

Please note required yellow highlighted areas, thank you.



State of Illinois  
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED  
CHILD CARE FACILITIES  
CFS 600  
Rev 11/2013



Student's Name Last First Middle			Birth Date Month/Day/Year	Sex	Race/Ethnicity	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 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:
Age/Grade																					P = Pass
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	F = Fail
Vision																					U = Unable to test
Hearing																					R = Referred
																					G/C = Glasses/Contacts

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

**PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA**

<b>HEAD CIRCUMFERENCE</b>	<b>HEIGHT</b>	<b>WEIGHT</b>	<b>BMI</b>	<b>B/P</b>
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> 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  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"/> Controllor medication (e.g. inhaled corticosteroid)			Other	

<b>NEEDS/MODIFICATIONS</b> required in the school setting	<b>DIETARY</b> Needs/Restrictions
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**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)