

Certificate of Child Health Examination

Student's Name					Birth (Mo/Da		Sex	Race/I	thnicity		Scho	ol/Grad	de Level/ID#
Last	First		Middle										
Street Address		City		ZIP Code	Parent/G	Guardian					Tele	ohone (ho	me/work)
HEALTH HISTORY	r: MUST	BE COMPL	ETED AN	ID SIGNED	BY PAF	RENT/	GUAR	DIAN AN	D VERIFIE	D BY	HEALT	H CAR	E PROVIDER
ALLEDGIEG		List:				MEDIC			Yes	List:			
(Food, drug, insect, other)	□ No					(Prescrib regular b		aken on a	□ No				
Diagnosis of Asthma?			Yes [] No			Loss o	f function of	one of paired		Yes	No	
Child wakes during night coughin	ıg?		Yes [] No				s? (eye/ear/ talization?	kidney/testicle	2)	□ vos	ا م _{ام} ا-	
Birth Defects?			Yes [] No				? What for?			Yes		
Developmental delay?			Yes [] No				ry? (List all)			Yes	□No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain. Diabetes? Head injury/Concussion/Passed out?			Yes No				When? What for?					_ ,. ├	
Diabetes?			☐ Yes ☐ No				Serious injury or illness?			.12	Yes		
Head injury/Concussion/Passed out?			Yes No				TB skin test positive (past/prese			nt)?	Yes*		*If yes, refer to local health department
Seizures? What are they like?			Yes No				TB disease (past or present)?				Yes*		nealth department
Heart problem/Shortness of brea	ath?		Yes No				Tobacco use (type, frequency)?				Yes		
Heart murmur/High blood pressu	ıre?		Yes No				Alcohol/Drug use?				Yes	No _	
Dizziness or chest pain with exerc	cise?		Yes No				Family history of sudden death bage 50? (Cause?)				Yes	No	
Eye/Vision problems?		Glasses Cor	ntacts Last	exam by eye d	loctor			ental B	races Bri	dge [] Plate [Other	
Other concerns? (Crossed eye,	drooping li	ids, squinting, c	lifficulty rea	ıding)				onal Inform					
Ear/Hearing problems?			Yes						hared with appr	opriate p	ersonnel fo	or health a	nd educational purposes.
Bone/Joint problem/injury/scolic	osis?		☐ Yes ☐ No				Parent/Guardian Signatures:			Date:			
IMMUNIZATIONS: To be contraindicated, a separa explaining the medical res	te writte	n statement	must be										
REQUIRED Vaccine/Dose	1	OOSE 1 DA YR		OSE 2 DA YR		DOSE 3 DA Y	'R		SE 4 DA YR	N	DOSE 5		DOSE 6 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	☐ Tda	ıp 🗌 Td	☐ DT	☐ Tdap ☐ Td ☐ DT
Polio (Check specific type)	☐ IP	V DPV	☐ IPV	☐ OPV	☐ IP	o 🗌 V	PV	☐ IPV	☐ OPV		IPV 🗌	OPV	☐ IPV ☐ OPV
Hib Haemophiles Influenza Type B													
Pneumococcal Conjugate													
Hepatitis B													
MMR Measles, Mumps, Rubella								Commen	ts: * ir	ndicate	s invalid	dose	
Varicella (Chickenpox)													
Meningococcal Conjugate													
RECOMMENDED, BUT NOT REC	QUIRED Va	accine/Dose			1								
Hepatitis A													
HPV													
Influenza													
Other: Specify Immunization													
Administered/Dates					1			I					
Health care provider (MD, DO	0 404: 5	A	 	1 to 101	- ff: - : - : 1)		- b -		ua bir				
If adding dates to the above in								 - immuniza	tion history	must s	gn belov	v.	
Signature								 immuniza	tion history	 must s	gn belov	v. Dat	

