

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
CERTIFICATE OF CHILD HEALTH EXAMINATION**

(Information on this form may be shared with appropriate personnel for health and educational purposes.)

PLEASE PRINT

STUDENT'S NAME (Last) (First) (Middle)			BIRTHDATE MO DA YR			SEX	GRADE LEVEL	SOCIAL SECURITY #
ADDRESS (Street) (City) (Zip Code)			PARENT/GUARDIAN TELEPHONE # (Home) (Work)				SCHOOL	
PARENT OR GUARDIAN			ADDRESS					

HEALTH HISTORY To be completed by parent or guardian (Circle yes or no) Comments		IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for every dose administered. The day and month is required if you cannot determine if the vaccine was given after the minimum interval or age.																
		DOSE	1			2			3			4			5			ALTERNATIVE PROOF OF IMMUNITY 1. Clinical diagnosis is acceptable if verified by Physician. MEASLES _____ MO DA YR MUMPS _____ MO DA YR 2. Laboratory confirmation of any disease is acceptable DISEASE _____ MO DA YR Lab Results _____
Chicken Pox Yes No _____		Diphtheria, Pertussis & Tetanus (DTP or DTaP)	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	
TB/TB Contact Yes No _____		Diphtheria and Tetanus (DT or Td)																
Birth Defects Yes No _____		Polio (TOPV or IPV) Specify if IPV																
Hemophilia _____ Sickle Cell _____		Haemophilus influenza type b (Hib)																
Other _____		Comb. Measles/Mumps Rubella (MMR)																
Diabetes Yes No _____		Measles (Rubella)																
Seizures Yes No _____		Rubella (3-day or German Measles)																
Heart Problems Yes No _____		Mumps																
Ear/Hearing Problems Yes No _____		Hepatitis B (HB)																
Speech Problems Yes No _____		Other (e.g. Varicella)																
Eye/Vision Problems Yes No _____		HEALTH PROVIDER VERIFICATION (PHYSICIAN, SCHOOL HEALTH PROFESSIONAL OR HEALTH OFFICIAL)																
Serious Injuries Yes No _____		Signature _____ Date _____																
Bone/Joint Problems Yes No _____		Signature _____ Date _____																
Surgery Yes No _____		Signature _____ Date _____																
When _____ What for _____		Physician's Signature/Date _____																
Hospitalization When _____ What for _____																		
Asthma Yes No _____																		
Developmental Delay Yes No _____																		
Allergies (list) _____																		
Medications (list) _____																		
Other Concerns _____																		
Parent or Guardian's Signature/Date _____																		

TO BE COMPLETED BY PHYSICIAN									
REQUIRED	HEIGHT	WEIGHT	B/P	Lead Assessment* Date	Lead Screening Indicated? Yes	No	Results		
STRONGLY RECOMMENDED	Date	Results					Needs/modifications required in the school setting		
Hemoglobin* or Hematocrit*							Medications		
Urinalysis							Dietary		
Sickle Cell* (as needed)							Special Equipment		
TB Skin Test* (as indicated)							Other		
*Mandated for state licensed child care facilities or approved schools and programs									

PHYSICAL EXAMINATION REQUIREMENTS										
	(Normal)	Comments/Follow-up					(Normal)	Comments/Follow-up		
Skin							Gastrointestinal			
Ears							Genito-Urinary			
Eyes							Neurological			
Nose							Musculoskeletal			
Throat							Spinal Examination			
Mouth/Dental							Nutritional Status			
Cardiovascular							Mental Health			
Respiratory							General comments			
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 (for one year): YES NO LIMITED										
PHYSICIAN'S NAME (print)					PHYSICIAN'S SIGNATURE					
ADDRESS					PHONE					DATE

VISION AND HEARING SCREENING DATA															
This section to be completed by IDPH certified screening personnel, if pre-existing approved IDPH form is not available. Pre-school - during first year School-age-during school year at required grade level															
Date															Code
Grade															P - Pass F - Fail U - Unable to test R - Referred
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision															
Hearing															