



Certificate of Child Health Examination

Student's Name	Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Last _____ First _____ Middle _____				

Street Address _____ City _____ ZIP Code _____ Parent/Guardian _____ Telephone (home/work) _____

HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.

ALERGIAS (Alimentos, drogas, insectos, otro)	<input type="checkbox"/> Sí <input type="checkbox"/> No	Anote todas las alergias:	MEDICAMENTOS (Recetados o tomados con regularidad)	<input type="checkbox"/> Sí <input type="checkbox"/> No	Anote todos los medicamentos:
¿Tiene diagnóstico de asthma?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Tiene pérdida de funciones en uno de los órganos?(Ojos/Oídos/Riñones/Testículos)	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Despierta el niño tosiendo en la noche?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha sido hospitalizado?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene defectos de nacimiento?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Cuándo? ¿Para qué?		
¿Tiene retrasos del desarrollo?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha tenido alguna cirugía?(anótelas todas)	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique.	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Cuándo? ¿Para qué?		
¿Tiene diabetes?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Ha tenido heridas graves o enfermedades?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene heridas en la cabeza/golpe/desmayo?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Prueba positiva de TB (Pasado o Presente)?	<input type="checkbox"/> Sí* <input type="checkbox"/> No	*Si contestó sí, refiera al departamento de salud local
¿Tiene convulsiones? Cómo se manifiestan?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Enfermedad de TB (Pasado o Presente)?	<input type="checkbox"/> Sí* <input type="checkbox"/> No	
¿Tiene problemas cardiacos/Dificultad para respirar?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Usa tabaco (tipo, frecuencia)?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene soplo en el corazón/presión arterial alta?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Toma alcohol/drogas?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?	<input type="checkbox"/> Sí <input type="checkbox"/> No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	<input type="checkbox"/> Sí <input type="checkbox"/> No	
¿Problemas con los ojos/visión? _____	<input type="checkbox"/> Lentes <input type="checkbox"/> Lentes de Contacto	Último examen _____	<input type="checkbox"/> Dental <input type="checkbox"/> Frenos <input type="checkbox"/> Puente <input type="checkbox"/> Placas <input type="checkbox"/> Otro		
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee) _____	Información Adicional:				
¿Tiene problemas de los oídos/no oye bien?	<input type="checkbox"/> Sí <input type="checkbox"/> No	La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.			
¿Tiene problemas de los huesos/articulaciones/heridas/ escoliosis?	<input type="checkbox"/> Sí <input type="checkbox"/> No	Firma del Padre/Tutor: _____ Fecha: _____			

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			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT	<input type="checkbox"/> Tdap	<input type="checkbox"/> Td	<input type="checkbox"/> DT
Polio (Check specific type)	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV
Hib Haemophiles Influenza Type B																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles, Mumps, Rubella																		
Varicella (Chickenpox)																		
Meningococcal Conjugate																		
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

Comments: * indicates invalid dose

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 <i>Maintained</i> 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) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No And any two of the following: Family History <input type="checkbox"/> Yes <input type="checkbox"/> No						
Ethnic Minority <input type="checkbox"/> Yes <input type="checkbox"/> No Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) <input type="checkbox"/> Yes <input type="checkbox"/> No At Risk <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Blood Test Indicated? <input type="checkbox"/> Yes <input type="checkbox"/> 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						
<input type="checkbox"/> No test needed <input type="checkbox"/> Test performed		Skin Test: Date Read _____		Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative mm _____		
		Blood Test: Date Reported _____		Result: <input type="checkbox"/> Positive <input type="checkbox"/> 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"/>	LMP:
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: <input type="checkbox"/> Quick-relief medication (e.g., Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g., inhaled corticosteroid)				Other	<input type="checkbox"/>	
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified		INTERSCHOLASTIC SPORTS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified				
Print Name _____				<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> APN <input type="checkbox"/> PA Signature _____		Date _____
Address _____					Phone _____	