Student's Name				Birth Date (Mo/Day/Yr)	Sex School			Grade Level/ID#				
Last		First	Middle									
Certificate	s of Re	eligious Exer	nption to Immunizatior are reviewed and <i>Mai</i>					of Med	ical Contraind	ication		
ALTERNATIVE PRO	OF OF	IMMUNITY		•			•					
1. Clinical diagnosi	s (meas	les, mumps, he	patitis B) is allowed when veri	fied by physic	ian and su	upported w	ith lab con	firmatio	n. Attach copy of	ab result.		
*MEASLES (Rubeola)	(MO/DA	/YR)	**MUMPS (MO/DA/YR)	НЕ	PATITIS B	(MO/DA/YR)		VA	RICELLA (MO/DA/YR)			
2. History of varice verifies that the pa	Ila (chio rent/gua	kenpox) diseas rdian's description	e is acceptable if verified by hear of varicella disease history is ind	ealth care pro icative of past ir	vider, sch fection and	ool health d is acceptin	profession g such histor	al or hea y as docu	Ith official. Person mentation of disease	signing below		
Date of Disease		Signatur	e				Title					
3. Laboratory Evide	ence of	Immunity (chec	k one)	Mumps**	Rube	ella 🔲	Varicella	Δ	ttach copy of lab	result.		
			July 1, 2002, must be confirn r July 1, 2013, must be confir									
'		•	The submitted to IDPH for re-									
			ccompanied by Labs & Physician									
PHYSICAL EXAMIN		•		•	eted by I	MD/DO/A	-					
HEAD CIRCUMFEREN			HEIGHT	WEIGHT	BN			CENTILE				
DIABETES SCREENIN	G: (NOT R	EQUIRED FOR DAY CA	BMI>85% age/sex	Yes No	And any	two of the f	ollowing: Fa	mily Hist	ory 🗌 Yes 🗌 No			
	NNAIRE	Required for child	nsulin Resistance (hypertension, dysli ren aged 6 months through 6 years er				- · -					
(Blood test required if r Questionnaire Admi				☐ Yes ☐ No	ВІ	ood Test Da	ite		Result			
TB SKIN OR BLOOD	TEST: Re	commended only fo	or children in high-risk groups includir nigh-risk categories. See CDC guidelin	ng children immur						o or born in high		
,		•	kin Test: Date Read		_				ng/Tb_testing.ntm.			
No test fleeded	□ Tes	•	lood Test: Date Reported			e 🗌 Nega ositive 🔲		'' Value				
LAB TESTS (Recomme	ended)	Date	Results		SCREENIN	GS	D	ate	Resul	ts		
Hemoglobin or Hema	tocrit			Developmen	relopmental Screening Completed N/A							
Urinalysis				Social and Er	ial and Emotional Screening Completed N,							
Sickle Cell (when indi	cated			Other:								
SYSTEM REVIEW	Normal	Comments/Follo	ow-up/Needs			Normal	Comments	/Follow-u	p/Needs			
Skin				Endocri	ne							
Ears			Screening Result:	Gastroi	Gastrointestinal							
Eyes			Screening Result:	Genito-	Urinary				LMP:			
Nose				Neurol	ogical							
Throat				Muscul	oskeletal							
Mouth/Dental				Spinal I	xam							
Cardiovascular/HTN				Nutritio	nal Status							
Respiratory			Diagnosis of	Asthma Mental	Health							
Currently Prescribed	Other											
NEEDS/MODIFICATION		.g., inhaled cortic	· · · · · · · · · · · · · · · · · · ·	DIETAR	Y Needs/Res	strictions	<u> </u>					
SPECIAL INSTRUCTIO	NS/DEVI	CES (e.g., safety gla	sses, glass eye, chest protector for arrh	ythmia, pacemake	r, prosthetic	device, denta	bridge, false t	teeth, athle	tic support/cup)			
_		, .	ne school should know about this stude									
· ·			chool or school health personnel, check			er Couns		<u> </u>	s hoort proble12			
Yes No If y			o child's health condition (e.g., seizures	, astnma, insect sti	ng, tood, pe	anut allergy, b	ieeaing proble	rn, diabete	s, neart problem)?			
			this child's participation in		/1-	f No or Modifi	ed please atta	ch explanat	ion.)			
PHYSICAL EDUCATION				SPORTS Ye	•		•					
1						_						
Print Name			☐ MD ☐ DO ☐	APN □ PA S	ignature		>>-	<<	Date			