STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

Student's Name Last First Middle	**Birth Date** Month/Day/ Year	**Sex**	**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 MO	1 DA	1 YR	2 MO	2 DA	2 YR	3 MO	3 DA	3 YR	4 MO	4 DA	4 YR	5 MO	5 DA	5 YR	6 MO	6 DA	6 YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)																		
Diphtheria and Tetanus (Pediatric DT or Td)																		
Inactivated Polio (IPV)																		
Oral Polio (OPV)																		
Haemophilus influenzae type b (Hib)																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										Comments								
Combined Measles, Mumps and Rubella (MMR)																		
Measles (Rubeola)																		
Rubella (3-day measles)																		
Mumps																		
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23			☐PCV7 ☐PPV23		
Check specific type (PCV7, PPV23)																		
Other (Specify hepatitis A, meningococcal, etc.)																		

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **Title** **Date**

Signature
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.) **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 report, if available.)**

VISION AND HEARING SCREENING DATA

Pre-school – annually beginning at age 3; School age – during school year at required grade levels

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	R	L	R	L	R	L	
Vision																					
Hearing																					

Printed by Authority of the State of Illinois

(Complete Both Sides)

IL444-4737 (R-01-05)

Student's Name 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? Child wakes during the night coughing	Yes No Yes No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No	
Birth defects?	Yes No		Hospitalizations? When? What for?	Yes No	
Developmental delay?	Yes No				
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		Surgery? (List all.) 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 _______ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Dental ☐Braces ☐Bridge ☐Plate Other Other concerns?		
Ear/Hearing problems?	Yes No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**		
Bone/Joint problem/injury/scoliosis?	Yes No				

Entire section below to be completed by MD/DO/APN/PA

(***INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES**)

PHYSICAL EXAMINATION REQUIREMENTS **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING **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 Indicated? Yes ☐ No ☐ **Blood Test Date** **Blood Test Result** (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. **Date Read** / / **Result** **mm**

LAB TESTS ***INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES**	Date	Results		Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)		
Urinalysis			Other		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears			Gastrointestinal		
Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____________ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

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** ☐

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name **Signature** **Date**

Address **Phone**

(Complete both sides)

NEW TRIER HIGH SCHOOL HEALTH SERVICES

GUIDELINES for completion of the "Certificate of Child Health Examination"

The School Code of Illinois provides for exclusion from school for students not in compliance with health requirements. Students may not attend classes at New Trier until a health examination and immunization record is on file and in compliance with the regulations noted below.

1. Information, including student's name, should be entered on both sides of the double-sided state form, "Certificate of Child Health Examination."

2. Exam must be clearly dated no earlier than one year prior to the first day of attendance at New Trier.

3. Signature of the examining physician (MD or DO), advanced practice nurse (APN), or physician's assistant (PA) must be included under both the immunization and physical exam sections.

4. Health History (upper half page) must be completed and signed by parent/guardian.

5. Approval to participate in Physical Education and Interscholastic Sports (near the bottom of the page) must be checked by the examining physician, advanced practice nurse, or physician's assistant. Modifications, if indicated, must be specified.

6. Immunization History must include specific dates (month/day/year) and include at least the minimum number of doses at intervals noted below:
   A. Diphtheria, Pertussis, Tetanus (DPT, DtaP, DT or Td)--requires a minimum of three doses, no less than 28 days apart. The last dose must be on or after the fourth birthday and the interval between the second and third or final dose at least six months. A booster is required every 10 years. **The Advisory Committee on Immunization Practices recommends that all adolescents be given a dose of Tdap (Tetanus, diphtheria, acellular pertussis).**
   B. Polio--requires a minimum of three doses of the same type of Polio vaccine or four doses, if any combination of Polio vaccine types is given. The minimum interval between the doses is 28 days. The final dose must be received on or after the fourth birthday.
   C. Measles--requires two doses, the first on or after the first birthday and the second dose no less than 28 days later. Physician certification of having had the disease prior to July 1, 2002 or laboratory evidence of measles immunity is also acceptable. A diagnosis of measles disease made by a physician on or after July 1, 2002 must be confirmed by laboratory evidence.
   D. Mumps--requires immunization on or after the first birthday, physician diagnosed mumps disease or laboratory evidence of mumps immunity.
   E. Rubella--requires immunization on or after the first birthday or laboratory evidence of rubella immunity. Disease history is NOT an acceptable proof of immunity.
   F. Hepatitis B—requires a series of three immunizations. The first two doses must be no less than 28 days apart and the interval between the second and third doses no less than 56 days. A four month minimum interval between the first and third doses is required. Laboratory evidence of prior or current infection is also acceptable. A 2-dose schedule using Recombivax-HB for students 11-15 years old is allowed. It must be begun on or after the 11th birthday and be completed prior to the 16th birthday with a minimum four month interval between the two doses.
   G. Varicella (Chicken Pox)—Not mandated for high school students at this time (until students entering in 2011). History of disease should be reported to your physician, verified by description of the disease, and included in the child's medical record.
   H. Medical contraindication—a statement from the MD, DO, APN or PA indicating that an immunization is "medically contraindicated" and detailing what the medical condition is that prevents the child from receiving the vaccine is acceptable and will be attached to the student's physical exam form in lieu of the vaccination. In case of disease outbreak, the student must be excluded from school. Should the condition of the child later permit immunization, the requirement will then have to be met.
   I. Religious Exemption requires the filing of a signed statement setting forth specific religious objections to physical exam, health screenings, and/or immunizations on religious grounds. General philosophical or moral reluctance will not provide a sufficient basis for exemption. In case of disease outbreak, the student must be excluded from school.

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