

Certificate of Child Health Examination

Student's Name					Birth (Mo/Da		Sex	Sex Race/Ethnicity		School/Grade Level/ID#					
Last	First		Middle	e											
Street Address		City		ZIP Code	Parent/G	iuardian					Tele	phone (ho	ome/work)		
HEALTH HISTORY	r: MUS	T BE COMPL	ETED AN	D SIGNED	BY PAF	RENT/	GUAR	DIAN AND	VERIFIE	D BY	HEALT	H CAR	E PROVIDER		
ALLERGIES	Yes	List:				MEDIC	ATION	N	Yes	List:					
(Food, drug, insect, other)	□ □ No					(Prescrib regular b		aken on a	□ No						
Diagnosis of Asthma?			Yes [No No			Loss o	f function of o	ne of paired	1	Yes	☐ No			
Child wakes during night coughin	ıg?		Yes [] No				talization?	iney/testicie	2)	Yes				
Birth Defects?			Yes [] No				? What for?			☐ 163				
Developmental delay?			Yes [] No				ry? (List all)			Yes	□ No □			
Blood disorder? Hemophilia, Sick	le Cell, Ot	her? Explain.	Yes [] No				? What for?			□ vos				
Diabetes?			Yes [] No			-	is injury or illn		+>2	☐ Yes	_			
Head injury/Concussion/Passed of	out?		Yes [] No				n test positive		nt)?	Yes*	_	*If yes, refer to local health department		
Seizures? What are they like?			Yes [] No				ease (past or p	,		Yes*	_ F	neath department		
Heart problem/Shortness of brea	ith?		Yes [] No				co use (type, f	requency)?		Yes	_ F			
Heart murmur/High blood pressu	ıre?		Yes [] No				ol/Drug use?			Yes	_ F			
Dizziness or chest pain with exerc	cise?		Yes [] No				/ history of sud)? (Cause?)	lden death t	petore	Yes	∐ No			
Eye/Vision problems?		Glasses Cor	ntacts Last	exam by eye d	octor			ental Bra	ces 🗌 Bri	idge [] Plate [Other	r		
Other concerns? (Crossed eye,	drooping	lids, squinting, o	lifficulty rea	ding)			Additi	onal Informat	ion:						
Ear/Hearing problems?			Yes No				Information may be shared with appropriate personnel for health and educational purposes.								
Bone/Joint problem/injury/scolic	osis?		Yes No				Parent/Guardian Signatures: Date:								
IMMUNIZATIONS: To be c contraindicated, a separa explaining the medical res	te writt	en statement	must be												
REQUIRED Vaccine/Dose	1	DOSE 1 D DA YR		OSE 2 DA YR	l l	DOSE 3 DA Y	'R	DOS MO D		N	DOSE 5		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	☐ Tda	p 🗌 Td	☐ DT	☐ Tdap ☐ Td ☐ DT		
Polio (Check specific type)		PV DPV	☐ IPV	☐ OPV	☐ IP	°V □ 0	PV	☐ IPV	☐ OPV		IPV 🗌	OPV	☐ IPV ☐ OPV		
Hib Haemophiles Influenza Type B															
Pneumococcal Conjugate															
Hepatitis B															
MMR Measles, Mumps, Rubella								Comments: * indicates invalid dose							
Varicella (Chickenpox)															
Meningococcal Conjugate															
RECOMMENDED, BUT NOT REC	QUIRED \	/accine/Dose													
Hepatitis A															
HPV															
Influenza															
Other: Specify Immunization Administered/Dates															
Health care provider (MD, DO								immunizati	on history	must si	gn belov	w.	1		
If adding dates to the above in	mmuniza	ation history sec	ction, put y	our initials b	y date(s)	and sign	here.								

