State of Illinois
Certification of Child Health Examination

Student's Name	Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Chuckie Cheese Test	1/1/2002	male		

Address	Parent/Guardian	Telephone # Home	Work
123 Milky Way Dr. Madison WI 53558			

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the heath examination explaining the medical reason for the contraindication.

VACCINE/DOSE	DATE	DATE	DATE	DATE	DATE	DATE
DTP or DTaP	4/1/2002	6/1/2002	3/1/2003	3/1/2005	4/1/2005	1/1/2007
Td or Pediatric DT						
Tdap						
Inactivated Polio (IPV)	2/1/2002	4/1/2002	9/1/2002	3/1/2005	4/1/2005	1/1/2007
Oral Polio (OPV)						
Hib Haemophilus influenza type b	2/1/2002	4/1/2002	3/1/2003	4/1/2005		
Pneumococcal Conjugate						
Pneumococcal Conjugate (PCV13)	2/1/2002	4/1/2002	6/1/2002	3/1/2003		
Hepatitis B (HB)	1/1/2002	2/1/2002	9/1/2002	3/1/2005		
Hep B, Pediatric/Adolescent						
MMR Combined Measles, Mumps, Rubella	3/1/2003	1/1/2007				
Measles (Rubeola)						
Rubella (3-day measles)						
Mumps						
Varicella (Chickenpox)	3/1/2003	1/1/2007				
Meningococcal	6/1/2013	3/1/2018				
RECOMMENDED, BUT NOT REQUIRED						
Hepatitis A	3/1/2003	5/1/2003				
HPV	6/1/2013					
Influenza	9/1/2003	9/1/2004	9/1/2012	9/1/2014	9/1/2016	9/1/2017
Meningitis B	8/1/2015					
Other:Specify Immunization Administered/Dates						

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.

Electronically Signed By: Tomitra Latimer, MD **Date** 9/11/18

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 healthcare 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.

Completion of alternatives 1 or 3 MUST be accompanied by labs and physician signature:
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.

Student's Name	Birth Date	Sex	School	Grade Level/ ID
Chuckie Cheese Test	1/1/2002	male		

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes / No	List: Penicillins; Peanut; and Insect venom	MEDICATION (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 the night coughing?	Yes	No					
Birth Defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head Injury/Concussion/Passed out?	Yes	No		TB skin text positive (past/present)?	Yes	No	*If yes, refer to local health department
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	

Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading):

Dental: ☐ Braces ☐ Bridge ☐ Plate Other

Ear/Hearing problems?	Yes	No
Bone/Joint problem/injury/scoliosis?	Yes	No

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian Signature **Date**

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**
HEAD CIRCUMFERENCE if < 2-3 years old None **HEIGHT** 170.2 cm (67") **WEIGHT** 59.9 kg (132 lb) **BMI** 20.67 kg/m² **BMI PERCENTILE** 45 % **B/P** 110/70

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex:** No And any two of the following: **Family History** No **Ethnic Minority** No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) No **At Risk** No

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 **Blood Test Indicated?** Yes **Blood Test Date** 7/25/2018 **Results** 4 ug/dl

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/TB_testing.htm
Test Performed No test needed. Patient not at risk.
Skin Test: Date Read: N/A **Result: Positive** N/A **mm** N/A
Blood Test: Date Reported: N/A **Result: Positive** N/A **Value** N/A

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit	7/25/2018	12 gL	Sickle Cell(when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin	Yes		Endocrine	Yes	
Ears	Yes	Screening Result:	Gastrointestinal	Yes	
Eyes	Yes	Screening Result:	Genito-Urinary	Yes	LMP
Nose	Yes		Neurological	Yes	
Throat	Yes		Musculoskeletal	Yes	
Mouth/Dental	Yes		Spinal Exam	Yes	
Cardiovascular/HTN	Yes		Nutritional status	Yes	
Respiratory	Yes	☐ Diagnosis of Asthma	Mental Health	Yes	
			Other		

Currently Prescribed Asthma Medication:
☐ Quick-relief medication (e.g. Short Acting Beta Agonist)
☐ 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? No
If you would like to discuss this student's health with school or school health professional, 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)? No

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 **INTERSCHOLASTIC SPORTS:** Yes

Electronically Signed By: Tomitra Latimer, MD **Date** 9/11/18

Address 4867 N Broadway
Chicago IL 60640

Phone Dept: 312-227-2610