State of Illinois

Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Street Address City ZIP Code	Parent/Guardian			Telephone (home/work)

HEALTH HISTORY: MUST 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		Hospitalization? When? What for?	☐ Yes ☐ No	
Birth Defects?	☐ Yes ☐ No				
Developmental delay?	☐ Yes ☐ No		Surgery? (List all) When? What for?	☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	☐ 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 ______			☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other		
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) ______			Additional Information:		
Ear/Hearing problems?	☐ Yes ☐ No		Information may be shared with appropriate personnel for health and educational purposes.		
Bone/Joint problem/injury/scoliosis?	☐ Yes ☐ No		Parent/Guardian Signatures: ______ Date: ______		

IMMUNIZATIONS: To be completed by health care provider. The mo/day/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 Haemophiles Influenza Type B						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles, Mumps, Rubella				**Comments:** * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

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 ______

Student's Name			**Birth Date** (Mo/Day/Yr)	**Sex**	**School**	**Grade Level/ID#**
Last	First	Middle				

Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.

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.

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 CIRCUMFERENCE if < 2-3 years old ______ HEIGHT ______ WEIGHT ______ BMI ______ BMI PERCENTILE ______ 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 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 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**	**SCREENINGS**	**Date**	**Results**
Hemoglobin or Hematocrit			Developmental Screening		☐ Completed ☐ N/A
Urinalysis			Social and Emotional Screening		☐ Completed ☐ N/A
Sickle Cell (when indicated			Other:		

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
Illinois Department of Public Health

VISION EXAMINATION REPORT

Name ______ (Last) ______ (First) ______ (Initial)

Date ____________________

Name ______________________ Birth Date ______________ Sex ________ Grade ________

Parent or Guardian ______________________________ Phone ______________

Address ______________________________ County ______________

Testing Location ______________ Testing Agency ______________ Tester ______________

TO BE COMPLETED FOLLOWING SCREENING

TEST GIVEN

1. Instrument Used ______________________
   - a. ❑ Visual Acuity
   - b. ❑ Plus Sphere
   - c. ❑ Muscle Balance
   - d. ❑ Near and Far Binocular Vision
   - e. ❑ Other: ______________________

REASON FOR REFERRAL

1. ❑ Visual Acuity
2. ❑ Plus Sphere
3. ❑ Muscle Balance – Phoria
4. ❑ Near and Far Binocular Vision – Fusion

SYMPTOMS NOTED

1. ❑ Academic Achievement
2. ❑ Observable Signs: ______________________

TO THE DOCTOR

CHILD WEARING GLASSES OR UNDER CARE

Children wearing glasses or under care are not screened as part of the routine vision screening program. Observations by screening technicians possibly indicate the following:

❑ Frames broken / too small
❑ Lenses scratched / broken
❑ Two years since last examination
❑ Other: ______________________

TO BE COMPLETED BY EXAMINING DOCTOR

DISTANCE

(1) UNCORRECTED VISUAL ACUITY		(2) BEST CORRECTED VISUAL ACUITY	
RIGHT	LEFT	RIGHT	LEFT

(3) Ocularmotor Assessment ______________________

(4) Diagnosis ______________________

(5) Comments ______________________

PLEASE CHECK IF APPROPRIATE:

- ❑ Treatment recommended
  - ❑ Medical
  - ❑ Glasses
  - ❑ Contact Lenses
  - ❑ Other: ______________________
- ❑ Corrective lens prescribed
  - ❑ Constant Wear
  - ❑ Near Vision only
  - ❑ Far Vision only
  - ❑ May be removed for physical education
- ❑ Visual field restriction
- ❑ Amblyopia exists
- ❑ Muscle imbalance exists
  - ❑ Close work may be difficult or cause fatigue
- ❑ Preferential seating needed
- ❑ Re-examination advised
  - ❑ Six months
  - ❑ Twelve months
  - ❑ Other: ______________________

Please print or stamp

Doctors Name ______________________

Address ______________________

City ______________________

Date of Examination ______________________

CONSENT OF PARENT OR GUARDIAN

I agree to release the above information on my child or ward to appropriate school or health authorities.

