FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 5/2006

DCFS

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

Please Print

| Student's Name Last First Middle | Birth Date | Sex | Grade Level | ID# |
|---|---|---|---|---|
| | | | | |

Address Street City ZIP code | Parent/ Guardian | Telephone # Home Work

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 *after* 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 MO DA YR | 2 MO DA YR | 3 MO DA YR | 4 MO DA YR | 5 MO DA YR | 6 MO DA YR |
|---|---|---|---|---|---|---|
| Diphtheria, Tetanus and Pertussis (DTP or DTaP) | | | | | | |
| Diphtheria and Tetanus (Pediatric DT or Td) | | | | | | |
| Inactivated Polio (IPV) | | | | | | |
| Oral Polio (OPV) | | | | | | |
| Haemophilus influenzae type b (Hib) | | | | | | |
| Hepatitis B (HB) | | | | | | |
| Varicella (Chickenpox) | | | | Comments | | |
| Combined Measles, Mumps and Rubella (MMR) | | | | | | |
| Measles (Rubeola) | | | | | | |
| Rubella (3-day measles) | | | | | | |
| Mumps | | | | | | |
| Pneumococcal (not required for school entry) | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 | ☐PCV7 ☐PPV23 |
| Check specific type (PCV7, PPV23) Date | | | | | | |
| Other (Specify hepatitis A, meningococcal, etc.) | | | | | | |

**Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below.**

**Signature** **Title** **Date**

**Signature**
**(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)** **Title** **Date**

**Signature**
**(If adding dates to the above immunization history section, put your initials by date(s) and sign here.)** **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 report, if available.)**

## VISION AND HEARING SCREENING DATA

**Pre-school – annually beginning at age 3; School age – during school year at required grade levels**

| | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Date** | | | | | | | | | | | | | | | | | | | | | | |
| **Age/Grade** | | | | | | | | | | | | | | | | | | | | | | |
| | R | L | R | L | R | L | R | L | 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**

**Printed by Authority of the State of Illinois**
**(Complete Both Sides)**

IL444-4737 (R-01-05)

| Student's Name (Last, First, Middle) | Birth Date (Month/Day/Year) | Sex | School | Grade Level/ ID # |
|---|---|---|---|---|
| | | | | |

**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?<br>Child wakes during the night coughing? | Yes<br>Yes | No<br>No | Indicate Severity | Loss of function of one of paired organs? (eye/ear/kidney/testicle) | Yes | No | |
| Birth complications/prematurity? | Yes | No | | Hospitalizations?<br>When? What for? | Yes | No | |
| Developmental delay? | Yes | No | | | | | |
| Blood disorders? Hemophilia, Sickle Cell, Other? Explain. | Yes | No | | Surgery? (List all.)<br>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 (past/present)? | Yes* | No | *If yes, refer to local health department. |
| Seizures? What are they like? | Yes | No | | TB disease (past or present)? | Yes* | No | |
| 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 history of sudden death before age 50? (Cause?) | Yes | No | |
| Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____<br>Other concerns? (crossed eye, drooping lids, squinting, difficulty reading) | | | | Dental 9 Braces 9 Bridge 9 Plate Other<br>Other concerns? | | | |
| Ear/Hearing problems? | Yes | No | | Information may be shared with appropriate personnel for health and educational purposes.<br>**Parent/Guardian Signature** **Date** | | | |
| Bone/Joint problem/injury/scoliosis? | | | | | | | |

**Entire section below to be completed by MD/DO/APN/PA**

**PHYSICAL EXAMINATION REQUIREMENTS** **HEAD CIRCUMFERENCE** **HEIGHT** **WEIGHT** **BMI** **B/P**

**DIABETES SCREENING** (Not required for daycare.) **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 QUESTIONAIRRE** Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.
**Questionairre Administered?** Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Blood Test Result**
(If child resides in Chicago, blood test is required.)

**TB SKIN TEST** Recommended only for children in high-risk groups including children who are immunosuppressed due to HIV infection or other conditions, recent immigrants from high prevalence countries, or those exposed to adults in high-risk categories. See CDC guidelines. ☐ No Test Needed ☐ Test performed **Date Read** / / **Result** mm

| LAB TESTS (Recommended) | Date | Results | | Date | Results |
|---|---|---|---|---|---|
| Hemoglobin or Hematocrit | | | Sickle Cell (when indicated) | | |
| Urinalysis | | | Developmental Screening | | |

| SYSTEM REVIEW | Normal | Comments/Follow-up/Needs | | Normal | Comments/Follow-up/Needs |
|---|---|---|---|---|---|
| Skin | | | Endocrine | | |
| Ears | | | Gastrointestinal | | |
| Eyes Normal Yes☐ No☐ Objective screening Yes☐ No☐ Result_____<br>Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐ | | | Genito-Urinary | | LMP |
| | | | Neurological | | |
| Nose | | | Musculoskeletal | | |
| Throat | | | Spinal examination | | |
| Mouth/Dental | | | Nutritional status | | |
| Cardiovascular/HTN | | | Mental Health | | |
| Respiratory | | | | | |

**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 ☐**

Physician/Advanced Practice Nurse/Physician Assistant performing examination

**Print Name** **Signature** **Date**

**Address** **Phone**

**(Complete both sides)**

Illinois Department of Public Health

# Childhood Lead Risk Assessment Questionnaire

**ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING (410 ILCS 45/6.2)**

Name _____ Today's Date_____

Age _____ Birthdate _____ ZIP Code _____

| **Respond to the following questions by circling the appropriate answer.** | **RESPONSE** |
|---|---|
| 1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? | Yes No Don't Know |
| 2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher? | Yes No Don't Know |
| 3. Does this child live in or regularly visit a home built before 1978? | Yes No Don't Know |
| 4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978? | Yes No Don't Know |
| 5. Is this child a refugee or an adoptee from any foreign country? | Yes No Don't Know |
| 6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)? | Yes No Don't Know |
| 7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? | Yes No Don't Know |
| 8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)? | Yes No Don't Know |
| 9. Does this child reside in a high-risk ZIP code area? | Yes No Don't Know |

**A blood lead test should be performed on children:**

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _____ Test 2: Blood Lead Result_____mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_____ _____

Signature of Doctor/Nurse Date

**Illinois Lead Program**
**866-909-3572 or 217-782-3517**
**TTY (hearing impaired use only) 800-547-0466**