



**State of Illinois**  
**Certificate of Child Health Examination**

FOR USE IN DCFS LICENSED  
CHILD CARE FACILITIES  
CFS 600  
Rev 11/2013

Illinois Department of  
**DCFS**  
Children & Family Services

Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle	Month/Day/Year			
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
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					
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)					COMMENTS:	
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	Measles	Rubella	Mumps			
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	
<b>ALTERNATIVE PROOF OF IMMUNITY</b>			
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	(Attach copy of lab result)		
Lab Results	Date	MO DA YR	

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

Student's Name			Birth Date	Sex	School	Grade Level/ ID #
Last	First	Middle	Month/Day/ Year			

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

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

HEAD CIRCUMFERENCE	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. Questionnaire Administered? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Indicated? Yes <input type="checkbox"/> No <input type="checkbox"/> Blood Test Date (Blood test required if resides in Chicago.)					
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 Antagonist) <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 (for one year) 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)