

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 I	Oate		Sex	Race	e/Ethnici	ity	Scho	ol /Gra	de Leve	I/ID#
Last First Middle									Day/Year									
Address Stree	Zip Code				Parent/Gu				Home		Work							
	IMMUNIZATIONS : To be completed by health care provider. Note the mo/da/yr for <i>every</i> 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	se 1 MO DA YR				MO DA YR			MO DA YR			MO DA YR		5 MO DA YR			6 MO DA YR		
DTP or DTaP																		
Tdap; Td or Pediatric	□Tdap□Td□DT			□Tdap□Td□DT			□Td	□Tdap□Td□DT			dap□Tdl	□DT	OT □Tdap□Td□DT			□Tdap□Td□DT		
DT (Check specific type)																		
Polio (Check specific		PV 🗆	OPV		PV 🗆	OPV		□ IPV □ OPV			□ IPV □ OPV		V IPV C		OPV		IPV 🗆	OPV
type)																		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)										COMMENTS:								
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines]	Measles 	s]	Rubella	a 		Mump 	os	_								
Pneumococcal Conjugate																		
Other/Specify		•	•					•	•		<u>'</u>						•	
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								Ti	itle					Dat	e			
Signature								Ti	itle					Dat	e			
ALTERNATIVE PR																		
1. Clinical diagnosis is a	•		•	• •							er July 1, 2			rmed by l	laborator	y evideno	ce.)	
*MEASLES (Rubeola) 2. History of varicella (DA YI le if ver		ARICEL by health						gnature nal or he	alth offi	icial.			
Person signing below is veri	fying that	the paren			iption of v	varicella	a disease h	istory is i	indicative	of past i	nfection an	d is acce	pting such	history a	is docum	entation	of disease	
Date of Disease	4 (Signatu			М	r	7D1-	Title		notiti a D		1 Vo≗	ll _o	Date			
3. Laboratory confirma Lab Results	iuon (ch	ieck one	*	easles Date		lMum DA	ips l Yr	⊐Rube	118 	⊔He]	patitis B		IVarice Attach c		ab resu	lt)		
Dete		VISIO	N AND	HEAR	ING SC	REEN	NING BY	IDPH	CERTIF	FIED S	CREENI	ING TI	ECHNIC	CIAN				

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

					Birtl	n Date	Sex	Sc	hool			Grade Level/ ID		
Last	Firs			Middle	<u> </u>	Month/Day/ Year								
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER MEDICATION (t in all proprieted on taken)														
ALLERGIES (Food, drug, insect, other) MEDICATION (List all prescribed or taken on a regular basis.)														
Diagnosis of asthma? Child wakes during night co	oughing?	Yes Yes				Loss of function of one organs? (eye/ear/kidney		Yes	No					
Birth defects?		Yes	No			Hospitalizations?		Yes	No					
Developmental delay?		Yes	No			When? What for?								
Blood disorders? Hemophil Sickle Cell, Other? Explain		Yes	No			Surgery? (List all.) When? What for?			Yes	No				
Diabetes?	1.	Yes	No			Serious injury or illness		Yes	No					
Head injury/Concussion/Pa	ssed out?	Yes				TB skin test positive (pa)?	Yes*		If yes, refe	er to local health		
Seizures? What are they lil	ke?	Yes	No			TB disease (past or pres	ent)?		Yes*	No	department			
Heart problem/Shortness of	breath?	Yes	No			Tobacco use (type, frequ	uency)?		Yes	No				
Heart murmur/High blood	oressure?	Yes	No			Alcohol/Drug use?	-		Yes	No				
Dizziness or chest pain with exercise?	1	Yes	No			Family history of sudden death Yes No before age 50? (Cause?)								
Eye/Vision problems? Other concerns? (crossed eye				Last exam by eye doctor		Dental □ Braces	□ Brio	dge	□ Plate	e Other	Other			
Ear/Hearing problems?	-,	Yes				Information may be shared	with approp	riate p	ersonnel f	or health a	and education	nal purposes.		
Bone/Joint problem/injury/s	scoliosis?	Yes	No)		Parent/Guardian Signature			Date					
PHYSICAL EXAMINATION REQUIREMENTS HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI B/P														
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes \(\text{NO} \) No \(\text{NO} \) And any two of the following: Family History Yes \(\text{NO} \) No \(\text{DETHING (NOT REQUIRED FOR DAY CARE)} \) Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes \(\text{NO} \) No \(\text{DETHING (NOT REQUIRED FOR DAY CARE)} \) No \(\text{DETHING (NOT REQUIRED FOR DAY CARE)} \) No \(\text{DEMING (NOT REQUIRED FOR DAY CARE)} \) No \(DEMING (NOT REQUIRE														
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 \Book \No \Book Blood Test Indicated? Yes \Book No \Book 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 t	hose expos	ed to adults	in high-r	isk categories. See CDC guidelin	es.	No test needed □	Test p	erfor	med 🗆					
Skin Test: Date Rea Blood Test: Date Rep		1 1		Result: Positive \square Negati Result: Positive \square Negat		mm Value		_						
LAB TESTS (Recommended)		Da	ite	Results					D	ate		Results		
Hemoglobin or Hematocrit	t					Sickle Cell (when inc								
Urinalysis						Developmental Scree								
SYSTEM REVIEW	Normal	Comme	ts/Follo	w-up/Needs			Com	ments/F	ollow-u	p/Needs				
Skin						Endocrine								
Ears						Gastrointestinal								
Eyes				Amblyopia Yes□	No□	Genito-Urinary		LMP						
Nose						Neurological								
Throat						Musculoskeletal								
Mouth/Dental						Spinal Exam								
Cardiovascular/HTN						Nutritional status								
Respiratory				☐ Diagnosis of Asth	ma	Mental Health								
☐ Quick-relief	Currently Prescribed Asthma Medication: Quick-relief medication (e.g. Short Acting Beta Agonist) Other													
□ Controller medication (e.g. inhaled corticosteroid) 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: \Boxed Nurse \Boxed Teacher \Boxed Counselor \Boxed 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 PHYSICAL EDUCATIO					NTERS	(If No or Mo SCHOLASTIC SPOR		ase atta	ch explar	nation.) Yes [□ No □	Limited □		
Print Name	Print Name (MD,DO, APN, PA) Signature Date											Date		
Address					P	Phone		_						