

State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES CFS 600
Rev 12/2011

Student's Name								Birth Date			Sex	Rac	ce/Ethnicity Sch			hool /Grade Level/ID#			
Last	ast First Middle							Month/Day/Year											
Address Stre									Parent/Guardian Telephone # Home Work										
IMMUNIZATIONS determine if the vaccine attached explaining the	was gi	ven aft	er the min	imum in	terval o	т age. И													
Vaccine / Dose	1 MO DA YR			MO DA YR				MO DA YR			4 MO DA YR			5 MO DA YR			6 MO DA	YR	
DTP or DTaP					in the second														
Tdap; Td or Pediatric	□Tdap□Td□DT			□Tdap□Td□DT			□Tdap□Td□DT			ПТ	dap□To	TODE	T □Tdap□TdC			□DT □Tdap□Td□DT			
DT (Check specific type)												PV □ OPV □ IPV		1000					
Polio (Check specific type)		IPV D	OPV		PV 🗆	OPV		IPV 🗆	OPV		IPV 🗆	OPV		PV D	OPV		IPV C	OPV	
Hib Haemophilus influenza type b				100					20.00	Tila							76	-	
Hepatitis B (HB)		-					94				Market Street						Service.		
Varicella (Chickenpox)				COMMENTS:									Sinck 1						
MMR Combined Measles Mumps. Rubella					1115														
Single Antigen Vaccines	Measles			Rubella			Mumps												
Pneumococcal Conjugate											T								
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza		T																	
Health care provider () to the above immunizati									d) verify	ing ab	ove imm	unizati	on histo	ry must	sign be	elow. J	f addin	g dates	
Signature								Т	itle					Da	ite				
Signature		0.00						Т	itle					Da	ite				
ALTERNATIVE PR 1. Clinical diagnosis is		-			cian.	*(A	All measl	es cases o	liagnosed	on or af	ter July 1,	, 2002, m	ust be con	nfirmed b	y laborat	ory evide	nce.)		
*MEASLES (Rubeola) 2. History of varicella (Person signing below is ver	chicker	npox) (lisease is	accepta	ble if ve	erified b	y heal	th care j	provider	, schoo	l health		ional or	health			ion of dis	scase.	
Date of Disease	-)		Signati						Title				-		Date	177			
3. Laboratory confirma Lab Results	ation (c	heck o	ne) □N	Ieasles Date		DA Y		□Rub	ella	□Не	patitis)		□Vario Attach		lab resi	ult)			

				VISIO	ON ANI	HEAL	RING S	CREE	NING	BY IDI	PH CE	RTIFIE	DSCE	REENIN	G TECH	INICIA	N		
Date					-			12.11	-										Code:
Age/ Grade							400					1					- 19		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

