovascular/HTN   Method   Nutritional status	Hemoglobin * or Hematocrit *				Sickle Cell * (as	indicated)						
Ears   Gastrointestinal    Eyes Normal Yes   No   Objective screening Yes   No   Result   Genito-Urinary   LMP    Nose   Musculoskeletal    Throat   Spinal examination    Mouth/Dental   Spinal examination    Mouth/Dental   Mouth/Dental   Mouth/Dental    Cardiovascular/HTN   Mental Health    NEEDS/MODIFICATIONS required in the school setting    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., scizures, 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 PHYSICAL EDUCATION   Yes   No   Modified   INTERSCHOLASTIC SPORTS (for one year)   Yes   No   Limited   Physician/Advanced Practice Nurse/Physician Assistant performing examination	Urinalysis  SYSTEM REVIEW Normal	Comme	nts/Follow-up/Ne	eds	Other	Normal		(	Comm	ents/Follow	-un/Needs	
Eyes Normal Yes No Objective screening Yes No Result Genito-Urinary LMP  Nose Normal Yes No Objective screening Yes No Result Genito-Urinary LMP  Nose Normal Yes No Objective screening Yes No No Referred to Opthalmologist/Optometrist Yes No No Neurological  Nose Nose Normal Yes No Objective screening Yes No No Neurological  Nose Nose Normal Yes No Objective screening Yes No No Neurological  Nose Nose Normal Yes No Objective screening Yes No No Neurological  Nose Nose Normal Yes No Objective screening Yes No No Neurological  Nose Nose Normal Yes No Objective screening Yes No Objective Yes No Objective Yes No		Comme	its/10110W up/1VC	, cus	Endocrine	rvormar			-	ents/1 onow	up/11ccus	
Eyes Normal Yes No Objective screening Yes No Referred to Opthalmologist/Optometrist Yes No No Neurological  Nose Musculoskeletal  Throat Spinal examination  Mouth/Dental Nutritional status  Cardiovascular/HTN  Respiratory Mental Health  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 Modified, please attach explanation.  Physician/Advanced Practice Nurse/Physician Assistant performing examination												
Amblyopia Yes Not Referred to Opthalmologist/Optometrist Yes Not Neurological  Nose		iva aanaanina V	aa□ Na□ Baa	14						LMP		
Musculoskeletal  Throat  Spinal examination  Mouth/Dental  Nutritional status  Cardiovascular/HTN  Respiratory  Mental Health  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.  On the basis of the examination on this day, I approve this child's participation in PHYSICAL EDUCATION Yes   No   Modified   INTERSCHOLASTIC SPORTS (for one year) Yes   No   Limited    Physician/Advanced Practice Nurse/Physician Assistant performing examination					-							
Mouth/Dental   Nutritional status   Cardiovascular/HTN   Mental Health   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.    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	Nose				+							
Mouth/Dental   Nutritional status   Cardiovascular/HTN   Mental Health   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.   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	Throat				Spinal examination							
Cardiovascular/HTN   Mental Health   Mental Health    Respiratory   Mental Health    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.   Interest   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	Mouth/Dental				Nutritional status							
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:					Mental Health							
MENTAL HEALTH/OTHER		n the school setti	ng		DIETARY Needs/Restrictions							
MENTAL HEALTH/OTHER												
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 PHYSICAL EDUCATION Yes  No  Modified  INTERSCHOLASTIC SPORTS (for one year) Yes  No  Limited  Physician/Advanced Practice Nurse/Physician Assistant performing examination	SPECIAL INSTRUCTIONS/DEVICE	ES e.g. safety g	lasses, glass eye, ch	nest protector for ar	rhythmia, pacemaker, pro	osthetic device	, denta	al bridge	, false	teeth, athletic	support/cup	
Yes No I If yes, please describe.  On the basis of the examination on this day, I approve this child's participation in PHYSICAL EDUCATION Yes No Modified I INTERSCHOLASTIC SPORTS (for one year) Yes No Limited Physician/Advanced Practice Nurse/Physician Assistant performing examination						her 🗆 Cou	nselor	□ Pr	incipal	l		
PHYSICAL EDUCATION Yes No Modified Interscholastic sports (for one year) Yes No Limited Physician/Advanced Practice Nurse/Physician Assistant performing examination		e at school due to	child's health con	dition (e.g., seizure	es, asthma, insect sting, fo	ood, peanut all	ergy, l	oleeding	proble	m, diabetes, h	eart problem)?	
											☐ Limited ☐	
Print Name Signature Date	Physician/Advanced Practice Nurse/Physician	n Assistant perfo	rming examination									
	Print Name		Signa	ature						Date		

Address

Phone