**State of Illinois**  
Certificate of Child Health Examination  

**Students Name**  
Last                                        First                                                        Middle

**Birth Date**  
Month/Day/Year

**Sex**  
Race/Ethnicity

**School/Grade Level/ID#**  

**Address**  
Street                         City                      Zip Code

**Parent/Guardian**  
Telephone # Home                                                 Work

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**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**

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>DTP or DTaP</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Tdap, Td or Pediatric DT (Check specific type)</td>
<td></td>
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<tr>
<td>3</td>
<td>Polio (Check specific type)</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>Hib Haemophilus influenza type b</td>
<td></td>
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<tr>
<td>5</td>
<td>Hepatitis B (HB)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6</td>
<td>Varicella (Chickenpox)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>MMR Combined Measles Mumps. Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Single Antigen Vaccines</td>
<td>Measles</td>
<td>Rubella</td>
<td>Mumps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Pneumococcal Conjugate</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10</td>
<td>Other/Specify Meningococcal, Hepatitis A, HPV, Influenza</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**COMMENTS:**

**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

**Signature**                                                                     **Title**  
Date

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**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**

**Lab Results**  
**Date**  
**MO**  
**DA**  
**YR**  

**Laboratory confirmation (check one)**

- Measles  
- Mumps  
- Rubella  
- Hepatitis B  
- Varicella

**Lab Results**  
**Date**  
**MO**  
**DA**  
**YR**  

(Attach copy of lab result)

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**VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN**

**Code:**

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

**Date**  
**Age/Grade**  
**Vision**

<table>
<thead>
<tr>
<th>R</th>
<th>L</th>
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</thead>
</table>

**Hearing**

IL444-4737 (R-02-13)  
(COMplete BOTH SIDES)
**HEALTH HISTORY**

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

**ALLERGIES** (Food, drug, insect, other)

<table>
<thead>
<tr>
<th>Diagnosis of asthma?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child wheezes during night coughing?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Birth defects?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Developmental delay?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Blood disorders? Hemophilia, Sickle Cell, Other? Explain.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Diabetes?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Head injury/Concussion/Passed out?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Seizures? What are they like?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart problem/Shortness of breath?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Heart murmur/High blood pressure?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dizziness or chest pain with exercise?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Eye/Vision problems?</td>
<td>Glasses</td>
<td>Contacts</td>
</tr>
<tr>
<td>Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone/Joint problem/injury/scoliosis?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**MEDICATION** (List all prescribed or taken on a regular basis.)

| Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes | No |
| Hospitalizations? | When? | What for? |
| Surgery? (List all.) | When? | What for? |
| Tuberculosis (past/present)? | Yes* | No |

*If yes, refer to local health department.

**SYSTEM REVIEW Normal Comments/Follow-up/Needs**

- Respiratory
- Cardiovascular/HTN
- Gastrointestinal
- Endocrine
- Neurological
- Musculoskeletal
- Spinal Exam
- Mental Health

**LAB TESTS**

<table>
<thead>
<tr>
<th>Test performed</th>
<th>Date Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Test Date</td>
<td>Result</td>
</tr>
</tbody>
</table>

**PHYSICAL EXAMINATION REQUIREMENTS** Entire section below to be completed by MD/DO/APN/PA

- Head CIRCUMFERENCE if < 2-3 years old
- Height
- Weight
- BMI
- B/P

**DIABETES SCREENING (not required for day care)**

- BMI > 85% age/sex
- Ethnic Minority
- Signs of Insulin Resistance
- Family History
- At Risk

**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 required if resides in Chicago or high risk zip code.)

**Questionnaire Administered?** Yes | No

**Blood Test Indicated?** Yes | No

**Blood Test Date Result**

**LAB TESTS** (Recommended)

- Hemoglobin or Hematocrit
- Unrelated

**SYSTEM REVIEW**

- Normal
- Comments/Follow-up/Needs

- Normal
- Comments/Follow-up/Needs

- Skin
- Endocrine
- Gastrointestinal
- Eyes
- Amblyopia
- Genito-Urinary
- Nose
- Neurological
- Throat
- Musculoskeletal
- Mouth/Dental
- Spinal Exam
- Cardiovascular/HTN
- Nutritional status
- Respiratory
- Diagnosis of Asthma
- Other

**NEEDS/MODIFICATIONS**

required in the school setting

- Dietary Needs/Restrictions

- e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

**MENTAL HEALTH/OTHER**

- 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.

**PHYSICAL EDUCATION**

- Yes | No | Modified

**INTERSCHOLASTIC SPORTS**

- Yes | No | Limited

**(Print Name)** (MD, DO, APN, PA)

**Address**

**Phone**

(Complete Both Sides)