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

State of Illinois
Certificate of Child Health Examination

Student's Name	**Birth Date**	**Sex**	**Race/Ethnicit**	**School/Grade Level/ID#**
Margolis, Samuel Trimble	5/30/2019	Male	Not hispanic, latino/a, or spanish origin	
Address	**Parent/Guardian**		**Telephone # Home**	**Work**
5342 S Greenwood Ave Apt 3 Chicago IL 60615			206-554-9250 (home) 000-000-0000 (work)	

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every dose administered is required. **If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.**

VACCINE/DOSE	DATE	DATE	DATE	DATE	DATE
DTP or DTaP	7/30/2019	9/30/2019	1/6/2020	10/5/2020	8/15/2023
Tdap					
Td					
DT					
IPV	7/30/2019	9/30/2019	1/6/2020	8/15/2023	
OPV					
Hib	7/30/2019	9/30/2019	1/6/2020	10/5/2020	
Hepatitis B	5/31/2019	9/30/2019	10/5/2020		
Varicella (Chickenpox)	8/1/2020	8/15/2023			
MMR	8/1/2020	8/15/2023			
Measles					
Rubella					
Mumps					
Pneumococcal Conjugate (PCV)	7/30/2019	9/30/2019	1/6/2020	8/1/2020	
Pneumococcal Polysaccharide (PPV)					
Hepatitis A	8/1/2020	6/3/2021			
Meningococcal Conjugate (MCV)					
Meningococcal Polysaccharide (MPV)					
HPV					
Rotavirus	7/30/2019	9/30/2019			
Influenza	12/3/2019	1/6/2020	10/5/2020	10/2/2021	9/12/2022
MMR + Varivax	8/15/2023				
Covid (Pfizer)	11/11/2023				
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 professional, health official) verifying above immunization history must sign below. If adding dates to the immunization history section, put your initials by the date(s) and sign here

Electronic Signature Tara M Sajn, A.P.N. **Date** 8/22/2024

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.

***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional, or health official.

Person signing below verifies 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**

3. Laboratory Evidence of Immunity (check one) **__ Measles*** **__ Mumps**** **__ Rubella** **__ Varicella** **Attach copy of lab result**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

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**

Student's Name	Birth Date	Sex	School	Grade Level/ID#
Margolis, Samuel Trimble	5/30/2019	Male		

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? Child wakes during the night coughing	Yes No Yes No			Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Birth Defects? Developmental delay?	Yes No Yes No			Hospitalizations? When? What for?	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 text positive (past/present)?	Yes* No	*If yes, refer to local	
Seizures? What are they like?	Yes No			TB disease (past or present)?	Yes* No	*health department	
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 hx of sudden death before age 50? (Cause?)	Yes No		
Eye/Vision problems? _____ Glasses __ Contacts __ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental: __Braces __Bridge __ Plate __ Other: Other concerns?			
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 if < 2-3 years old Height: 113 cm (44.49") (71%, Z= 0.55, Source: CDC (Boys, 2-20 Years)) Weight: 18.7 kg (41 lb 3.6 oz) (47%, Z= -0.09, Source: CDC (Boys, 2-20 Years)) BMI: Body mass index is 14.65 kg/m². B/P: 96/56

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** no And any two of the following: **Family History yes** **Ethnic Minority no Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) no **At Risk** 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? **Blood Test Indicated?** yes **Blood Test Date** 8/22/2024 **Result**

TB SKIN TEST Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, frequent travelto 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	Yes		**Endocrine**	Yes	
Ears	Yes		**Gastrointestinal**	Yes	
Eyes	Yes	Amblyopia No	**Genito-Urinary**	Yes	LMP
Nose	Yes		**Neurological**	Yes	
Throat	Yes		**Musculoskeletal**	Yes	
Mouth/Dental	Yes		**Spinal Exam**	Yes	
Cardiovascular/HTN	Yes		**Nutritional status**	Yes	
Respiratory	Yes	Diagnosis of Asthma No	**Mental Health**	Yes	
Currently Prescribed Asthma Medication: __ Quick-relief medication (e.g., Short Acting Beta Antagonist) __ Controller Medication (e.g., inhaled corticosteroid)			**Other**	Yes	

NEEDS/MODIFICATIONS required in the school setting
None

DIETARY Needs/Restrictions
None

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup
None

MENTAL HEALTH/OTHER Is there anything else the school should know about this student? No
If you would like to discuss this student's health with school or school health professional, 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)?
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 **INTERSCHOLASTIC SPORTS** (for one year) Yes

Print Name Tara M Sajn, A.P.N. **Electronic Signature** Tara M Sajn, A.P.N. **Date** 8/22/2024

Address/Phone
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Chicago, Illinois 60637
Phone: 773 702-6169