



STATE OF ILLINOIS  
DEPARTMENT OF HUMAN SERVICES  
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

|                                                                   |  |  |                                                       |                        |                                      |                                      |
|-------------------------------------------------------------------|--|--|-------------------------------------------------------|------------------------|--------------------------------------|--------------------------------------|
| <b>Student's Name</b><br>Last <u>Doe</u> First <u>JANE</u> Middle |  |  | <b>Birth Date</b><br>Month/Day/Year<br><u>11-4-02</u> | <b>Sex</b><br><u>F</u> | <b>School</b><br><u>PLEASANTDALE</u> | <b>Grade Level /ID#</b><br><u>K.</u> |
|-------------------------------------------------------------------|--|--|-------------------------------------------------------|------------------------|--------------------------------------|--------------------------------------|

|                                                                                               |                                           |                                                |
|-----------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------|
| <b>Address</b><br>Street <u>8100 School St.</u> City <u>Liberage IL</u> ZIP code <u>60528</u> | <b>Parent/Guardian</b><br><u>Mary Doe</u> | <b>Telephone #</b><br>Home <u>708-246-4700</u> |
|-----------------------------------------------------------------------------------------------|-------------------------------------------|------------------------------------------------|

**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.

| VACCINE/DOSE                                     | 1                                                            |    |    | 2                                                            |    |    | 3                                                            |    |    | 4                                                            |    |    | 5                                                            |    |    | 6                                                            |    |    |  |  |  |
|--------------------------------------------------|--------------------------------------------------------------|----|----|--------------------------------------------------------------|----|----|--------------------------------------------------------------|----|----|--------------------------------------------------------------|----|----|--------------------------------------------------------------|----|----|--------------------------------------------------------------|----|----|--|--|--|
|                                                  | MO                                                           | DA | YR | MO                                                           | DA | YR | MO                                                           | DA | YR | MO                                                           | DA | YR | MO                                                           | DA | YR | MO                                                           | DA | YR |  |  |  |
| Diphtheria, Tetanus and Pertussis (DTP or DTaP)  | 12                                                           | 30 | 02 | 3                                                            | 6  | 03 | 6                                                            | 18 | 03 | 04                                                           | 21 | 04 | 11                                                           | 6  | 07 |                                                              |    |    |  |  |  |
| Diphtheria and Tetanus (Pediatric DT or Td)      |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Inactivated Polio (IPV)                          | 12                                                           | 30 | 02 | 3                                                            | 6  | 03 | 4                                                            | 21 | 04 | 11                                                           | 6  | 07 |                                                              |    |    |                                                              |    |    |  |  |  |
| Oral Polio (OPV)                                 |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Haemophilus influenzae type b (Hib)              | 2                                                            | 30 | 02 | 3                                                            | 6  | 03 | 2                                                            | 18 | 04 |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Hepatitis B (HB)                                 | 2                                                            | 30 | 02 | 3                                                            | 6  | 03 | 2                                                            | 18 | 04 |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Varicella (Chickenpox)                           | 4                                                            | 21 | 04 | 11                                                           | 6  | 07 |                                                              |    |    | Comments                                                     |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Combined Measles, Mumps and Rubella (MMR)        | 2                                                            | 18 | 04 | 11                                                           | 6  | 07 |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Measles (Rubeola)                                |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Rubella (3-day measles)                          |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Mumps                                            |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Pneumococcal (not required for school entry)     | <input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23 |    |    | <input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23 |    |    | <input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23 |    |    | <input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23 |    |    | <input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23 |    |    | <input type="checkbox"/> PCV7 <input type="checkbox"/> PPV23 |    |    |  |  |  |
| Check specific type (PCV7, PPV23)                |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |
| Other (Specify hepatitis A, meningococcal, etc.) |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |                                                              |    |    |  |  |  |

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

|                                                                                                                              |                             |                              |
|------------------------------------------------------------------------------------------------------------------------------|-----------------------------|------------------------------|
| <b>Signature</b><br><u>Dr Curreall</u>                                                                                       | <b>Title</b><br><u>M.D.</u> | <b>Date</b><br><u>6/6/08</u> |
| <b>Signature</b><br>(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) | <b>Title</b>                | <b>Date</b>                  |
| <b>Signature</b><br>(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) | <b>Title</b>                | <b>Date</b>                  |

**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.)

\*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature

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.

|                 |           |       |      |
|-----------------|-----------|-------|------|
| Date of Disease | Signature | Title | Date |
|-----------------|-----------|-------|------|

3. Laboratory confirmation (check one)  Measles  Mumps  Rubella  Hepatitis B  Varicella  
Lab Results Date MO DA YR (Attach copy of lab report, if available.)

| VISION AND HEARING SCREENING DATA                                                                  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |                                                                                               |   |
|----------------------------------------------------------------------------------------------------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|-----------------------------------------------------------------------------------------------|---|
| Pre-school - annually beginning at age 3; School age - during school year at required grade levels |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |                                                                                               |   |
| Date                                                                                               |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   | Code:<br>P = Pass<br>F = Fail<br>U = Unable to test<br>R = Referred<br>G/C = Glasses/Contacts |   |
| Age/Grade                                                                                          |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |                                                                                               |   |
|                                                                                                    | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R |                                                                                               | L |
| Vision                                                                                             |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |                                                                                               |   |
| Hearing                                                                                            |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |                                                                                               |   |