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Ethnic Minority Yes No Signs of Insulin Resistance (hypertension, dyslipatems, polycopic ourser syndrome, scenthrosis registers Yes No At Risk Yes No LEAD RISK QUESTIONNAIRE. Required for children aged of months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Illipation of the resident in Chicago high high size pock on high risk is pock or high risk is possible or high risk and provided in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Blood Test Date Result Positive Negative No No No No No No No N	Student's Name		Birth (Mo/Da		Sex		Scho	ol	Grade Level/ID#					
Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and Minintrained by the School Authority. Alternative PRODE OF IMMUNITY 1. Cinical diagnosis (measles, mumps, hepatitis jis allowed when verified by hysician and supported with lab confirmation. Attach copy of lab result. 1. Cinical diagnosis (measles, mumps, hepatitis jis allowed when verified by hysician and supported with lab confirmation. Attach copy of lab result. 1. AMRASIS (Blacobia) (Monta)	Last		First	Middle										
ALTERNATIVE PROOF OF IMMUNITY 1. Clinical diagnosis (measles, mumps, hepatitis 8) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. 1. Clinical diagnosis (measles, mumps, hepatitis 8) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. 1. WARLES (blaceous) (MODA/WI) 1. HEPATITIS & MODA/WI) 2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing brow verifies that the provider of varieties and school and the provider of the providers of the providers. 2. Laboratory Evidence of Immunity (heek one) Measles' Mumps* Rubella Varicella Attach copy of lab result. 2. Laboratory Evidence of Immunity (MIDE to July 1, 2002, must be confirmed by laboratory evidence. 3. Laboratory Evidence of Immunity (MIDE to July 1, 2002, must be confirmed by laboratory evidence. 3. Laboratory Evidence of Immunity (MIDE Submitted to 10PH for review. 4. History Immunity (and the providers of the providence.) 4. History Immunity (and the providence of the providence		s of Re		nption to Immunization							of Med	ical Contraindication		
1. Clinical diagnosis (measles, mumps, hepatitis b); allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. **MIMASSIES (Ruberals) (bioplayins) **MI	ALTERNIATIVE DD	00E 0E	INANALINITY	are reviewed and ividin	iituiiie	eu by	ine sci	11001 7	\util	ority.				
**MARGELA (MODIOW?) **ARCHELA (MODIOW?) **ARCH				natitis B) is allowed when veri	fied by	nhysicis	an and c	unnort	od w	ith lah con	firmatio	n. Attach conv. of lab result		
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below retriles that the persity justical of scription of varicella disease history is indicative of past infection and is accepting such history as documentation of disease. Date of Disease Signature Itale Attach copy of lab result. All ineacles cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence. Physician Statements of immunity MUST be submitted to 10PH for review. Completion of Alternatives 1 or a MUST be accompanied by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of immunity MUST be submitted by Lab & Physician Statements of the following Family Must be submitted by Lab & Physician Statements of the following Family Must be submitted by Lab & Physician Statements of the following Family Must be submitted by Lab & Physician Statements of the following Physician Statements of the following Physician Statements	1	•		•	•	• •		• •				• •		
"All manys cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence." "All manys cases diagnosed on or after July 1, 2003, must be confirmed by laboratory evidence." Physician Statements of immunity MUST be submitted to IDPH for review. Compeletion of Jule Annabus in Comments of Statements of Immunity MUST be submitted to IDPH for review. Entire section below to be completed by MD/DO/APN/PA HEGHT WEIGHT BMI BMI PRECITITE BMI BMI BMI BMI PRECITITE BMI BMI BMI BMI PRECITITE BMI	2. History of varice	ella (chic	kenpox) diseas	e is acceptable if verified by he	ealth ca	re prov	ider, sch	hool he	alth p	rofessiona	al or hea	Ith official. Person signing below		
"All manys cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence." "All manys cases diagnosed on or after July 1, 2003, must be confirmed by laboratory evidence." Physician Statements of immunity MUST be submitted to IDPH for review. Compeletion of Jule Annabus in Comments of Statements of Immunity MUST be submitted to IDPH for review. Entire section below to be completed by MD/DO/APN/PA HEGHT WEIGHT BMI BMI PRECITITE BMI BMI BMI BMI PRECITITE BMI BMI BMI BMI PRECITITE BMI	Date of Disease		Signatur	e						Title				
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence. Physician Statements of Immunity MUST be submitted to IDPH for review. Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA HEAD CRECUMPERCENT (* 2-2) years old BMI PERCENTILE										Varicella	Δ	attach copy of lab result.		
