Please Print

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

Student's Name Last First Middle	Birth Date Month/Day/ Year	Sex	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	1 DA	1 YR	2 MO	2 DA	2 YR	3 MO	3 DA	3 YR	4 MO	4 DA	4 YR	5 MO	5 DA	5 YR	6 MO	6 DA	6 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)																		
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																					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 U = Unable to test
Vision																					R = Referred
Hearing																					G/C = Glasses/ Contacts

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(Complete Both Sides)

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