



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	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	
DTP or DTaP								
Tdap; Td or Pediatric DT (Check specific type)	☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT		☐ Tdap ☐ Td ☐ DT	
Polio (Check specific type)	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Hib Haemophilus influenza type b								
Hepatitis B (HB)								
Varicella (Chickenpox)							COMMENTS:	
MMR Combined Measles Mumps. Rubella								
Single Antigen Vaccines								
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) ☐ 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	
Vision															
Hearing															

Student's Name			Birth Date		Sex	School	Grade Level/ ID #
LastFirstMiddle			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?		Yes	No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes	No
Child wakes during the night		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 test positive (past/present)?		Yes*	No
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 _____				Dental ☐ Braces ☐ Bridge ☐ Plate Other			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)							
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 ☐ 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 QUESTIONAIRRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. Questionairre Administered ? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ 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 ☐ 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) ☐ Controllor 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 (for one year) Yes ☐ No ☐ Limited ☐			
Print Name		(MD,DO, APN, PA)		Signature		Date	
Address				Phone			

(Complete both sides)