



## State of Illinois Certificate of Child Health Examination

Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#												
Last	First	Middle	Month/Day/Year															
Address			Parent/Guardian		Telephone # Home	Work												
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> 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.</b>																		
REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										<b>Comments:</b> * indicates invalid dose								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		
<b>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.</b>																		
Signature			Title			Date												
Signature			Title			Date												
<b>ALTERNATIVE PROOF OF IMMUNITY</b>																		
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> *MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR																		
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> 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. <b>Date of Disease</b> Signature Title																		
<b>3. Laboratory Evidence of Immunity (check one)</b> <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella <b>Attach copy of lab result.</b> *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.																		
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature:</b> _____ 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.

Last			First			Middle			Birth Date Month/Day/ Year			Sex	School			Grade Level/ ID		
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>																		
<b>ALLERGIES</b> (Food, drug, insect, other)			Yes	No	List:			<b>MEDICATION</b> (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				Hospitalizations? When? What for?			Yes	No						
Birth defects?			Yes	No				Surgery? (List all.) When? What for?			Yes	No						
Developmental delay?			Yes	No				Serious injury or illness?			Yes	No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes	No				TB skin test positive (past/present)?			Yes*	No	*If yes, refer to local health department.					
Diabetes?			Yes	No				TB disease (past or present)?			Yes*	No						
Head injury/Concussion/Passed out?			Yes	No				Tobacco use (type, frequency)?			Yes	No						
Seizures? What are they like?			Yes	No				Alcohol/Drug use?			Yes	No						
Heart problem/Shortness of breath?			Yes	No				Family history of sudden death before age 50? (Cause?)			Yes	No						
Heart murmur/High blood pressure?			Yes	No				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other										
Dizziness or chest pain with exercise?			Yes	No				Information may be shared with appropriate personnel for health and educational purposes.										
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____									<b>Parent/Guardian Signature</b>									
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)									<b>Date</b>									
Ear/Hearing problems?			Yes	No														
Bone/Joint problem/injury/scoliosis?			Yes	No														
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>																		
HEAD CIRCUMFERENCE if < 2-3 years old			HEIGHT			WEIGHT			BMI			BMI PERCENTILE			B/P			
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>																		
<b>LEAD RISK QUESTIONNAIRE:</b> 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.) <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Result</b> _____																		
<b>TB SKIN OR BLOOD TEST</b> 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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____																		
<b>LAB TESTS (Recommended)</b>			Date			Results			Date			Results						
Hemoglobin or Hematocrit						Sickle Cell (when indicated)												
Urinalysis						Developmental Screening Tool												
<b>SYSTEM REVIEW</b>		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			<input type="checkbox"/> Diagnosis of Asthma					Mental Health										
Currently Prescribed Asthma Medication:							Other											
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																		
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																		
<b>NEEDS/MODIFICATIONS</b> required in the school setting							<b>DIETARY</b> Needs/Restrictions											
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																		
<b>MENTAL HEALTH/OTHER</b> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal																		
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> 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.)																		
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			<b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>															
Print Name						(MD,DO, APN, PA) Signature						Date						
Address												Phone						



## PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the second, sixth and ninth grades of any public, private or parochial school shall have a dental examination. The examination must have taken place within 18 months prior to May 15 of the school year. A licensed dentist must complete the examination, sign and date this Proof of School Dental Examination Form. If you are unable to get this required examination for your child, fill out a separate Dental Examination Waiver Form.

This important examination will let you know if there are any dental problems that need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy and ready to learn. Poor oral health has been related to lower school performance, poor social relationships, and less success later in life. For this reason, we thank you for making this contribution to the health and well-being of your child.

**To be completed by the parent or guardian (please print):**

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year)
Address:	Street	City		ZIP Code
Name of School:	ZIP Code		Grade Level:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Last Name		First Name	
Student's Race/Ethnicity:				
<input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Asian <input type="checkbox"/> Native American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Multi-racial <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				

**To be completed by dentist:**

Date of Most Recent Examination: \_\_\_\_\_ (Check all services provided at this examination date)  
 Dental Cleaning       Sealant       Fluoride treatment       Restoration of teeth due to caries

**Oral Health Status (check all that apply)**

- Yes  No      **Dental Sealants Present on Permanent Molars**
- Yes  No      **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1st molars.
- Yes  No      **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.
- Yes  No      **Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

**Treatment Needs (check all that apply). For Head Start Agencies, please also list appointment date or date of most recent treatment completion date.**

- Restorative Care** — amalgams, composites, crowns, etc.      Appointment Date: \_\_\_\_\_
- Preventive Care** — sealants, fluoride treatment, prophylaxis      Appointment Date: \_\_\_\_\_
- Pediatric Dentist Referral Recommended**      Treatment Completion Date: \_\_\_\_\_

Additional comments: \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