Student's Name			Middle	Birtl	n Date Mostly/Day/ Year	Sex	School		Grade Level/ ID #			
HEALTH HISTORY TO BI	E COMPLE	TED AN		ENT/GI	UARDIAN AND VERIFI	ED BY HE	EALTH CA	ARE PE	ROVIDER			
ALLERGIES (Food, drug, insect, other)	COME	TED PER	Dordrand	_	MEDICATION (List all pos	-	-	_				
Diagnosis of asthma? Child wakes during the night	Yes N			1000	Loss of function of one of organs? (eye/ear/kidney/te		Yes	No				
Birth defects?	Yes N	_			Hospitalizations?	Yes	No					
Developmental delay?	Yes N	0			When? What for?	-	-					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes N	0	nieto glacinate d'u	iner	Surgery? (List all.) When? What for?		Yes	No	A P. B. Communication of the second state of t			
Diabetes?	Yes N	0			Serious injury or illness?		Yes	No				
Head injury/Concussion/Passed out?	Yes N				TB skin test positive (past		Yes*	No No	*If yes, refer to local health department.			
Seizures? What are they like?	Yes N				TB disease (past or preser				96335			
Heart problem/Shortness of breath?	Yes N				Tobacco use (type, freque	ency)?	Yes	No				
Heart murmur/High blood pressure?	Yes N				Alcohol/Drug use?	daeth	Yes	No No	The second of the second			
Dizziness or chest pain with exercise?	Yes N				Family history of sudden- before age 50? (Cause?) Dental Braces	□ • Bridge			and allowed to the first			
Eye/Vision problems? Glasse Other concerns? (crossed eye, drooping I			st exam by eye doctor . y reading)		Dental Li Braces	□ · Bridge	: Li Flat	e Our				
Ear/Hearing problems?	Yes N	To			Information may be shared w. Parent/Guardian	ith appropria	te personnel	for healti	n and educational purposes.			
Bone/Joint problem/injury/scoliosis?	Yes N	lo			Signature				Date			
PHYSICAL EXAMINATION R	EQUIRE	MENTS	S Entire section	belov	to be completed by	MD/DO/	APN/PA		d hate supplying			
HEAD CIRCUMFERENCE		HE	IGHT	London Company	WEIGHT		BMI		B/P			
DIABETES SCREENING (NOT REQUESTING Minority Yes No Signs												
LEAD RISK QUESTIONAIRRE R. Questionairre Administered ? Yes D	equired for ch	ildren age		ırs enrol	led in licensed or public scho	ool operated	day care, p	reschool				
TB SKIN OR BLOOD TEST Recon	nmended only	for childs	ren in high-risk groups is	ncluding	children immunosuppressed	due to HIV	infection o	r other o	conditions, frequent travel to or born in			
high prevalence countries or those exposed to Skin Test: Date Read	o adults in hig		egories. See CDC guide alt: Positive \(\square\) Ne			Test per	rformed [
Blood Test: Date Reported	11		alt: Positive Ne						The second secon			
LAB TESTS (Recommended)	Date	1	Results				T	ate	Results			
Hemoglobin or Hematocrit	Detto	1	TOU SUITS		Sickle Cell (when indi	icated)			100000			
Urinalysis					Developmental Screen							
SYSTEM REVIEW Normal Con	nments/Fol	low-up/l	Needs		N	formal Co	omments/	Follow-	-up/Needs			
Skin					Endocrine							
Ears				TTA	Gastrointestinal							
Eyes			Amblyopia Yes□	No□	Genito-Urinary		ONE SIE	LMP /				
Nose					Neurological							
Throat				Musculoskeletal								
Mouth/Dental					Spinal Exam							
Cardiovascular/HTN					Nutritional status	Lacy of		1,95-				
Respiratory			☐ Diagnosis of Astl	nma	Mental Health		s so know a To					
Currently Prescribed Asthma M Quick-relief medication Controller medication (n (e.g.Short	400			Other	Martin Co.		IZCEN GEORGIA	olugat riini an to yacerit ii.			
NEEDS/MODIFICATIONS required			and the same of th		DIETARY Needs/Rest	trictions						
SPECIAL INSTRUCTIONS/DEVICE	CES e.g. safe	ety glasses	s, glass eye, chest protec	tor for a	rrhythmia, pacemaker, prost	hetic device	, dental brid	ge, false	e teeth, athletic support/cup			
MENTAL HEALTH/OTHER 1st	there anything	else the s	school should know abou	it this st	udent?				and the second s			
If you would like to discuss this student's be	ealth with sch	ool or sch	ool health personnel, ch	eck title	: Nurse	r 🗆 Cour	nselor 🗆	Princip	al			
	EMERGENCY ACTION needed while at school due to child's health condition (e.gseizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?											
Yes □ No □ If yes, please describe.						4 110 1						
	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 (for one year) Yes No Limited INTERSCHOLASTIC SPORTS (for one year)											
Print Name			(MD,DO, APN, PA)	Sign	ature				Date			
Address					Phone				and a second second			