



## State of Illinois Certificate of Child Health Examination

<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				Parent/Guardian		Telephone # Home						
Street				City		Zip Code						
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.</b>												
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>		<b>DOSE 2</b>		<b>DOSE 3</b>		<b>DOSE 4</b>		<b>DOSE 5</b>		<b>DOSE 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)	<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	
<b>Polio</b> (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	
<b>Hib</b> Haemophilus influenza type b												
<b>Pneumococcal Conjugate</b>												
<b>Hepatitis B</b>												
<b>MMR</b> Measles Mumps. Rubella												
<b>Varicella</b> (Chickenpox)												
<b>Meningococcal conjugate (MCV4)</b>												
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>												
<b>Hepatitis A</b>												
<b>HPV</b>												
<b>Influenza</b>												
<b>Other: Specify Immunization Administered/Dates</b>												
<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 (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> <b>*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR</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 verifies 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> <span style="margin-left: 100px;"><b>Signature</b></span> <span style="margin-left: 100px;"><b>Title</b></span>												
<b>3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/>Measles* <input type="checkbox"/>Mumps** <input type="checkbox"/>Rubella <input type="checkbox"/>Varicella Attach copy of lab result.</b> *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.												
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b> Physician Statements of Immunity MUST be submitted to IDPH for review.												

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last			First			Middle			Birth Date Month/Day/ Year			Sex		School		Grade Level/ ID	
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>																	
<b>ALLERGIES</b> (Food, drug, insect, other)			Yes No		List:			<b>MEDICATION</b> (Prescribed or taken on a regular basis.)			Yes No		List:				
Diagnosis of asthma?			Yes No		Child wakes during night coughing?			Loss of function of one of paired organs? (eye/ear/kidney/testicle)			Yes No						
Birth defects?			Yes No		Developmental delay?			Hospitalizations? When? What for?			Yes No						
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes No		Diabetes?			Surgery? (List all.) When? What for?			Yes No						
Head injury/Concussion/Passed out?			Yes No		Seizures? What are they like?			TB skin test positive (past/present)?			Yes* No		*If yes, refer to local health department.				
Heart problem/Shortness of breath?			Yes No		Heart murmur/High blood pressure?			TB disease (past or present)?			Yes* No						
Dizziness or chest pain with exercise?			Yes No		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)			Serious injury or illness?			Yes No						
Ear/Hearing problems?			Yes No		Bone/Joint problem/injury/scoliosis?			Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			Yes No						
								Information may be shared with appropriate personnel for health and educational purposes.									
								Parent/Guardian Signature			Date						
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>																	
HEAD CIRCUMFERENCE if < 2-3 years old			HEIGHT			WEIGHT			BMI			B/P					
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE)</b> BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>																	
<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. (Blood test required if resides in Chicago or high risk zip code.) <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Result</b> _____																	
<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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____																	
<b>LAB TESTS (Recommended)</b>			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					
Skin								Endocrine									
Ears				Screening Result:				Gastrointestinal									
Eyes				Screening Result:				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:								Other									
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																	
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																	
<b>NEEDS/MODIFICATIONS</b> required in the school setting								<b>DIETARY</b> Needs/Restrictions									
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																	
<b>MENTAL HEALTH/OTHER</b> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal																	
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> 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.)																	
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> <b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>																	
Print Name						(MD,DO, APN, PA) Signature						Date					
Address												Phone					



## State of Illinois Certificate of Child Health Examination

<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				Parent/Guardian		Telephone # Home						
Street		City		Zip Code		Work						
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for <i>every</i> dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.</b>												
<b>REQUIRED Vaccine / Dose</b>	<b>DOSE 1</b>		<b>DOSE 2</b>		<b>DOSE 3</b>		<b>DOSE 4</b>		<b>DOSE 5</b>		<b>DOSE 6</b>	
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
<b>DTP or DTaP</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Tdap; Td or Pediatric DT</b> (Check specific type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Polio</b> (Check specific type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hib</b> Haemophilus influenza type b	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Pneumococcal Conjugate</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hepatitis B</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>MMR</b> Measles Mumps. Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Varicella</b> (Chickenpox)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Meningococcal conjugate (MCV4)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>												
<b>Hepatitis A</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>HPV</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Influenza</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other: Specify Immunization Administered/Dates</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<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 (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.</b> <b>*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR</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 verifies 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>3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella Attach copy of lab result.</b> *All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.												
<b>Completion of Alternatives 1 or 3 MUST be accompanied by Labs &amp; Physician Signature: _____</b> Physician Statements of Immunity MUST be submitted to IDPH for review.												

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last			First			Middle			Birth Date Month/Day/ Year			Sex		School		Grade Level/ ID	
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>																	
<b>ALLERGIES</b> (Food, drug, insect, other)			Yes No		List:			<b>MEDICATION</b> (Prescribed or taken on a regular basis.)			Yes No		List:				
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)			Yes		No			<b>Parent/Guardian Signature</b>			<b>Date</b>						
Ear/Hearing problems?			Yes		No												
Bone/Joint problem/injury/scoliosis?			Yes		No												
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>																	
HEAD CIRCUMFERENCE if <2-3 years old						HEIGHT			WEIGHT			BMI			B/P		
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>																	
<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. (Blood test required if resides in Chicago or high risk zip code.) <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Result</b> _____																	
<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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> / / <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____																	
<b>LAB TESTS (Recommended)</b>		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									
Skin						Endocrine											
Ears				Screening Result:		Gastrointestinal											
Eyes				Screening Result:		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:						Other											
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																	
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																	
<b>NEEDS/MODIFICATIONS</b> required in the school setting						<b>DIETARY</b> Needs/Restrictions											
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup																	
<b>MENTAL HEALTH/OTHER</b> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal																	
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> 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.)																	
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>						<b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>											
Print Name						(MD,DO, APN, PA) Signature						Date					
Address _____ Phone _____																	