# State of Illinois
# Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

DCFS

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

**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<br>MO DA YR | 2<br>MO DA YR | 3<br>MO DA YR | 4<br>MO DA YR | 5<br>MO DA YR | 6<br>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 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 Date MO DA YR (Attach copy of lab result)

## VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

| Date | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age/ Grade | | | | | | | | | | | | | | | | | | | | |
| | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L |
| Vision | | | | | | | | | | | | | | | | | | | | |
| Hearing | | | | | | | | | | | | | | | | | | | | |

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

| 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?<br>Child wakes during night coughing? | Yes<br>Yes | No<br>No | | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes | No | |
| Birth defects? | Yes | No | | Hospitalizations?<br>When? What for? | Yes | No | |
| Developmental delay? | Yes | No | | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes | No | | Surgery? (List all.)<br>When? What for? | Yes | No | |
| Diabetes? | Yes | No | | Serious injury or illness? | Yes | No | |
| Head injury/Concussion/Passed out? | Yes | No | | TB skin test positive (past/present)? | Yes* | No | *If yes, refer to local health department. |
| Seizures? What are they like? | Yes | No | | TB disease (past or present)? | Yes* | No | |
| Heart problem/Shortness of breath? | Yes | No | | Tobacco use (type, frequency)? | Yes | No | |
| Heart murmur/High blood pressure? | Yes | No | | Alcohol/Drug use? | Yes | No | |
| Dizziness or chest pain with exercise? | Yes | No | | Family history of sudden death before age 50? (Cause?) | Yes | No | |
| Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____<br>Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) | | | | Dental ☐ Braces ☐ Bridge ☐ Plate Other | | | |
| Ear/Hearing problems? | Yes | No | | Information may be shared with appropriate personnel for health and educational purposes.<br>Parent/Guardian Signature Date | | | |
| Bone/Joint problem/injury/scoliosis? | Yes | No | | | | | |

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA
HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI 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 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☐ No☐ | 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:<br>☐ Quick-relief medication (e.g. Short Acting Beta Antagonist)<br>☐ 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 (for one year) Yes ☐ No ☐ Limited ☐

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

Address Phone

(Complete Both Sides)