ILLINOIS DEPARTMENT OF PUBLIC HEALTH
ILLINOIS DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION
(Information on this form may be shared with appropriate personnel for health and educational purposes.)

Please Print

Student's Name	**Birth Date**	Sex	Grade Level	ID #
Address Street City ZIP Code	Parent/ Guardian	Telephone # Home:	Work	

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 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
Diphtheria, Tetanus and Pertussis (DTP or DTaP)						
Diphtheria and Tetanus (Pediatric DT or Td)						
Inactivated Polio (IPV)						
Oral Polio (OPV)						
Haemophilus influenzae type b (Hib)						
Hepatitis B (HB)						
Varicella (Chickenpox)						
Combined Measles, Mumps and Rubella (MMR)						
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Pneumococcal (not required for school entry)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23
Check specific type (PCV7, PPV23) Date						
Other (Specify: Hepatitis A, meningococcal, etc.)						

Comments:

Health care provider (MD, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature **Title** **Date**

Signature **Title** **Date**
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**
(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

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) ☐ **Measles** ☐ **Mumps** ☐ **Rubella** ☐ **Hepatitis B** ☐ **Varicella**

Lab Results **Date MO DA YR** **(Attach copy of lab report, if available.)**

VISION AND HEARING SCREENING DATA

This section to be completed by IDPH certified screening personnel, if pre-existing approved IDPH form is not available.
Pre-school - annually beginning at age 3; School age - during school year at required grade levels.

Date																					
Age/Grade																					
	R	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	**R**	**L**	
Vision																					
Hearing																					

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

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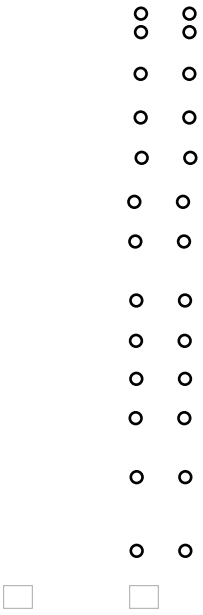
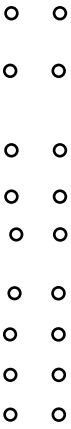
(over)





Skin

Ears

Eyes

Nose

Throat

Mouth/Dental

Cardiovascular/HTN

Respiratory

Endocrine

Gastrointestinal

Genito-Urinary

Neurological

Musculoskeletal

Spinal Examination

Nutritional Status

Mental Health

LMP