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		Serious injury or illness?	☐ Yes ☐ No	
Diabetes?	☐ Yes ☐ No		TB skin test positive (past/present)?	☐ Yes* ☐ No	*If yes, refer to local health department
Head injury/Concussion/Passed out?	☐ Yes ☐ No		TB disease (past or present)?	☐ Yes* ☐ No	
Seizures? What are they like?	☐ Yes ☐ No		Tobacco use (type, frequency)?	☐ Yes ☐ No	
Heart problem/Shortness of breath?	☐ Yes ☐ No		Alcohol/Drug use?	☐ Yes ☐ No	
Heart murmur/High blood pressure?	☐ Yes ☐ No		Family history of sudden death before age 50? (Cause?)	☐ 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		
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

Proof of School Dental Examination Form

Illinois law (Child Health Examination Code, 77 Ill. Adm. Code 665) states all children in kindergarten and the 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 and 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 need attention by a dentist. Children need good oral health to speak with confidence, express themselves, be healthy, and be 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*	
School: *Name*	*ZIP Code*	Grade Level:	Gender: ☐ Male ☐ Female
Parent or Guardian: *Last Name*	*First Name*		

Student's Race/Ethnicity:
☐ White ☐ Black or African American ☐ Hispanic or Latino ☐ Asian ☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander ☐ Middle Eastern or North African ☐ Two or More Races ☐ Unknown

To be completed by the dentist:

Date of Most Recent Examination: ____________ (Check all services provided at this examination date)

☐ Dental Cleaning ☐ Sealant ☐ Fluoride treatment ☐ Silver Diamine Fluoride ☐ Restoration of teeth due to caries

Oral Health Status *(check all that apply)*

☐ Dental Sealants Present on Permanent Molars

☐ 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 first molars.

☐ 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.

☐ Urgent Treatment — Abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling.

Treatment Needs *(check all that apply)*
For Head Start Agencies, please also list the appointment date or date of the most recent treatment.

☐ **Restorative Care** — amalgams, composites, crowns, etc. Appointment Date: ____________

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis Appointment Date: ____________

☐ **Pediatric Dentist Referral Recommended** Treatment Completion Date: ________

Office Address: ________________________________ Office Phone: ____________

Signature of Dentist: ________________________ License #: ______________ Date: ________

Illinois
Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15th of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the child beginning school.

Student Name: ______________________________ Birth Date: ____________ Sex: _____ Grade: _____
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: ______________________________ Phone: ______________
(Last) (First) (Area Code)

Address: ______________________________ County: ______________
(Number) (Street) (City) (Zip Code)

To Be Completed By Examining Doctor

Case History

Date of Exam: ____________

Ocular History: ❑ Normal or Positive for: ______________
Medical History: ❑ Normal or Positive for: ______________
Drug Allergies: ❑ None or Allergic to: ______________
Other Information: ______________

Examination

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /

Was refraction performed with cycloplegic agents? ❑ Yes ❑ No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	❑	❑	❑	______
Internal Exam (media, lens, fundus, etc.)	❑	❑	❑	______
Neurological Integrity (pupils)	❑	❑	❑	______
Binocular Function (stereopsis)	❑	❑	❑	______
Accommodation and Vergence	❑	❑	❑	______
Color Vision	❑	❑	❑	______
IOP (glaucoma)	❑	❑	❑	______
Oculomotor Assessment	❑	❑	❑	______
Other: ______	❑	❑	❑	______

Diagnosis

❑ Normal ❑ Myopia ❑ Hyperopia ❑ Astigmatism ❑ Strabismus ❑ Amblyopia

Other: ______________

Recommendations

1. Corrective Lenses: ❑ No ❑ Yes, glasses should be worn for: ❑ Constant Wear ❑ Near Vision ❑ Far Vision
   ❑ May Be Removed for Physical Education
2. Preferential seating recommended: ❑ No ❑ Yes Comments: ______________
3. Recommend re-examination: ❑ 3 months ❑ 6 months ❑ 12 months ❑ Other ________
4. ______________
5. ______________

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)

Print Name: ______________
Optometrist or Physician Who Provides Eye Examinations

Address: ______________

____

Signature: ______________
Optometrist or Physician Who Provides Eye Examinations

Phone: ______________