



State of Illinois  
Certificate of Child Health Examination

<b>Student's Name</b>				<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>											
Last		First		Middle		Month/Day/Year												
Address				Parent/Guardian		Telephone # Home Work												
Street				City		Zip Code												
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <u>every</u> 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.</b>																		
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>			<b>DOSE 2</b>			<b>DOSE 3</b>			<b>DOSE 4</b>			<b>DOSE 5</b>			<b>DOSE 6</b>		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
<b>DTP or DTap</b>																		
<b>Tdap; Td or Pediatric DT (Check specific type)</b>	<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		
<b>Polio (Check specific type)</b>	<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		
<b>Hib Haemophilus influenza type b</b>																		
<b>Pneumococcal Conjugate</b>																		
<b>Hepatitis B</b>																		
<b>MMR Measles Mumps Rubella</b>										<b>Comments:</b>								
<b>Varicella (Chickenpox)</b>																		
<b>Meningococcal conjugate (MCV4)</b>																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																		
<b>Hepatitis A</b>																		
<b>HPV</b>																		
<b>Influenza</b>																		
<b>Other: Specify Immunization Administered/Dates</b>																		
<b>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.</b>																		
<b>Signature</b>						<b>Title</b>						<b>Date</b>						
<b>Signature</b>						<b>Title</b>						<b>Date</b>						
<b>ALTERNATIVE PROOF OF IMMUNITY</b>																		
<b>1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b>																		
<b>*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR</b>																		
<b>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.</b>																		
<b>Date of Disease</b>						<b>Signature</b>						<b>Title</b>						
<b>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.</b>																		
<b>*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.</b>																		
<b>**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.</b>																		
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b>																		
<b>Physician Statements of Immunity MUST be submitted to IDPH for review.</b>																		

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last First Middle			Birth Date Month/Day/ Year		Sex	School	Grade Level/ ID
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other)		Yes <input type="checkbox"/> No <input type="checkbox"/>	List:		<b>MEDICATION</b> (Prescribed or taken on a regular basis.)		Yes <input type="checkbox"/> No <input type="checkbox"/>
Diagnosis of asthma?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Child wakes during night coughing?		Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes <input type="checkbox"/> No <input type="checkbox"/>
Birth defects?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Developmental delay?		Hospitalizations? When? What for?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes?		Surgery? (List all.) When? What for?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Head injury/Concussion/Passed out?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Scizures? What are they like?		Serious injury or illness?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart problem/Shortness of breath?		Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart murmur/High blood pressure?		TB skin test positive (past/present)?		Yes* <input type="checkbox"/> No <input type="checkbox"/>
Dizziness or chest pain with exercise?		Yes <input type="checkbox"/> No <input type="checkbox"/>			TB disease (past or present)?		Yes* <input type="checkbox"/> No <input type="checkbox"/>
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____		*If yes, refer to local health department.	
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 <input type="checkbox"/> No <input type="checkbox"/>	Bone/Joint problem/injury/scoliosis?		Parent/Guardian Signature		Date
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if <2-3 years old		HEIGHT		WEIGHT		BMI	B/P
<b>DIABETES SCREENING</b> (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"/>							
<b>LEAD RISK QUESTIONNAIRE:</b> Required for children age 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 <input type="checkbox"/> No <input type="checkbox"/>		Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/>		Blood Test Date		Result	
<b>TB SKIN OR BLOOD TEST</b> 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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . No test needed <input type="checkbox"/> Test performed <input type="checkbox"/> Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value _____							
<b>LAB TESTS</b> (Recommended)		Date	Results		Date	Results	
Hemoglobin or Hematocrit			Sickle Cell (when indicated)				
Urinalysis			Developmental Screening Tool				
<b>SYSTEM REVIEW</b>	Normal <input type="checkbox"/>	Comments/Follow-up/Needs		Normal <input type="checkbox"/>	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		<input type="checkbox"/> Diagnosis of Asthma		Mental Health			
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			
NEEDS/MODIFICATIONS required in the school setting				DIETARY Needs/Restrictions			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
<b>MENTAL HEALTH/OTHER</b> 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							
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> 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.)			
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>				<b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			
Print Name		(MD, DO, APN, PA)		Signature		Date	
Address				Phone			



## PROOF OF SCHOOL DENTAL EXAMINATION FORM

To be completed by the parent (please print):

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Parent or Guardian:	Address (of parent/guardian):			

To be completed by dentist:

Oral Health Status (check all that apply)

☐ Yes ☐ No **Dental Sealants Present**

☐ Yes ☐ No **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 1<sup>st</sup> molars.

☐ Yes ☐ No **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.

☐ Yes ☐ No **Soft Tissue Pathology**

☐ Yes ☐ No **Malocclusion**

Treatment Needs (check all that apply)

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

☐ **Restorative Care** — amalgams, composites, crowns, etc.

☐ **Preventive Care** — sealants, fluoride treatment, prophylaxis

☐ **Other** — periodontal, orthodontic

Please note \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date of Exam \_\_\_\_\_

Address \_\_\_\_\_  
Street City ZIP Code

Telephone \_\_\_\_\_





## State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 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 first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name \_\_\_\_\_  
(Last) (First) (Middle Initial)  
Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
(Month/Day/Year)  
Parent or Guardian \_\_\_\_\_  
(Last) (First)  
Phone \_\_\_\_\_  
(Area Code)  
Address \_\_\_\_\_  
(Number) (Street) (City) (ZIP Code)  
County \_\_\_\_\_

### 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: ☐ NKDA or Allergic to \_\_\_\_\_  
Other information \_\_\_\_\_

#### Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation? ☐ Yes ☐ No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

#### Diagnosis

☐ Normal ☐ Myopia ☐ Hyperopia ☐ Astigmatism ☐ Strabismus ☐ Amblyopia

Other \_\_\_\_\_



**Recommendations**

1. Corrective lenses: ☐ No ☐ Yes, glasses or contacts 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. \_\_\_\_\_

Print name \_\_\_\_\_  
Optometrist or physician (such as an ophthalmologist)  
who provided the eye examination ☐ MD ☐ OD ☐ DO

License Number \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

**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)

\_\_\_\_\_  
(Date)

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Source: Amended at 32 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)