



## State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES  
CFS 600  
Rev 2/2013



<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			
<b>Address</b>			<b>Parent/Guardian</b>		<b>Telephone # Home Work</b>	
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		
	<b>DTP or DTaP</b>																	
<b>Tdap; Td or Pediatric DT</b> (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		
<b>Polio</b> (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		
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>								
<b>MMR</b> Combined Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>											
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> 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.)

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**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													
<b>Date</b>													<b>Code:</b> P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
<b>Age/Grade</b>													
	R	L	R	L	R	L	R	L	R	L	R	L	
<b>Vision</b>													
<b>Hearing</b>													

Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID
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**HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (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 night coughing?	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
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)			<b>Parent/Guardian Signature</b>	<b>Date</b>	
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** 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. (Blood test required if resides in Chicago or high risk zip code.)

**Questionnaire Administered?** Yes  No       **Blood Test Indicated?** Yes  No       **Blood Test Date**      **Result**

**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
<b>Skin</b>			<b>Endocrine</b>	
<b>Ears</b>			<b>Gastrointestinal</b>	
<b>Eyes</b>		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Genito-Urinary</b>	LMP
<b>Nose</b>			<b>Neurological</b>	
<b>Throat</b>			<b>Musculoskeletal</b>	
<b>Mouth/Dental</b>			<b>Spinal Exam</b>	
<b>Cardiovascular/HTN</b>			<b>Nutritional status</b>	
<b>Respiratory</b>		<input type="checkbox"/> Diagnosis of Asthma	<b>Mental Health</b>	
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)			<b>Other</b>	

**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** Yes  No  Limited

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

Address \_\_\_\_\_      Phone \_\_\_\_\_

(Complete Both Sides)