



## State of Illinois Certificate of Child Health Examination

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



<b>Student's Name</b>				<b>Birth Date</b>		<b>Sex</b>	<b>Race/Ethnicity</b>		<b>School /Grade Level/ID#</b>						
Last		First		Middle		Month/Day/Year									
Address				Street		City		Zip Code		Parent/Guardian Telephone # Home Work					
<b>IMMUNIZATIONS:</b> 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 <i>after</i> the minimum interval or age. <b>If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.</b>															
<b>Vaccine / Dose</b>	<b>1</b>		<b>2</b>		<b>3</b>		<b>4</b>		<b>5</b>		<b>6</b>				
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR			
<b>DTP or DTaP</b>															
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	Tdap		Td	DT	Tdap		Td	DT	Tdap		Td	DT			
<b>Polio</b> (Check specific type)	IPV	OPV	IPV	OPV	IPV	OPV	IPV	OPV	IPV	OPV	IPV	OPV			
<b>Hib</b> Haemophilus influenza type b															
<b>Hepatitis B (HB)</b>															
<b>Varicella</b> (Chickenpox)										<b>COMMENTS:</b>					
<b>MMR Combined</b> Measles Mumps. Rubella															
<b>Single Antigen Vaccines</b>	<b>Measles</b>		<b>Rubella</b>		<b>Mumps</b>										
<b>Pneumococcal Conjugate</b>															
<b>Other/Specify</b> Meningococcal, Hepatitis A, HPV, Influenza															
<b>Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.</b> If adding dates to the above immunization history section, put your initials by date(s) and sign here.															
<b>Signature</b>				<b>Title</b>				<b>Date</b>							
<b>Signature</b>				<b>Title</b>				<b>Date</b>							
<b>ALTERNATIVE PROOF OF IMMUNITY</b>															
<b>1. Clinical diagnosis is acceptable if verified by physician.</b> *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)															
<b>*MEASLES (Rubeola) MO DA YR MUMPS MO DA YR VARICELLA MO DA YR Physician's Signature</b>															
<b>2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.</b> 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.															
<b>Date of Disease</b>		<b>Signature</b>		<b>Title</b>		<b>Date</b>									
<b>3. Laboratory confirmation (check one)</b>			<b>Measles</b>	<b>Mumps</b>	<b>Rubella</b>	<b>Hepatitis B</b>	<b>Varicella</b>								
<b>Lab Results</b>			<b>Date</b>	<b>MO</b>	<b>DA</b>	<b>YR</b>	<b>(Attach copy of lab result)</b>								

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN													
<b>Date</b>												<b>Code:</b> P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
<b>Age/Grade</b>													
	R	L	R	L	R	L	R	L	R	L	R		L
<b>Vision</b>													
<b>Hearing</b>													

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.
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**HISTORIAL MÉDICO - PARA SER COMPLETADO Y FIRMADO POR PADRES / TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD**

<b>ALERGIAS</b> (Alimentos, drogas, insectos, otro)			<b>MEDICINAS</b> (Anoté todas las recetas o tomadas con regularidad.)		
¿Tiene diagnóstico de asma?	Sí	No	¿Tiene pérdida de Funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí	No
¿Despierta el niño tosiendo en la noche?	Sí	No	¿Ha sido hospitalizado?	Sí	No
¿Tiene defectos de nacimiento?	Sí	No	¿Cuándo? ¿Por Qué?		
¿Tiene retrasos del desarrollo?	Sí	No	¿Ha atendido cirugía? (anótelas todas)	Sí	No
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí	No	¿Cuándo? ¿Para Qué?		
¿Tiene diabetes?	Sí	No	¿Ha tendido heridas graves o enfermedades?	Sí	No
¿Tiene heridas en la cabeza / golpe / desmayo?	Sí	No	¿Prueba positiva de TB (Pasado o Presente)?	Sí*	No
¿Tiene convulsiones? ¿Cómo se manifiestan?	Sí	No	¿Enfermedad de TB (Pasado o Presente)?	Sí*	No
¿Tiene problemas cardiacos / No respira bien?	Sí	No	¿Usa tabaco (tipo, Frecuencia)?	Sí	No
¿Tiene soplo en corazón / presión arterial alta?	Sí	No	¿Toma alcohol / drogas?	Sí	No
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí	No	¿Historial de familiares de muerte repentina antes de los 50 años? (¿Causa?)	Sí	No
¿Problemas con los Ojos? ___ Lentes ... Lentes de Contacto ... Último Examen ___			Dental ... Ganchos ... Puente ... Placas Otro		
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)					
¿Tiene problemas de oídos / No oye bien?	Sí	No	La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Tiene problemas de los huesos / articulaciones / heridas / escoliosis?	Sí	No	<b>Firma del Padre/Tutor</b> <span style="float: right;"><b>Fecha</b></span>		

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

<b>HEAD CIRCUMFERENCE</b> if < 2-3 years old	<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... No... And any two of the following: <b>Family History</b> Yes... No... <b>Ethnic Minority</b> Yes... No... <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes... No... <b>At Risk</b> Yes... No...				
<b>LEAD RISK QUESTIONNAIRE</b> Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.				
<b>Questionnaire Administered?</b> Yes... No... <b>Blood Test Indicated?</b> Yes... No... <b>Blood Test Date</b> (Blood test required if resides in Chicago.)				
<b>TB SKIN OR BLOOD TEST</b> 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. <b>No test needed</b> ... <b>Test performed</b> ...				
<b>Skin Test:</b>	<b>Date Read</b>	/ /	<b>Result: Positive</b> ... <b>Negative</b> ...	<b>mm</b> _____
<b>Blood Test:</b>	<b>Date Reported</b>	/ /	<b>Result: Positive</b> ... <b>Negative</b> ...	<b>Value</b> _____

<b>LAB TESTS</b> (Recommended)	Date	Results	Date	Results
Hemoglobin or Hematocrit				Sickle Cell (when indicated)
Urinalysis				Developmental Screening Tool

<b>SYSTEM REVIEW</b>	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
<b>Skin</b>			<b>Endocrine</b>	
<b>Ears</b>			<b>Gastrointestinal</b>	
<b>Eyes</b>		Amblyopia Yes... No...	<b>Genito-Urinary</b>	LMP
<b>Nose</b>			<b>Neurological</b>	
<b>Throat</b>			<b>Musculoskeletal</b>	
<b>Mouth/Dental</b>			<b>Spinal Exam</b>	
<b>Cardiovascular/HTN</b>			<b>Nutritional status</b>	
<b>Respiratory</b>		... Diagnosis of Asthma	<b>Mental Health</b>	
Currently Prescribed Asthma Medication: ... Quick-relief medication (e.g. Short Acting Beta Antagonist) ... Controller medication (e.g. inhaled corticosteroid)			<b>Other</b>	

<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
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Address	Phone
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(Complete Both Sides)