



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 <i>after</i> 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		2		3		4		5		6					
	MO	DA	YR	MO	DA	YR	MO	DA	YR	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		
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	
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) <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Varicella																
Lab Results		Date		MO		DA		YR		(Attach copy of lab result)						

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

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID
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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	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	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 _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Parent/Guardian Signature _____ Date _____				
Ear/Hearing problems?					
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. (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:
 Quick-relief medication (e.g. Short Acting Beta Agonist)
 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)