



**State of Illinois
Certificate of Child Health Examination**

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



Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle		Month/Day/Year			
Address				Parent/Guardian	Telephone # Home	Work	
Address	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
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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														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
Vision															
Hearing															

Student's Name			Birth Date		Sex	School	Grade Level/ ID #	
Last	First	Middle	Month/Day/ Year					
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?	Yes	No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No		
Child wakes during the night	Yes	No		Hospitalizations? When? What for?	Yes	No		
Birth defects?	Yes	No		Surgery? (List all.) When? What for?	Yes	No		
Developmental delay?	Yes	No		Serious injury or illness?	Yes	No		
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.	
Diabetes?	Yes	No		TB disease (past or present)?	Yes*	No		
Head injury/Concussion/Passed out?	Yes	No		Tobacco use (type, frequency)?	Yes	No		
Seizures? What are they like?	Yes	No		Alcohol/Drug use?	Yes	No		
Heart problem/Shortness of breath?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No		
Heart murmur/High blood pressure?	Yes	No		Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other				
Dizziness or chest pain with exercise?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes.				
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)				Parent/Guardian Signature _____ Date _____				
Ear/Hearing problems?	Yes	No						
Bone/Joint problem/injury/scoliosis?	Yes	No						
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 <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <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 _____				
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"/> 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: <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)? 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.)								
PHYSICAL EDUCATION Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>				INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>				
Print Name			(MD,DO, APN, PA) Signature		Date			
Address				Phone				

(Complete both sides)