



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

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



<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>
Last	First	Middle	Month/Day/Year			
<b>Address</b>			<b>Parent/Guardian</b>	<b>Telephone #</b>	<b>Home</b>	<b>Work</b>
Address	Street	City	Zin 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
<b>DTP or DTaP</b>																		
<b>Tdap, Td or Pediatric DT</b> (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		
<b>Polio</b> (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		
<b>Hib</b> Haemophilus influenza type b																		
<b>Hepatitis B (HB)</b>																		
<b>Varicella</b> (Chickenpox)																		
<b>MMR Combined</b> Measles Mumps. Rubella																		
<b>Single Antigen Vaccines</b>	<b>Measles</b>			<b>Rubella</b>			<b>Mumps</b>											
<b>Pneumococcal Conjugate</b>																		
<b>Other/Specify</b> 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.)

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**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.

<b>Date of Disease</b>	<b>Signature</b>	<b>Title</b>	<b>Date</b>
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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											
<b>Date</b>											<b>Code:</b> P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
<b>Age/Grade</b>											
	R	L	R	L	R	L	R	L	R	L	
<b>Vision</b>											
<b>Hearing</b>											

Last			First			Middle			Birth Date Month/Day/ Year			Sex	School			Grade Level/ ID	
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>																	
ALLERGIES (Food, drug, insect, other)		Yes	No	List:				MEDICATION (Prescribed or taken on a regular basis.)			Yes	No	List:				
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 Other									
Dizziness or chest pain with exercise?		Yes	No					Information may be shared with appropriate personnel for health and educational purposes.									
Eye/Vision problems? _____ 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														
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>																	
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. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> .																	
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															
Skin		Endocrine															
Ears		Screening Result: Gastrointestinal															
Eyes		Screening Result: 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:		Other															
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																	
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																	
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"/> Modified <input type="checkbox"/>																	
Print Name			(MD,DO, APN, PA) Signature			Date											
Address						Phone											





# State of Illinois Eye Examination Report

Illinois law requires that proof of an eye examination by an optometrist or physician (such as an ophthalmologist) who provides eye examinations be submitted to the school no later than October 15 of the year the child is first enrolled or as required by the school for other children. The examination must be completed within one year prior to the first day of the school year the child enters the Illinois school system for the first time. The parent of any child who is unable to obtain an examination must submit a waiver form to the school.

Student Name \_\_\_\_\_  
 (Last) (First) (Middle Initial)

Birth Date \_\_\_\_\_ Gender \_\_\_\_\_ Grade \_\_\_\_\_  
 (Month/Day/Year)

Parent or Guardian \_\_\_\_\_  
 (Last) (First)

Phone \_\_\_\_\_  
 (Area Code)

Address \_\_\_\_\_  
 (Number) (Street) (City) (ZIP Code)

County \_\_\_\_\_

### To Be Completed By Examining Doctor

#### Case History

Date of exam \_\_\_\_\_

Ocular history:  Normal or Positive for \_\_\_\_\_

Medical history:  Normal or Positive for \_\_\_\_\_

Drug allergies:  NKDA or Allergic to \_\_\_\_\_

Other information \_\_\_\_\_

#### Examination

	Distance			Near
	Right	Left	Both	Both
Uncorrected visual acuity	20/	20/	20/	20/
Best corrected visual acuity	20/	20/	20/	20/

Was refraction performed with dilation?  Yes  No

	Normal	Abnormal	Not Able to Assess	Comments
External exam (lids, lashes, cornea, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Internal exam (vitreous, lens, fundus, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pupillary reflex (pupils)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Binocular function (stereopsis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Accommodation and vergence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma evaluation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oculomotor assessment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

NOTE: "Not Able to Assess" refers to the inability of the child to complete the test, not the inability of the doctor to provide the test.

#### Diagnosis

Normal  Myopia  Hyperopia  Astigmatism  Strabismus  Amblyopia

Other \_\_\_\_\_



# State of Illinois Eye Examination Report

### Recommendations

1. Corrective lenses:  No  Yes, glasses or contacts should be worn for:  
 Constant wear  Near vision  Far vision  
 May be removed for physical education

2. Preferential seating recommended:  No  Yes

Comments \_\_\_\_\_  
 \_\_\_\_\_

3. Recommend re-examination:  3 months  6 months  12 months  
 Other \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Print name \_\_\_\_\_  
 Optometrist or physician (such as an ophthalmologist)  
 who provided the eye examination  MD  OD  DO

License Number \_\_\_\_\_

Address \_\_\_\_\_  
 \_\_\_\_\_

Phone \_\_\_\_\_

<p align="center"><b>Consent of Parent or Guardian</b></p> <p align="center">I agree to release the above information on my child or ward to appropriate school or health authorities.</p> <p align="center">_____ (Parent or Guardian's Signature)</p> <p align="center">_____ (Date)</p>
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Signature \_\_\_\_\_

Date \_\_\_\_\_

(Source: Amended at 32 Ill. Reg. \_\_\_\_\_, effective \_\_\_\_\_)

