| Last | First | Middle | Birth Date Month/Day/ Year | Sex | School | Grade Level/ ID |
|---|---|---|---|---|---|---|
| | | | | | | |

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

| **ALLERGIES** (Food, drug, insect, other) | Yes No | List: | **MEDICATION** (Prescribed or taken on a regular basis.) | Yes No | **List:** |
|---|---|---|---|---|---|
| Diagnosis of asthma? | Yes No | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes No | |
| Child wakes during night coughing? | Yes No | | | | |
| Birth defects? | Yes No | | Hospitalizations? When? What for? | Yes No | |
| Developmental delay? | 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 No | |
| Head injury/Concussion/Passed out? | Yes No | | TB skin test positive (past/present)? | Yes* No | *If yes, refer to local health department. |
| Seizures? What are they like? | Yes No | | TB disease (past or present)? | Yes* No | |
| Heart problem/Shortness of breath? | Yes No | | Tobacco use (type, frequency)? | Yes No | |
| Heart murmur/High blood pressure? | Yes No | | Alcohol/Drug use? | Yes No | |
| Dizziness or chest pain with exercise? | Yes No | | Family history of sudden death before age 50? (Cause?) | Yes No | |
| Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) | | | Dental ☐ Braces ☐ Bridge ☐ Plate Other | | |
| Ear/Hearing problems? | Yes No | | Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** | | **Date** |
| Bone/Joint problem/injury/scoliosis? | Yes No | | | | |

**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** 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 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**

**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.

**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 | | Date | Results |
|---|---|---|---|---|---|
| Hemoglobin or Hematocrit | | | Sickle Cell (when indicated) | | |
| Urinalysis | | | Developmental Screening Tool | | |

| **SYSTEM REVIEW** | **Normal** | **Comments/Follow-up/Needs** | | **Normal** | **Comments/Follow-up/Needs** |
|---|---|---|---|---|---|
| **Skin** | | | **Endocrine** | | |
| **Ears** | | Screening Result: | **Gastrointestinal** | | |
| **Eyes** | | Screening Result: | **Genito-Urinary** | | LMP |
| **Nose** | | | **Neurological** | | |
| **Throat** | | | **Musculoskeletal** | | |
| **Mouth/Dental** | | | **Spinal Exam** | | |
| **Cardiovascular/HTN** | | | **Nutritional status** | | |
| **Respiratory** | | ☐ Diagnosis of Asthma | **Mental Health** | | |
| Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid) | | | **Other** | | |

**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**

# State of Illinois
# Certificate of Child Health Examination

| Student's Name<br>Last First Middle | Birth Date<br>Month/Day/Year | Sex | Race/Ethnicity | School /Grade Level/ID# |
|---|---|---|---|---|
| Address Street City Zip Code | Parent/Guardian | Telephone # Home | | Work |

**IMMUNIZATIONS**: To be completed by health care provider. The mo/da/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 MO DA YR | DOSE 2 MO DA YR | DOSE 3 MO DA YR | DOSE 4 MO DA YR | DOSE 5 MO DA YR | DOSE 6 MO DA YR |
|---|---|---|---|---|---|---|
| **DTP** or **DTaP** | | | | | | |
| **Tdap**; **Td** or Pediatric **DT** (Check specific type) | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT |
| | | | | | | |
| **Polio** (Check specific type) | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV |
| | | | | | | |
| **Hib** Haemophilus influenza type b | | | | | | |
| **Pneumococcal Conjugate** | | | | | | |
| **Hepatitis B** | | | | | | |
| **MMR** Measles Mumps. Rubella | | | | | | |
| **Varicella** (Chickenpox) | | | | | | |
| **Meningococcal conjugate (MCV4)** | | | | | | |
| **RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose** | | | | | | |
| **Hepatitis A** | | | | | | |
| **HPV** | | | | | | |
| **Influenza** | | | | | | |
| **Other: Specify Immunization Administered/Dates** | | | | | | |
| | | | | | | |

**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**

## 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.

**Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:** _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

**Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.**