



**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			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			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	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	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV	<input type="checkbox"/> IPV	<input type="checkbox"/> OPV		
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)																		
<b>MMR Combined</b> Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>			COMMENTS:								
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> 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.)

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**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.

<b>Date of Disease</b>	<b>Signature</b>	<b>Title</b>	<b>Date</b>
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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**

<b>Date</b>																		
<b>Age/Grade</b>																		
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L
<b>Vision</b>																		
<b>Hearing</b>																		

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

<b>Student's Name</b>			<b>Birth Date</b>		<b>Sex</b>	<b>School</b>	<b>Grade Level/ ID #</b>
Last	First	Middle	Month/Day/ Year				
<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)				<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 the night	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	*If yes, refer to local health department.
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 <input type="checkbox"/> 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)				<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>							
<b>HEAD CIRCUMFERENCE</b>		<b>HEIGHT</b>		<b>WEIGHT</b>		<b>BMI</b>	<b>B/P</b>
<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. <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> _____ (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> <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>	<b>Date</b>	<b>Results</b>		<b>Date</b>	<b>Results</b>		
Hemoglobin or Hematocrit					Sickle Cell (when indicated)		
Urinalysis					Developmental Screening Tool		
<b>SYSTEM REVIEW</b>	<b>Normal</b>	<b>Comments/Follow-up/Needs</b>		<b>Normal</b>	<b>Comments/Follow-up/Needs</b>		
<b>Skin</b>				<b>Endocrine</b>			
<b>Ears</b>				<b>Gastrointestinal</b>			
<b>Eyes</b>		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>		<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>		<input type="checkbox"/> Diagnosis of Asthma		<b>Mental Health</b>			
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g.Short Acting Beta Antagonist ) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				<b>Other</b>			
<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)? <b>Yes</b> <input type="checkbox"/> <b>No</b> <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> (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>			
<b>Print Name</b>		(MD,DO, APN, PA)		<b>Signature</b>		<b>Date</b>	
<b>Address</b>				<b>Phone</b>			

(Complete both sides)