



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	Work	
Street				City				Zip Code

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			2			3			4			5			6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	Tdap Td DT			Tdap Td DT			Tdap Td DT			Tdap Td DT			Tdap Td DT			Tdap Td DT		
Polio (Check specific type)	IPV OPV			IPV OPV			IPV OPV			IPV OPV			IPV OPV			IPV OPV		
Hib Haemophilus influenza type b																		
Hepatitis B (HB)																		
Varicella (Chickenpox)																		
MMR Combined Measles Mumps. Rubella																		
Single Antigen Vaccines	Measles			Rubella			Mumps											
Pneumococcal Conjugate																		
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza																		

COMMENTS:

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
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3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B 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	R	L	R	L	R	L	
Vision																			
Hearing																			

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.
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HISTORIAL MÉDICO - PARA SER COMPLETADO Y FIRMADO POR PADRES / TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)			MEDICINAS (Anoté todas las recetas o tomadas con regularidad.)			
¿Tiene diagnóstico de asma?	Sí	No		¿Tiene pérdida de Funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí	No
¿Despierta el niño tosiendo en la noche?	Sí	No				
¿Tiene defectos de nacimiento?	Sí	No		¿Ha sido hospitalizado?	Sí	No
¿Tiene retrasos del desarrollo?	Sí	No		¿Cuándo? ¿Por Qué?		
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí	No		¿Ha atendido cirugía? (anótelas todas)	Sí	No
¿Tiene diabetes?	Sí	No		¿Cuándo? ¿Para Qué?		
¿Tiene heridas en la cabeza / golpe / desmayo?	Sí	No		¿Ha tendido heridas graves o enfermedades?	Sí	No
¿Tiene convulsiones? ¿Cómo se manifiestan?	Sí	No		¿Prueba positiva de TB (Pasado o Presente)?	Sí*	No
¿Tiene problemas cardiacos / No respira bien?	Sí	No		¿Enfermedad de TB (Pasado o Presente)?	Sí*	No
¿Tiene soplo en corazón / presión arterial alta?	Sí	No		¿Usa tabaco (tipo, Frecuencia)?	Sí	No
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí	No		¿Toma alcohol / drogas?	Sí	No
¿Problemas con los Ojos? ___ Lentes ... Lentes de Contacto ... Último Examen ___				¿Historial de familiares de muerte repentina antes de los 50 años ? (¿Causa?)	Sí	No
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)				Dental ... Ganchos ... Puente ... Placas Otro		
¿Tiene problemas de oídos / No oye bien?	Sí	No		La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Tiene problemas de los huesos / articulaciones / heridas / escoliosis?	Sí	No		Firma del Padre/Tutor Fecha		

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... No... And any two of the following: **Family History** Yes ... No ... **Ethnic Minority** Yes... No ... **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes... No ... **At Risk** Yes ... 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 Chicagoor high risk zipcode.)

Questionnaire Administered ? Yes No Blood Test Indicated? Yes No 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 ... Test performed ...

Skin Test: Date Read / / Result: Positive ... Negative ... mm _____

Blood Test: Date Reported / / Result: Positive ... Negative ... 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... No...	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		... Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ... Quick-relief medication (e.g. Short Acting Beta Antagonist) ... 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: ... 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)?
Yes ... No ... 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 No Modified **INTERSCHOLASTIC SPORTS** Yes No Limited

Print Name _____ (MD,DO, APN, PA) Signature _____ Date _____

Address _____ Phone _____