

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
CERTIFICATE OF CHILD HEALTH EXAMINATION**

(Information on this form may be shared with appropriate personnel for health and educational purposes.)

STUDENT'S NAME <small>(Last) (First) (Middle)</small>			BIRTHDATE <small>MO DA YR</small>			SEX	GRADE LEVEL	SOCIAL SECURITY #	
ADDRESS <small>(Street) (City) (Zip Code)</small>			PARENT/GUARDIAN TELEPHONE # <small>(Home) (Work)</small>				SCHOOL		
PARENT OR GUARDIAN			ADDRESS						

HEALTH HISTORY To be completed by parent or guardian <small>(Circle yes or no) Comments</small> Chicken Pox Yes No _____ TB/TB Contact Yes No _____ Birth Defects Yes No _____ Blood Disorders Yes No _____ Hemophilia Sickle Cell _____ Other _____ Diabetes Yes No _____ Seizures Yes No _____ Heart Problems Yes No _____ Ear/Hearing Problems Yes No _____ Ear Infections Yes No _____ Speech Problems Yes No _____ Eye/Vision Problems Yes No _____ Serious Injuries Yes No _____ Bone/Joint Problems Yes No _____ Surgery Yes No _____ When _____ What for _____ Hospitalization Yes No _____ When _____ What for _____ Asthma Yes No _____ Developmental Delay Yes No _____ Allergies (list) _____ Medications (list) _____	IMMUNIZATIONS. To be completed by health care provider. Note the mo/day/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. <table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th rowspan="2">DOSE</th> <th colspan="3">1</th> <th colspan="3">2</th> <th colspan="3">3</th> <th colspan="3">4</th> <th colspan="3">5</th> </tr> <tr> <th>MO</th><th>DA</th><th>YR</th> <th>MO</th><th>DA</th><th>YR</th> <th>MO</th><th>DA</th><th>YR</th> <th>MO</th><th>DA</th><th>YR</th> <th>MO</th><th>DA</th><th>YR</th> </tr> </thead> <tbody> <tr> <td>Diphtheria, Pertussis & Tetanus (DTP or DTap)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Diphtheria and Tetanus (DT or Td)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Polio (TCPV or IPV) Specify if IPV</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Haemophilus influenzae type b (Hib)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Comb. Measles/Mumps Rubella (MMR)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Measles (Rubella)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Rubella (3-day or German Measles)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Mumps</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Hepatitis B (HB)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> <tr> <td>Other (e.g. Varicella)</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </tbody> </table>	DOSE	1			2			3			4			5			MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	Diphtheria, Pertussis & Tetanus (DTP or DTap)																Diphtheria and Tetanus (DT or Td)																Polio (TCPV or IPV) Specify if IPV																Haemophilus influenzae type b (Hib)																Comb. Measles/Mumps Rubella (MMR)																Measles (Rubella)																Rubella (3-day or German Measles)																Mumps																Hepatitis B (HB)																Other (e.g. Varicella)																ALTERNATIVE PROOF OF IMMUNITY 1. Clinical diagnosis is acceptable if verified by Physician. MEASLES MO DA YR _____ MUMPS MO DA YR _____ 2. Laboratory confirmation of any disease is acceptable DISEASE _____ Lab Results MO DA YR _____
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TO BE COMPLETED BY PHYSICIAN				
REQUIRED	HEIGHT	WEIGHT	B/P	*Lead Assessment Date
STRONGLY RECOMMENDED	Date		Results	Lead Screening Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Results _____
Hemoglobin* or				Needs/modifications required in the school setting
Hematocrit*				Medications
Urinalysis				Dietary
Sickle Cell* (as needed)				Special Equipment
TB Skin Test* (as indicated)			mm	Other

PHYSICAL EXAMINATION REQUIREMENTS				
	(Normal)	Comments/Follow-up	(Normal)	Comments/Follow-up
Skin			Genito-Urinary	
Ears			Neurological	
Eyes			Musculoskeletal	
Nose			Spinal Examination	
Throat			Nutritional Status	
Mouth/Dental			Mental Health	
Cardiovascular			General comments	
Gastrointestinal				

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'S NAME (print)	PHYSICIAN'S SIGNATURE
ADDRESS	PHONE DATE

VISION AND HEARING SCREENING DATA												
<small>This section to be completed by IDPH certified screening personnel, if pre-existing approved IDPH form is not available.</small>												
<small>Pre-school - during first year</small>						<small>School-age-during school year at required grade level</small>						
Date												
Code	R	L	R	L	R	L	R	L	R	L	R	L
Vision												
Hearing												