



# 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 _____				

Street Address _____	City _____	ZIP Code _____	Parent/Guardian _____	Telephone (home/work) _____
----------------------	------------	----------------	-----------------------	-----------------------------

**HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<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			Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis? _____ <input type="checkbox"/> Yes <input type="checkbox"/> No			Parent/Guardian Signatures: _____ Date: _____		

**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.**

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	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (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
Polio (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	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
Hib Haemophiles Influenza Type B																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles, Mumps, Rubella																		
Varicella (Chickenpox)																		
Meningococcal Conjugate																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose</b>																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

**Comments:** \* indicates invalid dose

**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 \_\_\_\_\_

<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 \_\_\_\_\_