



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				Street		City		Zip Code		Parent/Guardian		Telephone # Home		Work	
<b>IMMUNIZATIONS:</b> 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. <b>If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.</b>															
Vaccine / Dose	1 MO DA YR		2 MO DA YR		3 MO DA YR		4 MO DA YR		5 MO DA YR		6 MO DA YR				
DTP or DTaP															
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT				
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> OPV		<input type="checkbox"/> IPV <input type="checkbox"/> 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							
<b>ALTERNATIVE PROOF OF IMMUNITY</b>															
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) <input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Rubella <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Varicella Lab Results Date MO DA YR (Attach copy of lab result)															

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN														
Date														
Age/ Grade														
	R	L	R	L	R	L	R	L	R	L	R	L	R	L
Vision														
Hearing														
Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts														

Last First Middle			Birth Date Month/Day/ Year		Sex	School	Grade Level/ ID
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>							
<b>ALLERGIES</b> (Food, drug, insect, other)				<b>MEDICATION</b> (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 <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> 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 <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____				<b>Parent/Guardian Signature</b>			
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				<b>Date</b>			
Ear/Hearing problems?	Yes	No					
Bone/Joint problem/injury/scoliosis?	Yes	No					
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>							
HEAD CIRCUMFERENCE if < 2-3 years old		HEIGHT		WEIGHT		BMI B/P	
<b>DIABETES SCREENING</b> (NOT REQUIRED FOR DAY CARE) <b>BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>							
<b>LEAD RISK QUESTIONNAIRE</b> 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.)							
<b>Questionnaire Administered ?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Blood Test Date</b>		<b>Result</b>	
<b>TB SKIN OR BLOOD TEST</b> 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. <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/>							
<b>Skin Test: Date Read</b> / /		<b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/>		<b>mm</b> _____			
<b>Blood Test: Date Reported</b> / /		<b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/>		<b>Value</b> _____			
<b>LAB TESTS</b> (Recommended)	Date	Results			Date	Results	
Hemoglobin or Hematocrit				Sickle Cell (when indicated)			
Urinalysis				Developmental Screening Tool			
<b>SYSTEM REVIEW</b>	Normal	<b>Comments/Follow-up/Needs</b>			Normal	<b>Comments/Follow-up/Needs</b>	
<b>Skin</b>				<b>Endocrine</b>			
<b>Ears</b>				<b>Gastrointestinal</b>			
<b>Eyes</b>		Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>		<b>Genito-Urinary</b>		LMP	
<b>Nose</b>				<b>Neurological</b>			
<b>Throat</b>				<b>Musculoskeletal</b>			
<b>Mouth/Dental</b>				<b>Spinal Exam</b>			
<b>Cardiovascular/HTN</b>				<b>Nutritional status</b>			
<b>Respiratory</b>		<input type="checkbox"/> Diagnosis of Asthma		<b>Mental Health</b>			
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)				<b>Other</b>			
<b>NEEDS/MODIFICATIONS</b> required in the school setting				<b>DIETARY</b> Needs/Restrictions			
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup							
<b>MENTAL HEALTH/OTHER</b> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> Principal							
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> 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.)			
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>				<b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>			
Print Name		(MD,DO, APN, PA)		Signature		Date	
Address				Phone			

(Complete Both Sides)