State of Illinois
Certificate of Child Health Examination

Student's Name

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>School/Grade Level/ID#</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Address

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>Zip Code</th>
<th>Parent/Guardian</th>
<th>Telephone</th>
<th>Home</th>
<th>Work</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for each 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>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Tdap, Td or Pediatric DT (Check specific type)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Polio (Check specific type)</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hib Haemophilus influenza type b</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B (HB)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella (Chickenpox)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>MMR Combined Measles Mumps Rubella</td>
<td></td>
<td></td>
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<tr>
<td>Single Antigen Vaccines</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>Rubella</td>
<td>Mumps</td>
<td></td>
<td></td>
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</tbody>
</table>

Pneumococcal Conjugate

Other/Specify Meningococcal, Hepatitis A, HPV, Influenza

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.)*

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

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

<table>
<thead>
<tr>
<th>Date</th>
<th>Age/Grade</th>
<th>Vision</th>
<th>Hearing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>R L R L R L R L R L R L R L R L</td>
<td></td>
<td></td>
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</tbody>
</table>

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

IL444-4737 (R-01-12)  (COMPLETE BOTH SIDES)  Printed by Authority of the State of Illinois
### Student's Name

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>School</th>
<th>Grade Level/ID #</th>
</tr>
</thead>
</table>

### 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):
- Loss of function of one of paired organs (eye, ear, kidney, testicle)
- Hospitalizations
- Surgery (List all)
- When? What for?
- When? What for?
- Serious injury or illness

**Developmental delay**
- Yes
- No

**Blood disorders?**
- Hemophilia
- Sickle Cell
- Yes
- No

**Diabetes?**
- Yes
- No

**Head injury/concussion/passed out?**
- Yes
- No

**Seizure?**
- 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?**
- Glasses
- Contacts
- Last exam by eye doctor

**Other concerns?**
- Crossed eyes
- Drooping lid
- Squinting
- Difficulty reading

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

**Bone/joint problem/juvenile arthritis?**
- Yes
- No

**Family history of sudden death before age 50?**
- Yes
- No

**Physical Examination Requirements**

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

**Head Circumference**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
</tr>
</thead>
</table>

**Diabetes Screening (not required for day care)**
- BMI > 85% age/sex
- Yes
- No

**Racial Minority**
- Yes
- No

**Signs of Incessant Resistance** (hyperactivity, dyslexia, polysubstance, etc.)
- Yes
- No

**Medical History**
- Blood Test Indicated?
- Yes
- No

**Blood Test Date**
- Blood test required if positive.

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**Lead Risk Questionnaire**

**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.**

**TB Skin or Blood Test**
- Yes
- No

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

**Bleed Test**
- Date
- Result
- Positive
- Negative

**Lab Tests (Recommended)**

<table>
<thead>
<tr>
<th>Hemoglobin or Hematocrit</th>
<th>Results</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
</table>

**Urinalysis**

<table>
<thead>
<tr>
<th>System Review</th>
<th>Normal</th>
<th>Comments/Follow-up/Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin</td>
<td>Endocrine</td>
<td></td>
</tr>
<tr>
<td>Ears</td>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Amblyopia</td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td>Neurological</td>
<td></td>
</tr>
<tr>
<td>Throat</td>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Mouth/Dental</td>
<td>Spinal Exam</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular/ITN</td>
<td>Nutritional status</td>
<td></td>
</tr>
</tbody>
</table>

**Respiratory**
- Diagnosis of Asthma
- Quick-acting medication
- Controller medication

**Currently Prescribed Asthma Medication:**
- Other

**Needs/Modifications**
- in the school setting

**Dietary Needs/Restrictions**

**Special Instructions/Devices**
- e.g. safety glasses, glass eye, chest protector for archery,...cup

**Mental Health/Others**
- Is there anything else the school should know about this student?

**Emergency Action**
- Needed while at school due to child's health condition (e.g., seizures, asthma, diabetes, heart problem)?
- Yes
- No

**Physical Education**
- Yes
- No

**InterScholastic Sports (for one year)**
- Yes
- No

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**Print Name**

(MD/DO, APN, PA)

**Signature**

**Date**

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**Complete both sides**