Sample - For Reference ONLY

First Page of Physical

Please complete the entire physical. The areas called out tend to be overlooked.
Please be sure to check they are completed properly.

State of Illinois
Certificate of Child Health Examination

Student's Name: Last / First / Middle	Birth Date: Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address: Street / City / Zip Code	Parent/Guardian	Telephone # Home	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.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 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	☐Tdap ☐Td ☐DT	☐Tdap ☐Td ☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps Rubella				Comments:		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered Dates						

Your child must have these vaccines to enter Kindergarten.

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 (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.

Please make sure the provider signed and dated the physical.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

(COMPLETE BOTH SIDES)

Printed by Authority of the State of Illinois

Sample Page 2

Second Page for Reverse Side of Physical

The top half of this page is to be completed by the parent., not the doctor. Please fill out before returning.

Please check that these are filled out.

Please make sure the doctor has signed and dated the physical.

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)	Yes / No	List:	**MEDICATION** (Prescribed or taken on a regular basis.)	Yes / No	List:	
Diagnosis of asthma? Child wakes during night coughing?	Yes / No Yes / No		Loss of function of one of paired organs? (eye/earkidney/testicle)	Yes / No		
Birth defects?	Yes / No		Hospitalizations? When? What for?	Yes / No		
Developmental delay?	Yes / No		Surgery? (List all.) When? What for?	Yes / No		
Blood disorders? Hemophilia, Sickle Cell Other? Explain.	Yes / No		Serious injury or illness?	Yes / No		
Diabetes?	Yes / No		TB skin test positive (past/present)?	Yes* / No	*If yes, refer to local health department.	
Head injury/Concussion/Passed out?	Yes / No		TB disease (past or present)?	Yes* / No		
Seizures? What are they like?	Yes / No		Tobacco use (type, frequency)?	Yes / No		
Heart problem/Shortness of breath?	Yes / No		Alcohol/Drug use?	Yes / No		
Heart murmur/High blood pressure?	Yes / No		Family history of sudden death before age 50? (Cause?)	Yes / No		
Dizziness or chest pain with exercise?	Yes / No					
Eye/Vision problems? ____ Glasses ☐ Contacts ☐ Last exam by eye doctor ____ Other concerns? (crossed eyes, drooping lids, squinting, difficulty reading)			Dental ☐ Braces ☐ Bridge ☐ Plate Other			
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 | WEIGHT | BMI | BP

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. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result

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 birth in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

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		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	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 Agonist) ☐ 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 file: ☐ 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 Yes ☐ No ☐ Modified ☐

Print Name (MD/DO/APN/PA) Signature Date

Address Phone