



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

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES  
CFS 600  
Rev 2/2013



Student's Name			Birth Date	Sex	Race/Ethnicity	School/Grade Level/ID#
Last	First	Middle	Month/Day/Year			
Address			Parent/Guardian	Telephone # Home	Work	
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)																		
MMR Combined Measles Mumps Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps			COMMENTS:								
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)	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella
Lab Results	Date MO DA YR	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Varicella
			(Attach copy of lab result)

**VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN**

Date											Code:		
Age/Grade												P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts	
	R	L	R	L	R	L	R	L	R	L	R		L
Vision													
Hearing													

<b>Last</b> _____ <b>First</b> _____ <b>Middle</b> _____	<b>Birth Date</b> Month/Day/ Year _____	<b>Sex</b> _____	<b>School</b> _____	<b>Grade Level/ ID</b> _____
--	--	---------------------	------------------------	---------------------------------

**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?	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 Other _____		
Dizziness or chest pain with exercise?	Yes	No	Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____		
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)		
Ear/Hearing problems?	Yes	No	Bone/Joint problem/injury/scoliosis?	Yes	No
Bone/Joint problem/injury/scoliosis?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes. <b>Parent/Guardian Signature</b> _____ <b>Date</b> _____		

**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. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes  No  Blood Test Indicated? Yes  No  Blood Test Date \_\_\_\_\_ Result \_\_\_\_\_

**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 Agonist) <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** Yes  No  Limited

**Print Name** \_\_\_\_\_ (MD,DO, APN, PA) **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Address** \_\_\_\_\_ **Phone** \_\_\_\_\_

(Complete Both Sides)