



**No Shots?  
No Records?  
NO SCHOOL!**

**PLEASE NOTE:** If you are registering a child for Kindergarten & 6<sup>th</sup> Grade, you will need a physical and immunizations before the first day of school.

**You do not need to have this done to register the child.**

**Beat the crowd, do it now!!**

**TENGA EN CUENTA:** Si está inscribiendo a un niño para el Jardín de Infancia y 6<sup>o</sup> Grado, necesitará un examen físico y vacunas antes del primer día de clases.

**No es necesario tenerlo listo para poder registrar al niño.**

**Venza a la multitud y hágalo ahora!!**



# Certificate of Child Health Examination

<b>Student's Name</b>			<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School/Grade Level/ID#</b>
Last	First	Middle				

Street Address	City	ZIP Code	Parent/Guardian	Telephone (home/work)
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**HEALTH HISTORY: MUST BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

<b>ALLERGIES</b> (Food, drug, insect, other)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>List:</b>	<b>MEDICATION</b> (Prescribed or taken on a regular basis)		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>List:</b>
Diagnosis of Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Child wakes during night coughing?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Hospitalization? When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Birth Defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Surgery? (List all) When? What for?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Developmental delay?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Serious Injury or illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No			TB skin test positive (past/present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No		*If yes, refer to local health department
Diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No			TB disease (past or present)?	<input type="checkbox"/> Yes* <input type="checkbox"/> No		
Head Injury/Concussion/Passed out?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Tobacco use (type, frequency)?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Seizures? What are they like?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Alcohol/Drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart problem/Shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No			Family history of sudden death before age 50? (Cause?)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Heart murmur/High blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Dizziness or chest pain with exercise?	<input type="checkbox"/> Yes <input type="checkbox"/> No						
Eye/Vision problems? _____	<input type="checkbox"/> Glasses <input type="checkbox"/> Contacts	Last exam by eye doctor _____		<input type="checkbox"/> Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Other concerns? (Crossed eye, drooping lids, squinting, difficulty reading) _____				<b>Additional Information:</b>			
Ear/Hearing problems? _____				Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/injury/scoliosis? _____				Parent/Guardian Signatures: _____ Date: _____			

**IMMUNIZATIONS: To be completed by health care provider. The mo/day/yr for every 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.**

REQUIRED Vaccine/Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	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	<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 Haemophiles Influenza Type B																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles, Mumps, Rubella																		
Varicella (Chickenpox)																		
Meningococcal Conjugate																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose</b>																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

**Comments:** \* indicates invalid dose

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 \_\_\_\_\_

<b>Student's Name</b>	<b>Birth Date</b> (Mo/Day/Yr)	<b>Sex</b>	<b>School</b>	<b>Grade Level/ID#</b>
Last _____ First _____ Middle _____				

**Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.**

**ALTERNATIVE PROOF OF IMMUNITY**

**1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.**

\*MEASLES (Rubeola) (MO/DA/YR) \_\_\_\_\_ \*\*MUMPS (MO/DA/YR) \_\_\_\_\_ HEPATITIS B (MO/DA/YR) \_\_\_\_\_ VARICELLA (MO/DA/YR) \_\_\_\_\_

**2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. 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.**

Date of Disease \_\_\_\_\_ Signature \_\_\_\_\_ Title \_\_\_\_\_

**3. Laboratory Evidence of Immunity (check one)**     Measles\*     Mumps\*\*     Rubella     Varicella    Attach copy of lab result.

\*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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: \_\_\_\_\_

**PHYSICAL EXAMINATION REQUIREMENTS    Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BMI \_\_\_\_\_ BMI PERCENTILE \_\_\_\_\_ 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 aged 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. [http://www.cdc.gov/tb/publications/factsheets/testing/TB\\_testing.htm](http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm).

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	SCREENINGS	Date	Results
Hemoglobin or Hematocrit			Developmental Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Urinalysis			Social and Emotional Screening		<input type="checkbox"/> Completed <input type="checkbox"/> N/A
Sickle Cell (when indicated)			Other:		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Normal	Comments/Follow-up/Needs
Skin	<input type="checkbox"/>		Endocrine	<input type="checkbox"/>	
Ears	<input type="checkbox"/>	Screening Result:	Gastrointestinal	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	Screening Result:	Genito-Urinary	<input type="checkbox"/>	LMP:
Nose	<input type="checkbox"/>		Neurological	<input type="checkbox"/>	
Throat	<input type="checkbox"/>		Musculoskeletal	<input type="checkbox"/>	
Mouth/Dental	<input type="checkbox"/>		Spinal Exam	<input type="checkbox"/>	
Cardiovascular/HTN	<input type="checkbox"/>		Nutritional Status	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis of Asthma	Mental Health	<input type="checkbox"/>	
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	<input type="checkbox"/>	
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  Modified

Print Name \_\_\_\_\_  MD  DO  APN  PA    Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

## State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician who provides complete eye examinations be submitted to the school no later than October 15<sup>th</sup> of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the child beginning school.

