# Certificate of Child Health Examination

**State of Illinois**

**Certificate of Child Health Examination**

**IL444-4737 (R-01-12)**

**Complete Both Sides**

**Printed by Authority of the State of Illinois**

## Student's Name
- Last
- First
- Middle

## Birth Date
- Month/Day/Year

## Sex

## Race/Ethnicity

## School/Grade Level/ID#

## Address
- Street
- City
- Zip Code

## Parent/Guardian
- Telephone # Home
- Work

### 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. If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.

<table>
<thead>
<tr>
<th>Vaccine / Dose</th>
<th>1 MO DA YR</th>
<th>2 MO DA YR</th>
<th>3 MO DA YR</th>
<th>4 MO DA YR</th>
<th>5 MO DA YR</th>
<th>6 MO DA YR</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
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<tr>
<td>Tdap; Td or Pediatric DT (Check specific type)</td>
<td>○ Tdap ○ Td ○ DT</td>
<td>○ Tdap ○ Td ○ DT</td>
<td>○ Tdap ○ Td ○ DT</td>
<td>○ Tdap ○ Td ○ DT</td>
<td>○ Tdap ○ Td ○ DT</td>
<td>○ Tdap ○ Td ○ DT</td>
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<tr>
<td>Polio (Check specific type)</td>
<td>○ IPV ○ OPV</td>
<td>○ IPV ○ OPV</td>
<td>○ IPV ○ OPV</td>
<td>○ IPV ○ OPV</td>
<td>○ IPV ○ OPV</td>
<td>○ IPV ○ OPV</td>
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<tr>
<td>Hib Haemophilus influenza type b</td>
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<tr>
<td>Hepatitis B (HB)</td>
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<tr>
<td>Varicella (Chickenpox)</td>
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<tr>
<td>MMR Combined Measles Mumps. Rubella</td>
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<tr>
<td>Single Antigen Vaccines</td>
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</tr>
<tr>
<td>Measles</td>
<td>Rubella</td>
<td>Mumps</td>
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<tr>
<td>Pneumococcal Conjugate</td>
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<tr>
<td>Other/Specify Meningococcal, Hepatitis A, HPV, Influenza</td>
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</tbody>
</table>

Comments:

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**

### ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)*

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.

Person signing below is verifying that the parent/guardian’s description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

<table>
<thead>
<tr>
<th>Date of Disease</th>
<th>Signature</th>
<th>Title</th>
<th>Date</th>
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</thead>
</table>

3. Laboratory confirmation (check one)

- **Measles**
- **Mumps**
- **Rubella**
- **Hepatitis B**
- **Varicella**

**Lab Results**

<table>
<thead>
<tr>
<th>Date</th>
<th>MO DA YR</th>
<th>Date</th>
<th>MO DA YR</th>
</tr>
</thead>
</table>

(Attach copy of lab result)

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### VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

<table>
<thead>
<tr>
<th>Date</th>
<th>Code:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>P = Pass</td>
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<tr>
<td></td>
<td>F = Fail</td>
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<tr>
<td></td>
<td>U = Unable to test</td>
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<tr>
<td></td>
<td>R = Referred</td>
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<tr>
<td></td>
<td>G/C = Glasses/Contacts</td>
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</table>

<table>
<thead>
<tr>
<th>Age/Grade</th>
<th>R</th>
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<tbody>
<tr>
<td>Vision</td>
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<tr>
<td>Hearing</td>
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</table>

(Attach copy of lab result)

IL444-4737 (R-01-12) (COMPLETE BOTH SIDES) Printed by Authority of the State of Illinois
HEALTH HISTORY  TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)
- Diagnosis of asthma?  Yes No
- Child wakes during the night?  Yes No
- Birth defects?  Yes No
- Developmental delay?  Yes No
- Blood disorders? Hemophilia, Sickle Cell, Other? Explain. Yes No
- Diabetes?  Yes No
- Head injury/Concussion/Passed out?  Yes No
- Seizures? What are they like?  Yes No
- Heart problem/Shortness of breath?  Yes No
- Heart murmur/High blood pressure?  Yes No
- Dizziness or chest pain with exercise?  Yes No
- Eye/Vision problems?  _____ Glasses  Contacts  Last exam by eye doctor  Dental  Braces  Bridge  Plate  Other Yes No
- Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)  Yes No
- Bone/Joint problem/injury/scoliosis?  Yes No
- Ear/Hearing problems?  Yes No
- TB disease (past or present)?  Yes* No
- Tobacco use (type, frequency)?  Yes No
- Serious injury or illness?  Yes No

MEASUREMENTS
- Head circumference
- Height
- Weight
- BMI
- B/P
- Family history of sudden death before age 50? (Cause?)  Yes No
- Bone/Joint problem/injury/scoliosis?  Yes No
- Birth defects?  Yes No
- Sickle Cell, Other? Explain.

PHYSICAL EXAMINATION REQUIREMENTS  Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE  HEIGHT  WEIGHT  BMI  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  Yes* No  (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans)

LEAD RISK QUESTIONNAIRE  Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
Questionnaire Administered?  Yes No  Blood Test Indicated?  Yes No  Blood Test Date (Blood test required if resides in Chicago.)

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.
- Skin Test:  Date Read  / /  Result: Positive  Negative  mm
- Blood Test:  Date Reported  / /  Result: Positive  Negative  Value

LAB TESTS (Recommended)
- Hemoglobin or Hematocrit
- Urinalysis

SYSTEM REVIEW  Normal  Comments/Follow-up/Needs  Normal  Comments/Follow-up/Needs
- Skin
- Ears
- Eyes
- Nose
- Throat
- Mouth/Dental
- Cardiovascular/HTN
- Respiratory
- Currently Prescribed Asthma Medication:
  - Quick-relief medication (e.g. Short Acting Beta Antagonist)
  - 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)?
- If No or Modified, please attach explanation.

PHYSICAL EDUCATION  Yes No Modified  INTERSCHOLASTIC SPORTS  for one year  Yes No Limited

Student’s Name
Last  First  Middle
Birth Date  Sex  School  Grade Level/ID #

Grade Level:
Signatures
Date

Health History:
- Blood Test:  Date Reported  / /  Result: Positive
- Ethnic Minority Questionnaire Administered?
- Lead Risk Questionnaire
- Laboratory Tests
- Physical Examination Requirements
- System Review
- Special Instructions/Devices
- Mental Health/Other
- Emergency Action
- Physical Education

Address
Telephone

(Complete both sides)