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(Complete Both Sides)

|                                                                   |                                                       |                        |                                |                                                 |
|-------------------------------------------------------------------|-------------------------------------------------------|------------------------|--------------------------------|-------------------------------------------------|
| <b>Student's Name</b><br>Last <u>Doe</u> First <u>JANE</u> Middle | <b>Birth Date</b><br><u>11-4-02</u><br>Month/Day/Year | <b>Sex</b><br><u>F</u> | <b>School</b><br><u>P-Dale</u> | <b>Grade Level/ ID #</b><br><u>Kindergarten</u> |
|-------------------------------------------------------------------|-------------------------------------------------------|------------------------|--------------------------------|-------------------------------------------------|

**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

|                                                                                                                                       |                                                                                                                                                       |
|---------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ALLERGIES</b> (Food, drug, insect, other)<br><u>Peanuts, Penicillin</u>                                                            | <b>MEDICATION</b> (List all prescribed or taken on a regular basis.)<br><u>Ritalin, Singular, &amp; Epipen</u>                                        |
| Diagnosis of asthma? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Indicate Severity <u>MILD</u>                | Loss of function of one of paired organs? (eye/ear/kidney/testicle) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>               |
| Child wakes during the night coughing? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                            | Hospitalizations? When? What for? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                 |
| Birth defects? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                    | Surgery? (List all.) When? What for? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                              |
| Developmental delay? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                              | Serious injury or illness? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                        |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>         | TB skin test positive (past/present)? Yes* <input type="checkbox"/> No <input checked="" type="checkbox"/> *If yes, refer to local health department. |
| Diabetes? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                         | TB disease (past or present)? Yes* <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                    |
| Head injury/Concussion/Passed out? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                | Tobacco use (type, frequency)? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                    |
| Seizures? What are they like? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                     | Alcohol/Drug use? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                                                 |
| Heart problem/Shortness of breath? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                | Family history of sudden death before age 50? (Cause?) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                            |
| Heart murmur/High blood pressure? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                 | Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other <u>none</u>      |
| Dizziness or chest pain with exercise? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                            | Other concerns? <u>none</u>                                                                                                                           |
| Eye/Vision problems? <u>yes</u> Glasses <input checked="" type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor | Information may be shared with appropriate personnel for health and educational purposes.                                                             |
| Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)                                                           | Parent/Guardian Signature <u>Mary Doe</u> Date <u>6/6/08</u>                                                                                          |
| Ear/Hearing problems? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                                             |                                                                                                                                                       |
| Bone/Joint problem/injury/scoliosis? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>                              |                                                                                                                                                       |

**Entire section below to be completed by MD/DO/APN/PA (\*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)**

**PHYSICAL EXAMINATION REQUIREMENTS** HEIGHT 43 1/2 in WEIGHT 43.5 lbs BMI 16.16 B/P 90/56

**DIABETES SCREENING** 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 age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.  
Blood Test Indicated? Yes  No  Blood Test Date \_\_\_\_\_ Blood Test Result \_\_\_\_\_ (Blood test required in Chicago and other high risk zip codes.)

**TB SKIN TEST** Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. Date Read 6/8/08 Result + mm

| LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES | Date | Results | Date                         | Results |
|--------------------------------------------------------------------------------|------|---------|------------------------------|---------|
| Hemoglobin * or Hematocrit *                                                   |      |         | Sickle Cell * (as indicated) |         |
| Urinalysis                                                                     |      |         | Other                        |         |

| SYSTEM REVIEW      | Normal                                                                                                                                                      | Comments/Follow-up/Needs                                                                                                                                                                                | Normal             | Comments/Follow-up/Needs                |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------|-----------------------------------------|
| Skin               | <input checked="" type="checkbox"/>                                                                                                                         |                                                                                                                                                                                                         | Endocrine          | <input checked="" type="checkbox"/>     |
| Ears               | <input checked="" type="checkbox"/>                                                                                                                         |                                                                                                                                                                                                         | Gastrointestinal   | <input checked="" type="checkbox"/>     |
| Eyes               | Normal Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>Amblyopia Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Objective screening Yes <input type="checkbox"/> No <input checked="" type="checkbox"/><br>Referred to Ophthalmologist/Optomestrist Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | Genito-Urinary     | <input checked="" type="checkbox"/> LMP |
| Nose               | <input checked="" type="checkbox"/>                                                                                                                         |                                                                                                                                                                                                         | Neurological       | <input checked="" type="checkbox"/>     |
| Throat             | <input checked="" type="checkbox"/>                                                                                                                         |                                                                                                                                                                                                         | Musculoskeletal    | <input checked="" type="checkbox"/>     |
| Mouth/Dental       | <input checked="" type="checkbox"/>                                                                                                                         |                                                                                                                                                                                                         | Spinal examination | <input checked="" type="checkbox"/>     |
| Cardiovascular/HTN | <input checked="" type="checkbox"/>                                                                                                                         |                                                                                                                                                                                                         | Nutritional status | <input checked="" type="checkbox"/>     |
| Respiratory        | <input checked="" type="checkbox"/>                                                                                                                         |                                                                                                                                                                                                         | Mental Health      | <input checked="" type="checkbox"/>     |

**NEEDS/MODIFICATIONS** required in the school setting 0 **DIETARY** Needs/Restrictions Vegetarian & Peanut free

**SPECIAL INSTRUCTIONS/DEVICES** e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup 0

**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. Epipen for Peanut allergy

On the basis of the examination on this day, I approve this child's participation in **PHYSICAL EDUCATION** Yes  No  Modified  **INTERSCHOLASTIC SPORTS** (for one year) Yes  No  Limited

Physician/Advanced Practice Nurse/Physician Assistant performing examination  
Print Name \_\_\_\_\_ Signature Dr. Curreall Date 6/6/08  
Address \_\_\_\_\_ Phone 708 246-4700

(Complete both sides)