



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 <i>every</i> 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	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		
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		
Lab Results		Date MO DA YR		☐ Hepatitis B		☐ Varicella		
						(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															

Last First Middle			Birth Date Month/Day/ Year		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 ☐ Braces ☐ Bridge ☐ 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 ☐ Contacts ☐ 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 ☐ 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 Chicago or high risk zip code.)							
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 Agonist) ☐ 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					

(Complete Both Sides)