



**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 Date	Sex	Race/Ethnicity	School /Grade Level/ID#					
Last		First		Middle		Month/Day/Year						
Address				Parent/Guardian		Telephone # Home						
Street				City		Zip Code						
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 <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	1 MO DA YR		2 MO DA YR		3 MO DA YR		4 MO DA YR		5 MO DA YR		6 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 Haemophilus influenza type b												
Hepatitis B (HB)												
Varicella (Chickenpox)					COMMENTS:							
MMR Combined Measles Mumps Rubella												
Single Antigen Vaccines	Measles		Rubella									
Pneumococcal Conjugate												
Other/Specify 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				Title				Date				
Signature				Title				Date				
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) <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Varicella Lab Results Date MO DA YR (Attach copy of lab result)												

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

Last	First	Middle	Birth Date <small>Month/Day/ Year</small>	Sex	School	Grade Level/ ID
HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER						
ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Child wakes during night coughing?	Yes	No	Hospitalizations? When? What for?	Yes	No	
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No	
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No	
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No	
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No	
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No	
Heart murmur/High blood pressure?	Yes	No	Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other			
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.			
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Parent/Guardian Signature _____ Date _____			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)						
Ear/Hearing problems?	Yes	No				
Bone/Joint problem/injury/scoliosis?	Yes	No				
PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA						
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>						
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 <input type="checkbox"/> No <input type="checkbox"/>		Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/>		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. No test needed <input type="checkbox"/> Test performed <input type="checkbox"/>						
Skin Test: Date Read / /		Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		mm _____		
Blood Test: Date Reported / /		Result: Positive <input type="checkbox"/> Negative <input type="checkbox"/>		Value _____		
LAB TESTS (Recommended)		Date	Results	Date	Results	
Hemoglobin or Hematocrit			Sickle Cell (when indicated)			
Urinalysis			Developmental Screening Tool			
SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs	
Skin				Endocrine		
Ears				Gastrointestinal		
Eyes		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>		Genito-Urinary	LMP	
Nose				Neurological		
Throat				Musculoskeletal		
Mouth/Dental				Spinal Exam		
Cardiovascular/HTN				Nutritional status		
Respiratory		<input type="checkbox"/> Diagnosis of Asthma		Mental Health		
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		
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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>			INTERSCHOLASTIC SPORTS		Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>	
Print Name _____ (MD,DO, APN, PA)			Signature _____		Date _____	
Address _____			Phone _____			

(Complete Both Sides)