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:	**All mumps case	s diagno	osed on or afte	r July 1, 2013, must be confirn	ned by									
Entire section below to be completed by MD/DO/APN/PA HEAD CIRCUMFERENCE if <2-3 years old	· ·		•											
HEAD CIRCUMFERENCE If < 2-3 years old	•					_								
DIABETES SCREENING: moT REQUIRED FOR DAY CARE; BMIN-85% age/Sex Yes No			-•-			-	-							
Ethnic Minority Yes No No Signs of insulin Resistance (hypertension, dynipidemia, polypotic varian syndrome, azentheus imprasma Yes No At Risk Yes No LEAD RISK QUESTIONALRE: Required for challers aged 6 months through 6 years enrolled in licensed or public-shool operated day are, preschool, nursery school and/or kindergainten. Resident Yes No Blood Test thought 6 years enrolled in licensed or public-shool operated day are, preschool, nursery school and/or kindergainten. Resident Yes No Blood Test thought 6 years Yes No Blood Test bate Reside Yes No Blood Test thought 6 years Yes No Blood Test thought 6 years Yes No Blood Test thought 6 years Yes No Blood Test Yes Yes No Blood Test Yes Yes				HEIGHT	WEIGHT	Т	Br	MI		BMI PERO	ENTILE	B/P		
LEAD RISK QUESTIONNAIRE: Required for children aged 6 months through 6 years enrolled in licensed or public-school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if realizes in Chicago or light-risk ap code.)	DIABETES SCREENING: (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes No And any two of the following: Family History Yes No													
Questionnaire Administered? Yes No Blood Test Indicated? Yes No Blood Test Date Result TB SKIN DR BLOOD TEST: Recommended only for children in high-risk categories. See OE guidelines http://www.dcd.gov/bf/publications/facsheets/testing/TB_testing.htm. No test needed Test performed Skin Test: Date Read Result: Positive Negative Walue	LEAD RISK QUESTIO	NNAIRE:	Required for child	ren aged 6 months through 6 years en										
TE SKIN OR BIJOOD TEST: Recommended only for children in high-risk groups including children immunosuppressed due to hill 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.dc.gov/tb/publications/factsheets/testing/TB_testing.htm. No test needed Test performed Skin Test: Date Read Result: Positive Negative mm	,				7 v	N.		1 T-	-+ D-			Danulk		
prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. https://www.dcd.gov/tb/publications/factsheets/testing/fb 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 SCREENINGS Date Results	☐ No test needed	☐ Test	t performed SI	kin Test: Date Read	F	Result:	Positiv	ve 🔲 1	Negat	ive mr	n			
Lab TESTS (Recommended) Date Results SCREENINGS Date Results			В	lood Test: Date Reported		Res	ult: 🗍 F	Positive		Negative	Value			
Dirinalysis Social and Emotional Screening Completed N/A	LAB TESTS (Recommo	ended)					SCREENIN	NGS		D	ate	Results		
Sickle Cell (when indicated	Hemoglobin or Hema	tocrit			Devel	lopmenta	al Screen	ing				☐ Completed ☐ N/A		
SYSTEM REVIEW Normal Comments/Follow-up/Needs Endocrine	Urinalysis									☐ Completed ☐ N/A				
Endocrine Ears Screening Result: Gastrointestinal	Sickle Cell (when indi	cated			Other	r:								
Endocrine Ears Screening Result: Gastrointestinal		I												
Screening Result: Gastrointestinal	SYSTEM REVIEW		Comments/Follo	ow-up/Needs						Comments/	Follow-u	p/Needs		
Screening Result: Genito-Urinary LMP:	Skin							L	싴					
Nose	Ears	Screening Result:					testinal							
Mouth/Dental Spinal Exam Nutritional Status Spinal Exam Nutritional Status Spinal Exam Nutritional Status Spinal Exam Spinal E	Eyes			Screening Result:				L	싴			LMP:		
Mouth/Dental	Nose					Neurolo	gical							
Cardiovascular/HTN	Throat					Musculo	skeletal							
Respiratory	Mouth/Dental					•								
Currently Prescribed Asthma Medication: Quick-relief medication (e.g., Short Acting Beta Agonist) Controller medication (e.g., inhaled corticosteroid) 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?	Cardiovascular/HTN							s [
Quick-relief medication (e.g., Short Acting Beta Agonist) Controller medication (e.g., inhaled corticosteroid) DIETARY Needs/Restrictions DIETARY Needs/R	Respiratory			Diagnosis of A			Health							
Controller medication (e.g., inhaled corticosteroid) DIETARY Needs/Restrictions				Beta Agonist)		Other			, l					
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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 Date Date														
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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	·		, •		_		_							
☐ 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 Date	-						_				-			
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PHYSICAL EDUCATION Yes No Modified INTERSCHOLASTIC SPORTS Yes No Modified Print Name Date				this child's participation in			((If No or N	/lodifie	d please attac	h explanat	tion.)		
					SPORTS	☐ Yes						•		
Address Phone	Print Name				APN	PA Si	gnature					Date		
	Address									_		Phone		