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Sex: \_\_\_\_\_ Grade: \_\_\_\_\_  
(Last) (First) (Middle Initial) (Mo.) (Day) (Yr.)

Parent or Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Last) (First) (Area Code)

Address: \_\_\_\_\_ County: \_\_\_\_\_  
(Number) (Street) (City) (Zip Code)

### To Be Completed By Examining Doctor

#### Case History

Date of Exam: \_\_\_\_\_

Ocular History:  Normal or Positive for: \_\_\_\_\_  
 Medical History:  Normal or Positive for: \_\_\_\_\_  
 Drug Allergies:  NKDA or Allergic to: \_\_\_\_\_  
 Other Information: \_\_\_\_\_

#### Examination

Refraction:	Distance			Near
	Right	Left	Both	Both
Unaided Visual Acuity:	20 /	20 /	20 /	20 /
Best Corrected Visual Acuity:	20 /	20 /	20 /	20 /

Was refraction performed with cycloplegic agents?  Yes  No

	Normal	Abnormal	Not Able to Assess	Comments
External Exam (eye and adnexa)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal Exam (media, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurological Integrity (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular Function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and Vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
IOP (glaucoma)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor Assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

#### Diagnosis

Normal  Myopia  Hyperopia  Astigmatism  Strabismus  Amblyopia

Other: \_\_\_\_\_

#### Recommendations

- Corrective Lenses:  No  Yes, glasses should be worn for:  Constant Wear  Near Vision  Far Vision  
 May Be Removed for Physical Education
- Preferential seating recommended:  No  Yes Comments: \_\_\_\_\_
- Recommend re-examination:  3 months  6 months  12 months  Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Print Name: \_\_\_\_\_  
Optometrist or Physician Who Provides Eye Examinations

Address: \_\_\_\_\_  
 \_\_\_\_\_

Signature: \_\_\_\_\_  
Optometrist or Physician Who Provides Eye Examinations

**Consent of Parent or Guardian**

I agree to release the above information on my child or ward to appropriate school or health authorities.

\_\_\_\_\_

(Parent or Guardian's Signature)

Phone: \_\_\_\_\_

**Illinois Department of Public Health  
PROOF OF SCHOOL DENTAL EXAMINATION FORM**



**To be completed by the parent (please print):**

Student's Name:	Last	First	Middle	Birth Date: (Month/Day/Year) / /
Address:	Street	City	ZIP Code	Telephone:
Name of School:	Grade Level:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent or Guardian:	Address (of parent/guardian):			

**To be completed by dentist:**

**Oral Health Status (check all that apply)**

Yes  No **Dental Sealants Present**

Yes  No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1<sup>st</sup> molars.

Yes  No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.

Yes  No **Soft Tissue Pathology**

Yes  No **Malocclusion**

**Treatment Needs (check all that apply)**

**Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling

**Restorative Care** — amalgams, composites, crowns, etc.

**Preventive Care** — sealants, fluoride treatment, prophylaxis

**Other** — periodontal, orthodontic

Please note \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City ZIP Code

Telephone \_\_\_\_\_

Illinois Department of Public Health, Division of Oral Health, 535 W. Jefferson St., Springfield, IL 62761  
217-785-4899 • TTY (hearing impaired use only) 800-547-0466 • www.idph.state.il.us



## FORMULARIO COMPROBANTE DEL EXAMEN DENTAL ESCOLAR

Para ser completado por el padre/madre (por favor impresión):

Nombre del Estudiante:	Apellido	Nombre	Inicial	Fecha de Nacimiento: / / (Mes/Día/Año)
Dirección:	Calle	Ciudad	Código Postal	Número de Teléfono:
Nombre de la Escuela:	Grado:		Sexo: <input type="checkbox"/> Masculino <input type="checkbox"/> Femenino	
Nombre del padre/madre o encargado:			Dirección del padre/madre o encargado:	

To be completed by dentist: (Para ser completado por el dentista:)

### Oral Health Status (check all that apply)

- Yes  No **Dental Sealants Present**
- Yes  No **Caries Experience / Restoration History** — A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR missing permanent 1<sup>st</sup> molars.
- Yes  No **Untreated Caries** — At least 1/2 mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pit and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present.
- Yes  No **Soft Tissue Pathology**
- Yes  No **Malocclusion**

### Treatment Needs (check all that apply)

- Urgent Treatment** — abscess, nerve exposure, advanced disease state, signs or symptoms that include pain, infection, or swelling
- Restorative Care** — amalgams, composites, crowns, etc.
- Preventive Care** — sealants, fluoride treatment, prophylaxis
- Other** — periodontal, orthodontic

Please note \_\_\_\_\_

Signature of Dentist \_\_\_\_\_

Date of Exam \_\_\_\_\_

Address \_\_\_\_\_  
Street City ZIP Code

Telephone \_\_\_\_\_