____
PARENT OR GUARDIAN'S SIGNATURE

____
DOCTOR'S SIGNATURE

State of Illinois
Illinois Department of Public Health

PROOF OF SCHOOL DENTAL EXAMINATION FORM

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten, 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 require 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:	
Parent or Guardian: Last Name	First Name		

Select from the below general racial category which most clearly reflects the student's recognition of his or her community or with which the student most identifies.

☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian
☐ American Indian or Alaska Native ☐ Native Hawaiian or Pacific Islander ☐ Two or More Races

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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). Please 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:_________________

Dental Office Address: ________________________________ Office phone number: ____________

Signature of Dentist ________________________________ Date ________________________

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

STATE LAW REQUIRES:
All children 6 years of age or younger must be evaluated for lead exposure.
All children must be assessed for risk of lead exposure and tested if necessary for enrollment into daycare, preschool, and kindergarten.

Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children ages 12 and 24 months of age (at minimum) and once a year at annual well-child-visits at ages 3, 4, 5, and 6 years.

- If responses to all the questions are “NO,” re-evaluate at next age referenced above or more often if deemed necessary.
- If any response is “YES” or “DON’T KNOW,” a blood lead test must be obtained.
- If there are any “YES” or “DON”T KNOW” answers ***and***
  - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 4.9 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 4.9 µg/dL or less, and
  - ✓ there has been no change in address of the child’s home/residential building, child care facility, school, or other frequently visited facilities and
  - ✓ risks of exposure to lead have not changed, further blood lead tests are not necessary.

Child’s name: ____________________ Today’s date: ____________

Age: ________ Birthdate: ____________ ZIP Code: ____________

Respond to the following questions by circling the appropriate answer. **RESPONSE**

1. Does this child reside or regularly visit a home/residential building, child-care setting, school or other facility built before 1978 or in a high risk ZIP code area? (see reverse side of page for high risk ZIP code area list) ❑ Yes ❑ No ❑ Don’t Know
2. Is this child eligible for or enrolled in Medicaid, All Kids, Head Start, WIC, or any HFS medical program? ❑ Yes ❑ No ❑ Don’t Know

   ***All Medicaid-eligible children and children enrolled in HFS medical programs shall have a blood lead test at 12 and at 24 months of age. If a Medicaid-eligible child or HFS medical program enrolled child between 36 months and 72 months of age has not been previously tested, a blood lead test shall be performed.
3. Does this child have a sibling with a confirmed blood lead level of 5 µg/dL or higher? ❑ Yes ❑ No ❑ Don’t Know
4. In the past year, has this child been exposed to repairs, repainting, or renovation of a building/home built before 1978? ❑ Yes ❑ No ❑ Don’t Know
5. Is this child a refugee, adoptee, or recent visitor of any foreign country? ❑ Yes ❑ No ❑ Don’t Know
6. Is this child frequently exposed to imported items (such as, ayurvedic medicine, folk medicines, cosmetics, toys, glazed pottery, spices or other food items, sindoor, or kumkum)? ❑ Yes ❑ No ❑ Don’t Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example; jewelry making, building renovation, bridge construction, plumbing, furniture refinishing, work with automobile batteries or radiators, lead solder, leaded glass, bullets, lead fishing sinkers, or recycling facility work)? ❑ Yes ❑ No ❑ Don’t Know
8. If the child is younger than 12 months of age, did the child’s mother have a past confirmed blood lead level of 5 µg/dL or higher? ❑ Yes ❑ No ❑ Don’t Know
9. Has the water in your home/residential building, child-care setting, school, or other regularly visited facility been tested and had a confirmed level of lead (5 ppb or higher)? ❑ Yes ❑ No ❑ Don’t Know
10. Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead? ❑ Yes ❑ No ❑ Don’t Know

