



State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED
CHILD CARE FACILITIES
CFS 600
Rev 11/2013



| | | | | | | |
|-----------------------|-------|----------|------------------------|------------|------------------------------|--------------------------------|
| Student's Name | | | Birth Date | Sex | Race/Ethnicity | School /Grade Level/ID# |
| Last | First | Middle | Month/Day/Year | | | |
| Address | | | Parent/Guardian | | Telephone # Home Work | |
| Street | City | Zip Code | | | | |

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 MO DA YR | | | 2 MO DA YR | | | 3 MO DA YR | | | 4 MO DA YR | | | 5 MO DA YR | | | 6 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 | | |
| Hib Haemophilus influenza type b | | | | | | | | | | | | | | | | | | |
| Hepatitis B (HB) | | | | | | | | | | | | | | | | | | |
| Varicella (Chickenpox) | | | | | | | | | | COMMENTS: | | | | | | | | |
| MMR Combined Measles Mumps. Rubella | | | | | | | | | | | | | | | | | | |
| Single Antigen Vaccines | Measles | | | Rubella | | | Mumps | | | | | | | | | | | |
| Pneumococcal Conjugate | | | | | | | | | | | | | | | | | | |
| Other/Specify Meningococcal, Hepatitis A, HPV, Influenza | | | | | | | | | | | | | | | | | | |

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 |
| 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.)

*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 (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

| | | | | | | | | | | | | | | | | | | | | | |
|-----------|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|--|
| Date | | | | | | | | | | | | | | | | | | | | | Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts |
| Age/Grade | | | | | | | | | | | | | | | | | | | | | |
| | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | |
| Vision | | | | | | | | | | | | | | | | | | | | | |
| Hearing | | | | | | | | | | | | | | | | | | | | | |

| | | | | | | |
|--|--|--|--------------------------------------|------------|---------------|--------------------------|
| Student's Name Last First Middle | | | Birth Date Month/Day/ Year | Sex | School | Grade Level/ ID # |
|--|--|--|--------------------------------------|------------|---------------|--------------------------|

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

| | | | | | |
|--|------------------|--|--|---------|--|
| ALLERGIES (Food, drug, insect, other) | | | MEDICATION (List all prescribed or taken on a regular basis.) | | |
| Diagnosis of asthma? Child wakes during the night | Yes No Yes No | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes No | |
| Birth defects? | Yes No | | Hospitalizations? When? What for? | Yes No | |
| Developmental delay? | Yes No | | Surgery? (List all.) When? What for? | Yes No | |
| Blood disorders? 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 | | Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other | | |
| Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) | | | Information may be shared with appropriate personnel for health and educational purposes. | | |
| Ear/Hearing problems? | Yes No | | Parent/Guardian Signature | | |
| Bone/Joint problem/injury/scoliosis? | Yes No | | Date | | |

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 <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | |

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. **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 | Date | Results |
|--------------------------|------|---------|------|------------------------------|
| Hemoglobin or Hematocrit | | | | Sickle Cell (when indicated) |
| Urinalysis | | | | Developmental Screening Tool |

| SYSTEM REVIEW | Normal | Comments/Follow-up/Needs | Normal | Comments/Follow-up/Needs |
|---|--------|--|--------------------|--------------------------|
| Skin | | | Endocrine | |
| Ears | | | Gastrointestinal | |
| Eyes | | Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/> | Genito-Urinary | LMP |
| Nose | | | Neurological | |
| Throat | | | Musculoskeletal | |
| Mouth/Dental | | | Spinal Exam | |
| Cardiovascular/HTN | | | Nutritional status | |
| Respiratory | | <input type="checkbox"/> Diagnosis of Asthma | Mental Health | |
| Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist) <input type="checkbox"/> Controllor 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** (for one year) Yes No Limited

| | | |
|-------------------|-----------------------------------|-------------|
| Print Name | (MD,DO, APN, PA) Signature | Date |
| Address | Phone | |

(Complete both sides)