$Name: Samuel\ Trimble\ Margolis\ |\ DOB:\ 5/30/2019\ |\ MRN:\ 3869114\ |\ PCP:\ Tara\ M\ Sajn,\ A.P.N.\ |\ Legal\ Name:\ Samuel\ Trimble\ Margolis\ MRN:\ A.P.N.\ |\ A.P.N.\ |$



State of Illinois Certificate of Child Health Examination

Student's Name		Birth Date	Sex	Race/Eth	nicit	School/Grade Level/ID#	
Margolis, Samuel Trimble					nic, latino/a, or		
				spanish or			
Address		Parent/Guardi	an	Telephone	e# Home	Work	
5342 S Greenwood Ave				206-554-9	250 (home)		
Apt 3				000-000-0	000 (work)		
Chicago IL 60615							
IMMUNIZATIONS: To be completed by health car	-			_	_		
contraindicated, a separate written statement mus	•	he health care p	rovider re	sponsible for co	ompleting the he	alth examination	
explaining the medical reason for the contraindica							
VACCINE/DOSE	DATE	DATE		DATE	DATE	DATE	
DTP or DTaP	7/30/2019	9/30/20	19	1/6/2020	10/5/2020	8/15/2023	
Tdap							
Td							
DT							
IPV	7/30/2019	9/30/20	19	1/6/2020	8/15/2023		
OPV							
Hib	7/30/2019	9/30/20	19	1/6/2020	10/5/2020		
Hepatitis B	5/31/2019	9/30/20	19	10/5/2020			
Varicella (Chickenpox)	8/1/2020	8/15/20	23				
MMR	8/1/2020	8/15/20	23				
Measles							
Rubella							
Mumps							
Pneumococcal Conjugate (PCV)	7/30/2019	9/30/20	19	1/6/2020	8/1/2020		
Pneumococcal Polysaccharide (PPV)							
Hepatitis A	8/1/2020	6/3/202	1				
Meningococcal Conjugate (MCV)							
Meningococcal Polysaccharide (MPV)							
HPV							
Rotavirus	7/30/2019	9/30/20	19				
Influenza	12/3/2019	1/6/202	0	10/5/2020	10/2/2021	9/12/2022	
MMR + Varivax	8/15/2023						
Covid (Pfizer)	11/11/2023	3					
Covid (Moderna)	6/25/2022						
Covid (Janssen)							
Covid (Pfizer 5 -11 years)							
Covid (Pfizer 6 months - 4 years							
Covid (Pfizer) Booster (5 -11 years)							
Covid (Pfizer Booster (12 years to adult)							
Health care provider (MD, DO, APN, PA, school	health professions	l. health officia) verifying	ahove immuni	zation history m	ust sign below. If adding	
dates to the immunization history section, put your in	_		, vernying	, above minian	zation mstory n	aust sign below. If adding	
auto to the minumzation instory section, put your it.	s oy the date(s	, and sign note					
Electronic Signature Tara M Sajn, A.P.N.		Date 8	/22/2024				
		Dutt 0					
ALTERNATIVE PROOF OF IMMUNITY							
Clinical diagnosis (measles, mumps, hepatitis E	R) is allowed when	verified by phy	sician and	sunnorted with	lab confirmation	on. Attach conv of lab	
result.	, anonea mien	.c.med by pmy	Januariu	sapported with			
İ							

