



**State of Illinois
Certificate of Child Health Examination**

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



Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle	Month/Day/Year			
Address			Parent/Guardian	Telephone # Home	Work	
Address	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
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)												
MMR Combined Measles Mumps. Rubella												
Single Antigen Vaccines	Measles		Rubella		Mumps							
Pneumococcal Conjugate												
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza												

COMMENTS:

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	F = Fail
Vision													U = Unable to test
Hearing													R = Referred
													G/C = Glasses/Contacts

Student's Name	Birth Date	Sex	School	Grade Level/ ID #
Last _____ First _____ Middle _____	Month/Day/ Year _____			

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 <input type="checkbox"/> No <input type="checkbox"/>	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Child wakes during the night	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hospitalizations? When? What for?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Birth defects?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Surgery? (List all.) When? What for?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Developmental delay?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Serious injury or illness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes <input type="checkbox"/> No <input type="checkbox"/>	TB skin test positive (past/present)?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
Diabetes?	Yes <input type="checkbox"/> No <input type="checkbox"/>	TB disease (past or present)?	Yes* <input type="checkbox"/> No <input type="checkbox"/>
Head injury/Concussion/Passed out?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Tobacco use (type, frequency)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures? What are they like?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alcohol/Drug use?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart problem/Shortness of breath?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Family history of sudden death before age 50? (Cause?)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Heart murmur/High blood pressure?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other _____	
Dizziness or chest pain with exercise?	Yes <input type="checkbox"/> No <input type="checkbox"/>	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 _____		Parent/Guardian Signature _____ Date _____	
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			
Ear/Hearing problems?	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Bone/Joint problem/injury/scoliosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>		

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

HEAD CIRCUMFERENCE	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI > 85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk 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 <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> Test performed <input type="checkbox"/>				
Skin Test: Date Read / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> mm _____ Blood Test: Date Reported / / Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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
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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)