



State of Illinois Certificate of Child Health Examination

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



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 every 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		2		3		4		5		6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	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		Hepatitis B		Varicella		
Lab Results			Date		MO DA YR						(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
Vision													
Hearing													

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.
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HISTORIAL MÉDICO - PARA SER COMPLETADO Y FIRMADO POR PADRES / TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)			MEDICINAS (Anoté todas las recetas o tomadas con regularidad.)			
¿Tiene diagnóstico de asma?	Sí	No	¿Tiene pérdida de Funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí	No	
¿Despierta el niño tosiendo en la noche?	Sí	No	¿Ha sido hospitalizado?	Sí	No	
¿Tiene defectos de nacimiento?	Sí	No	¿Cuándo? ¿Por Qué?			
¿Tiene retrasos del desarrollo?	Sí	No	¿Ha atendido cirugía? (anótelas todas)	Sí	No	
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí	No	¿Cuándo? ¿Para Qué?			
¿Tiene diabetes?	Sí	No	¿Ha tendido heridas graves o enfermedades?	Sí	No	
¿Tiene heridas en la cabeza / golpe / desmayo?	Sí	No	¿Prueba positiva de TB (Pasado o Presente)?	Sí*	No	*Si contestó sí, refiera al departamento de salud local
¿Tiene convulsiones? ¿Cómo se manifiestan?	Sí	No	¿Enfermedad de TB (Pasado o Presente)?	Sí*	No	
¿Tiene problemas cardiacos / No respira bien?	Sí	No	¿Usa tabaco (tipo, Frecuencia)?	Sí	No	
¿Tiene soplo en corazón / presión arterial alta?	Sí	No	¿Toma alcohol / drogas?	Sí	No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí	No	¿Historial de familiares de muerte repentina antes de los 50 años ? (¿Causa?)	Sí	No	
¿Problemas con los Ojos? ___ Lentes ... Lentes de Contacto ... Último Examen ___			Dental ... Ganchos ... Puente ... Placas Otro			
¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)						
¿Tiene problemas de oídos / No oye bien?	Sí	No	La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.			
¿Tiene problemas de los huesos / articulaciones / heridas / escoliosis?	Sí	No	Firma del Padre/Tutor		Fecha	

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.

Questionnaire Administered? Yes... No... **Blood Test Indicated?** Yes... No... **Blood Test Date** (Blood test required if resides in Chicago.)

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 Antagonist) ... 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** (for one year) Yes... No... Limited...

Print Name	(MD,DO, APN, PA)	Signature	Date
Address	Phone		

(Complete Both Sides)