



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 | |
| 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 |
|-----------------|-----------|-------|------|

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 | |
| Vision | | | | | | | | | | | | | |
| Hearing | | | | | | | | | | | | | |

| | | | | |
|-------------------------|-------------------------------|-----|--------|-----------------|
| 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? | 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) | | | Parent/Guardian | | |
| Ear/Hearing problems? | Yes | No | Signature | | |
| Bone/Joint problem/injury/scoliosis? | Yes | No | Date | | |

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.

Questionnaire Administered? Yes No **Blood Test Indicated?** Yes No **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** **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 |
|---|--------|--|--------------------|--------------------------|
| 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: 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

Print Name _____ (MD,DO, APN, PA) Signature _____ Date _____

Address _____ Phone _____

(Complete Both Sides)