FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 12/2011

DCFS

# State of Illinois
# Certificate of Child Health Examination

| 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) | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT | ☐Tdap☐Td☐DT |
| | | | | | | |
| **Polio** (Check specific type) | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ 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** | | | | | | | | | | | | | | | | | | | | | |
| **Age/ Grade** | | | | | | | | | | | | | | | | | | | | | |
| | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | R | L | |
| **Vision** | | | | | | | | | | | | | | | | | | | | | |
| **Hearing** | | | | | | | | | | | | | | | | | | | | | |

**Code:**
**P** = Pass
**F** = Fail
**U** = Unable to test
**R** = Referred
**G/C** = Glasses/Contacts

| 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 | | | | | |
| 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 | | | |
| 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 | | | | | |

**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☐ No☐ | **Genito-Urinary** | | LMP |
| **Nose** | | | **Neurological** | | |
| **Throat** | | | **Musculoskeletal** | | |
| **Mouth/Dental** | | | **Spinal Exam** | | |
| **Cardiovascular/HTN** | | | **Nutritional status** | | |
| **Respiratory** | | ☐ Diagnosis of Asthma | **Mental Health** | | |
| Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Antagonist) ☐ 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)**