State of Illinois  
Certificate of Child Health Examination  

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Birth Date</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
<th>School/Grade Level/ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last</td>
<td>First</td>
<td>Middle</td>
<td>Month/Day/Year</td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>Street</td>
<td>City</td>
<td>Zip Code</td>
<td>Parent/Guardian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Telephone # Home</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Work</td>
</tr>
</tbody>
</table>

**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**

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTP or DTaP</td>
<td>Tdap</td>
<td>Tdap</td>
<td>Tdap</td>
<td>Tdap</td>
<td>Tdap</td>
</tr>
</tbody>
</table>

**Polio** (Check specific type)

- IPV
- OPV

**Hepatitis B**

- IPV
- OPV

**Varicella (Chickenpox)**

- IPV
- OPV

**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.

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

**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 (Rubella)**

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>
</tr>
</thead>
</table>

3. Laboratory confirmation (check one)

- Measles
- Mumps
- Rubella
- Hepatitis B
- Varicella

<table>
<thead>
<tr>
<th>Lab Results</th>
<th>Date</th>
<th>Signature</th>
<th>Title</th>
<th>Date</th>
</tr>
</thead>
</table>

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

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

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

MEDICATION (List all prescribed or taken on a regular basis.)

Diagnosis of asthma? Yes No

Child wakes during the night Yes No

Birth defects? Yes No

Developmental delay? Yes No

Blood disorders? Hemophilia, Sickler Cell, Other? Yes No

Diabetes? Yes No

Head injury/Concussion/Passed out? Yes No

Seizures? 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? Yes No

Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) Yes No

Pharmaceuticals

Hemoglobin or Hematocrit Yes No

Sickle Cell (when indicated) Yes No

Skin Test: Date Read mm __________ Value __________

Blood Test: Date Reported mm __________ Value __________

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

Current Prescribed Asthma Medication: Yes No

Quick-relief medication (e.g. Short Acting Beta Antagonist ) Yes No

Controller medication (e.g. Inhaled Corticosteroid) Yes No

Other

DIFFERENT 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:

Yes No 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

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

Print Name (MD, DO, APN, PA) Signature Date

Address Phone

(COMPLETE BOTH SIDES)