ALTERNATIVE PROOF OF IM	MUNITY					
1. Clinical diagnosis (measles, mu	ımps, hepatitis B) i	is allowed whe	n verified by physi	cian and sup	ported with lab co	onfirmation. Attach copy of lab
result.						
*MEASLES (Rubeola) MO DA	YR **MUMPS	MO DA YR	HEPATITIS B M	IO DA YR	VARICELLA	MO DA YR
2. History of varicella (chickenpo	x) disease is accept	table if verified	d by health care pr	ovider, schoo	l health professio	nal, or health official.
Parcon cionino balow varifies that the no	rent/guardian's descrip	tion of varicella d	dicasca history is india	ative of past inf	ection and is acceptin	ng such history as documentation of disease.
i crson signing below verifies that the pa			disease mistory is mure	ative of past inf	ection and is accepting	
reison signing below vermes that the pa	g	aton of varietia c	insease mistory is mule	ative of past inf	ection and is accepting	is such mistory as accumentation of assease.
Date of Disease	Signature	non or varietian c	insease mistory is mule	ative of past ini	Title	g stem moory as documentation or disease.
	Signature		Mumps**	Rubella	Title	Attach copy of lab result
Date of Disease	Signature nity (check one)	Measles*	Mumps**	Rubella	Title	
Date of Disease 3. Laboratory Evidence of Immu	Signature nity (check one) after July 1, 2002, r	Measles*	Mumps**	Rubella	Title	
Date of Disease 3. Laboratory Evidence of Immu *All measles cases diagnosed on or	Signature nity (check one) after July 1, 2002, r	Measles*	Mumps**	Rubella	Title	
Date of Disease 3. Laboratory Evidence of Immu *All measles cases diagnosed on or	Signature nity (check one) after July 1, 2002, r after July 1, 2013,	Measles* must be confirm	Mumps** ned by laboratory evened by laboratory e	Rubella vidence. vidence.	Title	

