



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?, Child wakes during night coughing?, Birth Defects?, Developmental delay?, Blood disorder?, Diabetes?, Head injury/Concussion/Passed out?, Seizures?, Heart problem/Shortness of breath?, Heart murmur/High blood pressure?, Dizziness or chest pain with exercise?; Loss of function of one of paired organs?, Hospitalization?, Surgery?, Serious injury or illness?, TB skin test positive?, TB disease?, Tobacco use?, Alcohol/Drug use?, Family history of sudden death before age 50?; Eye/Vision problems?, Other concerns?, Ear/Hearing problems?, Bone/Joint problem/injury/scoliosis?

Additional Information: Information may be shared with appropriate personnel for health and educational purposes.

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.

Table with columns for DOSE 1 through DOSE 6 (MO, DA, YR) and rows for various vaccines: DTP or DTaP, Tdap, Polio, Hib, Pneumococcal, Hepatitis B, MMR, Varicella, Meningococcal, Hepatitis A, HPV, Influenza, and 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		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Sickle Cell (when indicated)			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>
Ears	<input type="checkbox"/>	Screening Result:	Gastrointestinal	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	Screening Result:	Genito-Urinary	<input type="checkbox"/>
Nose	<input type="checkbox"/>		Neurological	<input type="checkbox"/>
Throat	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>
Mouth/Dental	<input type="checkbox"/>		Spinal Exam	<input type="checkbox"/>
Cardiovascular/HTN	<input type="checkbox"/>		Nutritional Status	<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis of Asthma	Mental Health	<input type="checkbox"/>
Currently Prescribed Asthma Medication:			Other	<input type="checkbox"/>
<input type="checkbox"/> Quick-relief medication (e.g., Short Acting Beta Agonist)				
<input type="checkbox"/> 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?

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 _____