*****ALL blood lead test results MUST be submitted to the Illinois Lead Program.**
Fax: 217-557-1188 Phone: 866-909-3572

______________________________ ____________
Signature of Doctor/Nurse *Date*

Illinois Lead Program 866-909-3572 or 217-782-3517 email: dph.lead@illinois.gov
TTY (hearing impaired use only) 800-547-0466

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State of Illinois
Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

The ** indicate that any ZIP code **within a county** with the preceding numbers are considered high risk

Adams
62301
62320
62324
62338
62339
62346
62347
62348
62349
62351
62360
62365
62376

Alexander
62914
62957
62988
62990

Bond
62086
62246
62262
62273
62284

Boone
61012
61038

Brown
623**

Bureau
613**

Calhoun
62006
62013
62036
62045
62053
62070

Carroll
61014
61046
61051
61053
61074
61078

Cass
626**

Champaign
60949
61815
61816
61821
61845
61849
61851
61852
61862
61863
61866
61872

Christian
62083
625**

Clark
62420
62441
62442
62474
62477
62478

Clay
62434
628**

Clinton
62219
62250
62253
62266

Coles
61912
61920
61931
61938
61943
62469

Cook
606**
60018
60022
60043
60053
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60091
60093
60104
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602**
603**
60402
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60456
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60469
60472
60473
60475
60476
60501
60513
60526
60534
60546
60701
60706
60707
60712
60714
60803
60804
60805
60827

Crawford
62427
62433
62449
62451
62454
62478

Cumberland
62428
62447
62468

DeKalb
60111
60129
60146
60520
60550
60552

DeWitt
617**
618**

Douglas
61913
61930
61941
61942
61956

DuPage
60181
60519

Edgar
619**

Edwards
62476
62806
62815
62818

Effingham
62414
62426
62445
62461
62467

Fayette
62011
62418
62458
62471
62838
62880
62885

Ford
609**
61773

Franklin
62812
62819
62822
62825
62874
62884
62891
62896
629**

Fulton
614**
615**

Gallatin
62934
62979

Greene
620**

Grundy
60416
60424
60437
60444
60450
60474
60479

Hamilton
62817
62828
62829
62859

Hancock
61450
623**

Hardin
62919
62982

Henderson
614**

Henry
61234
61233
61235
61238
61254
61258
61262
61273
61274
614**

Iroquois
609**

Jackson
62916
62927
62932
62940
62942
62950

Jasper
62432
62434
62448
62459
62475
62480
62481

Jefferson
62814
62864
62883
62898

Jersey
62028
62030
62031
62052
62063

Jo Daviess
61001
61028
61036
61041
61075
61085
61087

Johnson
62908
62912
62923
62939
62972
62985
62995

Kane
60109
60120
60121
60144
60505
60506
60507

Kankakee
60901
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60954
60958
60961
60964
60969

Kendall
60536
60541
60650

Knox
61401
61402
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61489
61572

Lake
60040
60041
60064
60085
60099

LaSalle
60470
60518
60531
60549
60557
61301
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61321
61325
61332
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61370
61372

Lawrence
624**

Lee
605**
610**
61310
61318
61324
61331
61353
61378

Livingston
604**
609**
613**
617**

Logan
617**
625**
626**

Macon
61756
62501
62513
62514
6252*
62532
62537
62544
62551
62573

Macoupin
62009
62023
62033
62069
62085
62088
62093
62626
62630
62640
62649
62667
62672
62674
62685
62686
62690

Madison
62001
62002
62018
62024
62040
62048
62058
62060
62084
62087
62090
62095
62281

Marion
62801
62807
62849
62854
62870
62875
62882
62893

Marshall
61369
61377
61424
615**

Mason
615**
626**

Massac
62908
62953

McDonough
614**
623**

McHenry
60034
60180

McLean
61701
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61744
61754
61770
61772
61774

Menard
62642
62673
62675
62688

Mercer
612**
614**

Monroe
62279
62295
62298

Montgomery
62015
62019
62032
62049
62051
62056
62075
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62091
62094
62533
62538
62560

