FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

DCFS

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. 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
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						
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:**
Age/ Grade																					**P = Pass**
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	**F = Fail**
Vision																					**U = Unable to test**
Hearing																					**R = Referred** **G/C = Glasses/Contacts**

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.

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 (**Anote todas las recetadas o tomadas con regularidad.)			
¿Tiene diagnóstico de asma? ¿Despierta el niño tosiendo en la noche?	Sí No Sí No		¿Tiene pérdida de Funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí No		
¿Tiene defectos de nacimiento?	Sí No		¿Ha sido hospitalizado? ¿Cuándo? ¿Por Qué?	Sí No		
¿Tiene retrasos del desarrollo?	Sí No					
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí No		¿Ha atendido cirugía? (anótelas todas) ¿Cuándo? ¿Para Qué?	Sí No		
¿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 _____ ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)			Dental … Ganchos … Puente … Placas Otro			
¿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. (Blood test required if resides in Chicagoor high risk zipcode.)

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 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 Yes ☐ No ☐ Limited ☐**

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)