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

11/2015 (COMPLETE BOTH SIDES) Printed by Authority of the State of Illinois

1 of 3

Student's Name					Birth D	Date	Sex	School		Grade Level/ID#
Margolis, Samuel Trimb	le				5/30/20	19	Male			
HEALTH HIS	STORY	то ве	COM	IPLETED AND	SIGNED	BY PAR	ENT/GUARE	IAN AND VE	RIFIED BY	HEALTH CARE PROVID
ALLERGIES (Food, dru	ig, insect, other	:)				MEDIC	ATION (List:	all prescribed or t	aken on a regul	ar basis.)
Discounting Condenses		¥7	NT.			T C C	`	. C i 1	37 NI.	
Diagnosis of asthma?	.1.1.4	Yes	No				unction of one	•	Yes No	
Child wakes during the n	night	Yes	No			organs? (eye/ear/kidne	y/testicle)		
coughing										
Birth Defects?		Yes	No			Hospitali	izations? Who	n? What for?	Yes No	
Developmental delay?		Yes	No							
Blood disorders? Hemoj	philia, Sickle	Yes	No				(List all.)		Yes No	
Cell, Other? Explain.						When?	What for?			
Diabetes?		Yes	No			Serious i	njury or illnes	s?	Yes No	
Head Injury/Concussion/	Passed out?	Yes	No			TB skin t	text positive (j	oast/present)?	Yes* No	*If yes, refer to local
Seizures? What are they	like?	Yes	No			TB disea	se (past or pre	sent)?	Yes* No	*health department
Heart problem/Shortness	of breath?	Yes	No			Tobacco	use (type, free	uency)?	Yes No	
Heart murmur/High bloo	od pressure?	Yes	No			Alcohol/	Drug use?		Yes No	
Dizziness or chest pain v	vith exercise	Yes	No			Family h	x of sudden de	eath before age	Yes No	
•						50? (Cau		C		
Eye/Vision problems?	Glasses	Conta	acts	Last exam by eye d	loctor			Bridge Plat	e Other	
J F			_			Other co				
Other concerns? (crossed	eve drooping	lide equin	tina dif	fficulty reading)		o uner co				
Ear/Hearing problems?	eye, drooping		No	incuity reading)		Informatic		I with appropriate	- managed for	health and educational purposes
0.1	. /1::-0	Yes				1		і witti арргорпац	e personner for	nearm and educational purposes
Bone/Joint problem/inju	ry/scoliosis?	Yes	No				Guardian		,	
						Signatur	re			Date
PHYSICAL EXAMINA							_	AD/DO/APN/F		
								2-20 Years))	Weight: 18.7	kg (41 lb 3.6 oz) (47%, Z=
0.09, Source: CDC (Boy	ys, 2-20 Year	s)) BMI:	Body	mass index is 14.	.65 kg/m².	B/P: 96	/56			
DIABETES SCREENI	NG (NOT RE	QUIRED	FOR I	DAY CARE) BM	I>85% ag	ge/sex no	And any tv	o of the follow	ing: Family	History yes
Ethnic Minority no Si	gns of Insuli	n Resista	nce (h	ypertension, dyslipi	idemia, poly	cystic ova	rian syndrome, a	canthosis nigrica	ns) no At Ri	sk no
	ONNAIRE F	equired fo	or childs	ren age 6 months thr	rough 6 yea	rs enrolled	in licensed or p	ablic school opera	ated day care, p	reschool, nursery school and/or
LEAD RISK QUESTIC				gh risk zin code)						
LEAD RISK QUESTIO sindergarten. (Blood test req	quired if reside:	s in Chicag	go or hi	5						
				ndicated? yes	Blood	Test Date	e 8/22/202	4	Result	
cindergarten. (Blood test rec Questionnaire Adminis	tered?	Blood	Test I	ndicated? yes						conditions, frequent travelto or
cindergarten. (Blood test rec Questionnaire Adminis	mended only for	Blood or children	Test I	ndicated? yes	ing children	who are in	nmunosuppresso		ection or other	
cindergarten. (Blood test rec Questionnaire Adminis TB SKIN TEST Recommon in high prevalence coun	mended only for	Blood or children	Test I	ndicated? yes	ing children	who are in	nmunosuppressones. No T	ed due to HIV infe	ection or other	
cindergarten. (Blood test rec Questionnaire Adminis FB SKIN TEST Recommon in high prevalence cour Skin Test:	mended only for ntries or those	Blood or children	Test I	ndicated? yes n-risk groups includi in high-risk categori	ing children ies. See CI	who are in OC guidelin Negativ	mmunosuppressenes. No T	ed due to HIV infe	ection or other	
cindergarten. (Blood test rec Questionnaire Adminis FB SKIN TEST Recommon in high prevalence cour Skin Test:	mended only for ntries or those Date Read	Blood or children	Test I	ndicated? yes n-risk groups includir in high-risk categori Result: Po	ing children ies. See CI	who are in OC guidelin Negativ	mmunosuppressenes. No T	ed due to HIV info est Needed	ection or other	
cindergarten. (Blood test rec Questionnaire Adminis FB SKIN TEST Recommon in high prevalence cour Skin Test:	mended only for ntries or those Date Read Reported	Blood or children	Test I	ndicated? yes n-risk groups includir in high-risk categori Result: Po	ing children ies. See CI	who are in OC guidelin Negativ	mmunosuppressenes. No T	ed due to HIV info est Needed	ection or other	
cindergarten. (Blood test rec Questionnaire Adminis FB SKIN TEST Recommorn in high prevalence cou Skin Test: I Blood Test: Date	mended only for ntries or those Date Read Reported	Blood or children exposed to	Test I	ndicated? yes n-risk groups includi in high-risk categori Result: Po Result: Po	ing children ies. See CI	who are in OC guidelin Negativ	mmunosuppressenes. No T	ed due to HIV infi est Needed n due	Test Perfo	rmed
cindergarten. (Blood test rec Questionnaire Adminis FB SKIN TEST Recommorn in high prevalence cou- Skin Test: Blood Test: Date LAB TESTS (Recommed- Hemoglobin or Hematoc	mended only for ntries or those Date Read Reported	Blood or children exposed to	Test I	ndicated? yes n-risk groups includi in high-risk categori Result: Po Result: Po	ing children ies. See CI	who are in OC guidelin Negativ Negativ Sickle Co	nmunosuppresse nes. No T ve mr ve Va	d due to HIV info	Test Perfo	rmed
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