



## Certificate of Child Health Examination

<b>Student's Name</b>			<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School/Grade Level/ID#</b>
Last	First	Middle				
<b>Street Address</b>			<b>City</b>	<b>ZIP Code</b>	<b>Parent/Guardian</b>	<b>Telephone (home/work)</b>
<b>HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>						
<b>ALLERGIES</b> (Food, drug, insect, other)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>List:</b>	<b>MEDICATION</b> (Prescribed or taken on a regular basis)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>List:</b>	
Diagnosis of Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Child wakes during night coughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Hospitalization? When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Birth Defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Surgery? (List all) When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Developmental delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Serious injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB skin test positive (past/present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No		*If yes, refer to local health department
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No		TB disease (past or present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No		
Head injury/Concussion/Passed out?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Tobacco use (type, frequency)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Seizures? What are they like?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Alcohol/Drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart problem/Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No		Family history of sudden death before age 50? (Cause?)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart murmur/High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Dizziness or chest pain with exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No					
Eye/Vision problems? _____ <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts Last exam by eye doctor _____			<input type="checkbox"/> Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____			<b>Additional Information:</b>			
Ear/Hearing problems?			<input type="checkbox"/> Yes <input type="checkbox"/> No			
Bone/Joint problem/injury/scoliosis?			<input type="checkbox"/> Yes <input type="checkbox"/> No			
			Information may be shared with appropriate personnel for health and educational purposes.			
			<b>Parent/Guardian</b>			
			<b>Signatures:</b> _____ <b>Date:</b> _____			
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for every 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.</b>						
<b>REQUIRED Vaccine/Dose</b>	<b>DOSE 1</b> MO DA YR	<b>DOSE 2</b> MO DA YR	<b>DOSE 3</b> MO DA YR	<b>DOSE 4</b> MO DA YR	<b>DOSE 5</b> MO DA YR	<b>DOSE 6</b> MO DA YR
<b>DTP or DTaP</b>						
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT
<b>Polio</b> (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV	<input type="checkbox"/> IPV <input type="checkbox"/> OPV
<b>Hib Haemophiles Influenza Type B</b>						
<b>Pneumococcal Conjugate</b>						
<b>Hepatitis B</b>						
<b>MMR Measles, Mumps, Rubella</b>				<b>Comments:</b> * indicates invalid dose		
<b>Varicella</b> (Chickenpox)						
<b>Meningococcal Conjugate</b>						
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose</b>						
<b>Hepatitis A</b>						
<b>HPV</b>						
<b>Influenza</b>						
<b>Other: Specify Immunization Administered/Dates</b>						
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.						
Signature _____			Title _____		Date _____	

<b>Student's Name</b>			<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>School</b>	<b>Grade Level/ID#</b>
Last	First	Middle				

**Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.**

**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.

Physician Statements of Immunity MUST be submitted to IDPH for review.  
**Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:** \_\_\_\_\_

**PHYSICAL EXAMINATION REQUIREMENTS**      **Entire section below to be completed by MD/DO/APN/PA**  
 HEAD CIRCUMFERENCE if < 2-3 years old \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BMI \_\_\_\_\_ BMI PERCENTILE \_\_\_\_\_ 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 aged 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](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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Sickle Cell (when indicated)			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	Screening Result:	Gastrointestinal	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	Screening Result:	Genito-Urinary	<input type="checkbox"/>	LMP:
Nose	<input type="checkbox"/>		Neurological	<input type="checkbox"/>	
Throat	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	
Mouth/Dental	<input type="checkbox"/>		Spinal Exam	<input type="checkbox"/>	
Cardiovascular/HTN	<input type="checkbox"/>		Nutritional Status	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis of Asthma	Mental Health	<input type="checkbox"/>	
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g., Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g., inhaled corticosteroid)			Other	<input type="checkbox"/>	
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** ☐ Yes ☐ No ☐ Modified

Print Name \_\_\_\_\_ ☐ MD ☐ DO ☐ APN ☐ PA    Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_