

STATE OF ILLINOIS DEPARTMENT OF HUMAN SERVICES CERTIFICATE OF CHILD HEALTH EXAMINATION

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Diphtheria a	and Te	tanus (Pediatr	ric DT	or Td)																			
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Oral Polio (OPV)																							
Haemophilu	ıs influ	ienzae	type b	(Hib)																				
Hepatitis B	(HB)																							
Varicella (C	hicker	npox)														Comr	nents							
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Measles (Ru	ıbeola)																						
Rubella (3-d	lay me	easles)																						
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Student's Name		Birt	h Date	Sex	School		Grade Level/ ID #
Last First	Midd	le	Month/Day/ Year				
HEALTH HISTORY TO BE O	COMPLETED AND	SIGNED BY PARENT/GU	ARDIAN AND VERIFI	ED BY HE	ALTH CA	RE PR	OVIDER
ALLERGIES (Food, drug, insect, other)			MEDICATION (List all 1	prescribed or t	aken on a regul	lar basis.	
Diagnosis of asthma? Child wakes during the night coughing?	Yes No Indic Yes No	cate Severity	Loss of function of one organs? (eye/ear/kidney/		Yes	No	
Birth complications/prematurity?	Yes No		Hospitalizations? When? What for?		Yes	No	
Developmental delay?	Yes No		0 0 0 1 11				
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 (pa	st/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes No		TB disease (past or prese	ent)?	Yes*	No	department.
Heart problem/Shortness of breath?	Yes No		Tobacco use (type, frequ	uency)?	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 sudder before age 50? (Cause?)		Yes	No	
	☐ Contacts ☐ Last €		Dental ☐ Braces	☐ Bridg	ge 🗆 Pla	te Oth	ner
Other concerns? (crossed eye, drooping lids	, squinting, difficulty re	eading)	Other concerns?				
Ear/Hearing problems?	Yes No		Information may be shared v - Parent/Guardian	with appropri	ate personnel	for healt	th and educational purposes.
Bone/Joint problem/injury/scoliosis?	Yes No		Signature				Date
Entire section below to be com	pleted by MD/D	OO/APN/PA					
PHYSICAL EXAMINATION REQU	REMENTS HEA	AD CIRCUMFERENCE	HEIGHT	1	WEIGHT		BMI B/P
DIABETES SCREENING (Not require Ethnic Minority Yes□ No □ Signs of	Insulin Resistance	(hypertension, dyslipidemia, p		e, acanthosis	nigricans) Y	∕es□	No □ At Risk Yes □ No □
LEAD RISK QUESTIONAIRE Requ Questionairre Administered? Yes ☐ (If child resides in Chicago, blood to	No □ Blood Tes	months through 6 years enrolle at Indicated? Yes □ No			day care, pres		
TB SKIN TEST Recommended only for		oups including children who are	e immunosuppressed due to	HIV infecti	on or other co	ondition	s, recent immigrants from high
prevalence countries, or those exposed to adults	in high-risk categories	. See CDC guidelines. \square N	o Test Needed 🔲 Test	t performe	d Date Re	ead	/ / Result mm
LAB TESTS (Recommended)			3 Test 1100 de d	- F	<u> </u>		/ / Result IIIII
End Tests (Recommended)	Date	Results	5 1651 Notaba = 1651	r		Date	Results
Hemoglobin or Hematocrit	Date	Results	Sickle Cell (wher				
	Date	Results		n indicated)		
Hemoglobin or Hematocrit		Results	Sickle Cell (when	n indicated)	Date	
Hemoglobin or Hematocrit Urinalysis			Sickle Cell (wher	n indicated)	Date	Results
Hemoglobin or Hematocrit Urinalysis SYSTEM REVIEW Normal Skin			Sickle Cell (wher Developmental Science Endocrine	n indicated)	Date	Results
Hemoglobin or Hematocrit Urinalysis SYSTEM REVIEW Normal Skin Ears	Comments/Fo	llow-up/Needs	Sickle Cell (wher Developmental Scheme Endocrine Gastrointestinal	n indicated)	Date	Results nents/Follow-up/Needs
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