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

Please Print

Student's Name (Last / First / Middle)	Birth Date (Month/Day/ Year)	Sex	School	Grade Level /ID#
Address / Street / City / ZIP code	Parent/ Guardian	Telephone # Home	Work	

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.**

VACCINE/DOSE	1 MO	1 DA	1 YR	2 MO	2 DA	2 YR	3 MO	3 DA	3 YR	4 MO	4 DA	4 YR	5 MO	5 DA	5 YR	6 MO	6 DA	6 YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										Comments								
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23		
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

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

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.

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 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																				
Age/Grade																				
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision																				
Hearing																				

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

Printed by Authority of the State of Illinois

(Complete Both Sides)

IL444-4737 (R-01-05)

Nombre del Estudiante Apellido Nombre Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado / Núm. De Ident.

HISTORIAL DE SALUD PARA SER COMPLETADO Y FIRMADO POR EL PADRE / TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)			MEDICINAS (Anote todas las recetadas o tomadas con regularidad.)		
¿Diagnosis de Asma? ¿Niño(a) despierta tosiendo en la noche?	Sí No Sí No	Indique Severidad	¿Pérdida de las Funciones de uno de los pares de Órganos? (Ojos /Oídos / Riñones / Testículos)	Sí No	
¿Defectos de Nacimiento?	Sí No		¿Hospitalizaciones? ¿Cuándo? ¿Para Qué?	Sí No	
¿Retrasos del Desarrollo?	Sí No				
¿Problemas De La Sangre? Hemofilia, Glóbulos Falciformes, Otro Explique	Sí No		¿Cirugía? (Anótelas Todas) ¿Cuándo? ¿Para Qué?	Sí No	
¿Diabetes?	Sí No		¿Heridas Graves o Enfermedad?	Sí No	
¿Herida de la Cabeza / golpe / desmayo?	Sí No		¿Prueba positiva de la piel para el TB (Pasado o Presente)?	Sí * No	*Si contestó sí, referencia al departamento de salud local
¿Convulsiones? ¿Cómo Se Manifiestan?	Sí No		¿Enfermedad de TB (Pasado o Presente)?	Sí * No	
¿Problemas Cardiacos / Falta de Respiración?	Sí No		¿Uso de Tabaco (Tipo, Frecuencia)?	Sí No	
¿Soplo Cardiaco / Presión Arterial Alta?	Sí No		¿Uso de Alcohol / Drogas?	Sí No	
¿Mareos O Dolor De Pecho Al Hacer Ejercicio?	Sí No		¿Historial Familiar de Muerte Repentina antes de los 50 años? (¿Causa?)	Sí No	
¿Problemas con los Ojos / Visión? Lentes Lentes de Contacto Último Examen ____ ¿Otras Preocupaciones? (bizco, párpados caídos, entrrecerrar los ojos, dificultad cuando lee)			Dental Ganchos Puente Placas Otro ¿Otras Preocupaciones?		
¿Problemas de Audición?	Sí No		La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Problemas de los huesos / Articulaciones / Heridas / Escoliosis?			**Firma del Padre / Tutor** **Fecha**		

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS HEIGHT WEIGHT BMI B/P

DIABETES SCREENING 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 Indicated? Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** (Blood test required in Chicago and other high risk zip codes.)

TB 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 prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** mm

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result ____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

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

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)