

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

Student's Name									Birth Date			Se	Sex School				Grade Level /ID#							
Last First Middl									dle		Month/Day/ Year													
Address Street City							ZIP code				Parent/ Telephone #													
									der. No	ote the	Guardian Home Work ne mo/da/yr for every dose administered. The day and month is required if you cannot determine if													
the vaccine the medica							r age.	If a	specific	e vacc	ine is	nedical	ly con	raindi	icated,	a separ	ate wri	itten sta	atemer	nt mus	t be at	tached	explai	ining
			NE/DO				10 I	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	, Tetanı						-																	
Diphtheria	and Te	tanus	(Pedia	tric DI	or Td)																			
Inactivated	Polio ((IPV)																						
Oral Polio	(OPV)																							
Haemophil	us influ	ienza	e type l	o (Hib)																				
Hepatitis B	(HB)																							
Varicella (0		1 /														Com	nents							
Combined (MMR)	Measle	s, Mu	umps ai	nd Rub	ella																			
Measles (R	ubeola)																						
Rubella (3-	day me	easles)																					
Mumps	1.(· 10	1	1 /							DDV22			DDU22			DUGG			001/02			
Pneumococ	cal (no	ot requ	uired fo	or schoo	ol entry)]PCV	/ UP	PV23			PPV23			PPV23		CV7 □P	PV23		CV7 □F	PV23			PPV23
Check spec	ific typ	be (PC	CV7, Pl	PV23)																				
Other (Spec	• •										_													
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Student's Name		Birtl	n Date	Sex	School		Grade Level/ ID #					
Last First	Mide	lle	Month/Day/ Year									
				FIED BY H	EALTH	CARE PR	OVIDER					
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER ALLERGIES (Food, drug, insect, other) MEDICATION (List all prescribed or taken on a regular basis.)												
0	Yes No Indica Yes No	ate Severity	Loss of function of one organs? (eye/ear/kidney.		Yes	No						
Birth defects?	Yes No		Hospitalizations? When? What for?		V	N						
Developmental delay?	Yes No		when? what for?		Yes	No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) When? What for?		Yes	No						
Diabetes?	Yes No		Serious injury or illness		Yes							
Head injury/Concussion/Passed out?	Yes No		TB skin test positive (pa		? Yes	110	If yes, refer to local health department.					
Seizures? What are they like?	Yes No		TB disease (past or pres	· ·	Yes	* No						
1	Yes No		Tobacco use (type, frequ Alcohol/Drug use?	uency)?	Yes							
Heart murmur/High blood pressure? Dizziness or chest pain with	Yes No		Family history of sudder	n death	Ies	NO						
exercise?	Yes No	1 1 4	before age 50? (Cause?)	Yes							
Eye/Vision problems? Glasses Other concerns? (crossed eye, drooping lids	Contacts Last e , squinting, difficulty r		Dental Braces Bridge Other concerns?			te Other						
	Yes No Yes No		Information may be shared Parent/Guardian Signature	with appropr	and educational purposes.							
Entire section below to be com	Bone/Joint problem/injury/scoliosis? Yes No Signature Date Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)											
PHYSICAL EXAMINATION REQU	IREMENTS	HEIGHT	WEIGHT		BN	11	B/P					
DIABETES SCREENING BMI>85 Signs of Insulin Resistance (hypertension,						No □ t Risk	Ethnic Minority Yes □ No □ Yes □ No □					
LEAD RISK QUESTIONNAIRE* Req Blood Test Indicated? Yes No	uired for children age 6		ed in licensed or public scl	hool operate	d day care	, preschool,						
TB SKIN TEST Recommended only for c				1		e	Č I ,					
prevalence countries, or those exposed to adults			ate Read / /		Result		mm					
LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results				Date	Results					
Hemoglobin * or Hematocrit *			Sickle Cell * (as i	ndicated)								
Urinalysis			Other	I								
SYSTEM REVIEW Normal	Comments/Fol	low-up/Needs		Normal		Comme	ents/Follow-up/Needs					
Skin			Endocrine									
Ears			Gastrointestinal									
	e screening Yes□ 1 to Opthalmologist/Or	No□ Result ptometrist Yes□ No□	Genito-Urinary				LMP					
Nose	a to optiminologist of		Neurological Musculoskeletal									
Throat			Spinal examination									
Mouth/Dental			Nutritional status									
Cardiovascular/HTN			Turnonar status									
Respiratory			Mental Health									
NEEDS/MODIFICATIONS required in	the school setting		DIETARY Needs/Res	strictions								
SPECIAL INSTRUCTIONS/DEVICE	S e.g. safety glasses, g	glass eye, chest protector for an	rhythmia, pacemaker, pros	thetic device	, dental br	idge, false te	eeth, 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 Yes No I fyes, please describe.	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 D No D 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 e	examination										
Print Name		Signature					Date					
Address		1	Phone									