Morgan
62601
62628
62631
62638
62650
62651
62665
62692
62695

Moultrie
619**

Ogle
61007
61030
61043
61047
61049
61054
61061
61064
61091

Peoria
61451
61517
61523
61526
61529
61533
61536
61539
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61559
61569
6160*
61614
61615
61616

Perry
622**
62832
62997

Piatt
61813
61818
61830
61839
61855
61929
61936

Pike
623**

Pope
62938

Pulaski
62956
62963
62964
62970
62976
62992
62996

Putnam
61326
61336
61340
61363

Randolph
62217
62233
62242
62261
62272
62286
62288
62292

Richland
62419
62425
62450
62868

Rock Island
61201
61236
61237
61239
61244
61257
61259
61265
61266
61278
61279

St. Clair
62059
62201
62202
62203
62204
62205
62206
62207
62220
62223
62232
62240
62243
62255
62257
62258
62264
62289

Saline
62917
62930
62946
62965

Sangamon
62515
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Schuyler
61452
623**
626**

Scott
626**

Shelby
61957
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62553
62565

Stark
614**

Stephenson
610**

Tazewell
61534
61554
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61759

Union
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Vermilion
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Wabash
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Warren
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Washington
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Wayne
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White
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Whiteside
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Will
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Williamson
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Winnebago
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Woodford
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IDPH - Revised April 2023

1. Former high-risk ZIP Codes remained high risk (666); 2. Low to high-risk ZIP codes based on model Risk Index Score ≥15 (228); 3. Low to high-risk ZIP codes based on lead prevalence ≥7.5 at Risk Index Score <15 for ≥5 children tested with lead level ≥3.5 µg/dL% (118); 4. P.O. Box in the middle of high-risk areas (19)

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State of Illinois
Illinois Department of Public Health

Guidelines for Lead Risk Evaluation and Blood Lead Testing

- Lead risk evaluation is the use of the Childhood Lead Risk Questionnaire to determine the risk of potential for lead exposures.
- Blood lead testing is defined as obtaining a blood lead test either by capillary or venous methodology. Only a venous test can serve as a confirmatory blood test.
- A child is considered to have an elevated blood lead level once a venous test is conducted, confirming the blood lead level is ≥5 µg/dL. All capillary (finger/heel stick) test results of ≥5 µg/dL must be confirmed by venous draw. Point of care instruments such as the LeadCare® II cannot be used to confirm an elevated blood lead level, even if the sample is collected by venipuncture.
- It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or a potential exposure to lead has been identified, regardless of child's age.
- Federal mandates and the Illinois Department of Healthcare and Family Services' (HFS) policy require that all children enrolled in HFS medical programs be considered at risk for lead poisoning and receive a blood lead test at ages 12 months and 24 months. Children older than the age of 24 months, up to 72 months of age, for whom no record of a previous blood lead test exists, also must receive a blood lead test. All children enrolled in HFS medical programs (such as Medicaid, All Kids, Head Start, and WIC) are expected to receive a blood lead test regardless of where they live. (Consult Handbook for Providers of Healthy Kids Services, Chapter HK-203.3.1, for more blood lead testing and reporting information.)
- Illinois has defined ZIP code areas at high risk for lead exposure based on a variety of considerations, including housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.

Childhood Lead Risk Questionnaire

- ✓ Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children ages 12 and 24 months of age (at minimum) and once a year at annual well-child-visits at ages 3, 4, 5, and 6 years.
- ✓ If responses to all the questions are "NO," re-evaluate at next age referenced above or more often if deemed necessary.
- ✓ If any response is "YES" or "DON'T KNOW," obtain a blood lead test.
  - ◆ If there are any "YES" or "DON"T KNOW" answers and
    - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 4.9 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 4.9 µg/dL or less and
    - ✓ there has been no change in address of the child's home/residential building, child care facility, school, or other frequently visited facilities and
    - ✓ risks of exposure to lead have not changed, further blood lead tests are not necessary.

Illinois Lead Program
email: dph.lead@illinois.gov
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

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