# State of Illinois Certificate of Child Health Examination

**Student’s Name**
- Last
- First
- Middle

**Birth Date**
- Month/Day/Year

**Sex**

**Race/Ethnicity**

**School/Grade Level/ID#**

**Address**
- Street
- City
- Zip Code

**Parent/Guardian**
- Telephone # Home
- Work

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**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.

<table>
<thead>
<tr>
<th>Vaccine / Dose</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
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<tr>
<td>Tdap; Td or Pediatric DT</td>
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<tr>
<td>Polio (Check specific type)</td>
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<tr>
<td>Hib Haemophilus influenza type b</td>
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<tr>
<td>Hepatitis B (HB)</td>
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<tr>
<td>Varicella (Chickenpox)</td>
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<tr>
<td>MMR Combined Measles Mumps Rubella</td>
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<tr>
<td>Single Antigen Vaccines</td>
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<tr>
<td>Measles</td>
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<tr>
<td>Rubella</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Pneumococcal Conjugate</td>
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<tr>
<td>Other/Specify</td>
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</tbody>
</table>

**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

**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 (Rubella) 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 result)

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**VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN**

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

**Age/Grade**
- R L R L R L R L R L R L R L R L

**Vision**

**Hearing**

IL444-4737 (R-01-12)  (COMPLETE BOTH SIDES)  Printed by Authority of the State of Illinois
### HEALTH HISTORY

**HEALTH HISTORY**

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

**Diagnosis of asthma?**
- **Yes**
- **No**

**Child wakes during night coughing?**
- **Yes**
- **No**

**Birth defects?**
- **Yes**
- **No**

**Developmental delay?**
- **Yes**
- **No**

**Blood disorders? Hemophilia, Sickle Cell, Other? Explain.**
- **Yes**
- **No**

**Diabetes?**
- **Yes**
- **No**

**Head injury/Concussion/Passed out?**
- **Yes**
- **No**

**Seizures? What are they like?**
- **Yes**
- **No**

**Heart problem/Shortness of breath?**
- **Yes**
- **No**

**Heart murmur/High blood pressure?**
- **Yes**
- **No**

**Dizziness or chest pain with exercise?**
- **Yes**
- **No**

**Eye/Vision problems?**
- **Yes**
- **No**

**Other concerns?**
- **Crossed eye, drooping lids, squinting, difficulty reading**

**Ear/Hearing problems?**
- **Yes**
- **No**

**Bone/Joint problem/injury/scoliosis?**
- **Yes**
- **No**

**Symptoms of allergies?**
- **Yes**
- **No**

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### SYSTEM REVIEW

**Normal Comments/Follow-up/Needs**

- **Normal**
- **Comments/Follow-up/Needs**

### PHYSICAL EXAMINATION REQUIREMENTS

**Entire section below to be completed by MD/DO/APN/PA**

<table>
<thead>
<tr>
<th>HEAD CIRCUMFERENCE if &lt; 2-3 years old</th>
<th>HEIGHT</th>
<th>WEIGHT</th>
<th>BMI</th>
<th>B/P</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

**DIABETES SCREENING (NOT REQUIRED FOR DAY CARE)**

<table>
<thead>
<tr>
<th>BMI &gt; 85% age/sex</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic Minority</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Blood Test Indicated?**

- **Yes**
- **No**

**Blood Test Date**

(Blood test required if resides in Chicago.)

**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.

**Skin Test:**
- **Date Read**
- **Result:**
  - **Positive**
  - **Negative**

**Blood Test:**
- **Date Reported**
- **Result:**
  - **Positive**
  - **Negative**

**LAB TESTS (Recommended)**

- **Hemoglobin or Hematocrit**
- **Urinalysis**

**SYSTEM REVIEW**

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<th>Normal</th>
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</tbody>
</table>

**SKIN**

- **Eyes**
  - **Amblyopia**
  - **Genito-Urinary**

**Ear**

- **Gastrointestinal**

**Eye**

- **Nose**
  - **Neurological**

**Throat**

- **Musculoskeletal**

**Mouth/Dental**

- **Spinal Exam**

**Cardiovascular/HTN**

- **Nutritional status**

**Respiratory**

- **Diagnosis of Asthma**
  - **Quick-relief medication** (e.g. Short Acting Beta Antagonist)
  - **Controller medication** (e.g. inhaled corticosteroid)

**NEEDS/MODIFICATIONS**

**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?
  - **Yes**
  - **No**

**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**

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**

**School**

**Grade Level/ID**

**Last Name**

**First Name**

**Middle Name**

**Birth Date**

**Month/Day/ Year**

**Sex**

**School**

**Parent/Guardian**

**Signature**

**Date**

**Emergency Action**

**EMERGENCY ACTION**

If yes, please describe.

**Print Name**

(MD, DO, APN, PA)

**Signature**

**Date**

**Address**

**Phone**

(Complete Both Sides)