Dear Parents:

The following is now required by the State of Illinois:

Note: Screenings performed by the doctor's office as part of the school physical do not fulfill the mandate. Vision and hearing screenings are conducted at school by the Hoffman Estates Health & Human Services Department. These will be offered at a low cost to parents.

It is our policy to exclude children from school by October 15 if requirements for health examinations and immunizations are not met.

**PHYSICALS**
- Prior to initial enrollment
- At two year intervals for children under 5 years old
- Prior to Grades K, 6 & 9

**VISION**
- Screening beginning at age 3 in all licensed preschool programs
- An eye exam by a qualified eye doctor (optometrist or ophthalmologist) at Kindergarten or when entering an Illinois elementary program
- Screening at Grades 2 & 8
- Screening if new to the school/district
- Screening if referred by teacher

**HEARING**
- Screening beginning at age 3 in all licensed preschool programs
- Screening at Grades K, 1, 2 & 3
- Screening if new to school/district
- Screening if referred by teacher

**DENTAL** (Required by May 15)
- Dental exams at Grades K, 2 & 6
STATE OF ILLINOIS  
DEPARTMENT OF HUMAN SERVICES 
CERTIFICATE OF CHILD HEALTH EXAMINATION 

Please Print 

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

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** | MO | DA | YR | MO | DA | YR | MO | DA | YR | MO | DA | YR | 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) |
Combined Measles, Mumps and Rubella (MMR) |
Measles (Rubeola) |
Rubella (3-day measles) |
Mumps |
Pneumococcal (not required for school entry) |
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 |
--- | --- | --- |

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

Signature | Title | Date |
--- | --- | --- |

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

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 | 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 |

Vision |
Hearing |

Printed by Authority of the State of Illinois 
(Complete Both Sides)
**HEALTH HISTORY**  
TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

**ALLERGIES** (Food, drug, insect, other)

- Diagnosis of asthma? Yes No
- Child wakes during the night coughing Yes No
- Birth defects? Yes No
- Developmental delay? Yes No
- Blood disorders? Hemophilia, Sickle Cell, Other? Yes No
- Diabetes? Yes No
- Head injury/Concussion/Passed out? Yes No
- Seizures? What are they like? Yes No
- Heart problem/Shortness of breath? Yes No
- Heart murmur/High blood pressure? Yes No
- Dizziness or chest pain with exercise? Yes No
- Eye/Vision problems? Glasses Contacts Last exam by eye doctor
- Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

**PHYSICAL EXAMINATION REQUIREMENTS**

<table>
<thead>
<tr>
<th></th>
<th>Height</th>
<th>Weight</th>
<th>BMI</th>
<th>B/P</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIABETES SCREENING</strong></td>
<td>if BMI≥85%</td>
<td>age/sex</td>
<td>Yes No</td>
<td>And any two of the following:</td>
</tr>
<tr>
<td></td>
<td>Family History</td>
<td>Yes No</td>
<td>Ethnic Minority</td>
<td>Yes No</td>
</tr>
<tr>
<td><strong>Signs of Insulin Resistance</strong></td>
<td>hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans</td>
<td>Yes No</td>
<td>At Risk</td>
<td></td>
</tr>
<tr>
<td><strong>LEAD RISK QUESTIONNAIRE</strong></td>
<td>.Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten.</td>
<td>Blood Test Indicated</td>
<td>Yes No</td>
<td></td>
</tr>
<tr>
<td><strong>TB SKIN TEST</strong></td>
<td>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.</td>
<td>Date Read</td>
<td>Date Results</td>
<td></td>
</tr>
<tr>
<td><strong>LAB TESTS</strong></td>
<td>Indicates testing mandated for state licensed child care facilities.</td>
<td>Date Read</td>
<td>Date Results</td>
<td></td>
</tr>
<tr>
<td>Hemoglobin * or Hematocrit *</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urinalysis</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SYSTEM REVIEW**

- Normal comments/ Follow-up/ Needs
- Normal comments/ Follow-up/ Needs

- Skin
- Ears
- Eyes Normal No Objective screening Yes No Result;
- Amblyopia Yes No Referred to Ophthalmologist/Optometrist Yes No
- Nose
- Throat
- Mouth/Dental
- Cardiovascular/HTN
- 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 Mod 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)
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.

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 of 10 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 _________________
Blood lead screening is defined as obtaining a blood lead test. Lead risk assessment is defined as evaluation of potential for exposures to lead based on questionnaire responses.

It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or potential exposure to lead has been identified, regardless of child's age.

Illinois has defined ZIP code areas at high risk and low risk for lead exposure based on housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.

In Illinois, all children from low-income families (i.e., Medicaid-eligible children) should receive a blood lead test at ages 12 and 24 months, even if they live in a low-risk ZIP code area. If the child is 3 through 6 years old and has not been tested, a blood lead test is required.

Children Lead Risk Assessment Questionnaire

- Complete the Childhood Lead Risk Assessment Questionnaire during a health care visit at ages 12 and 24 months.
  - If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.
  - If any response is "YES" or "DON'T KNOW," obtain a blood lead test
- Consider evaluating children before 12 months of age, depending on the area.
- If the child is age 3-6 years and there is any "YES" or "DON'T KNOW" and
  - has had two successive blood lead test results that were each less than < 10 mcg/dL with one of these tests at age 2 years or older and
  - risks of exposure to lead have not changed, further blood lead tests are not necessary.
- If the child is 1) 3-6 years, and 2) all answers to the Childhood Lead Risk Assessment Questionnaire are "NO," and 3) risks of exposure to lead have not changed, a blood lead test is not necessary.
- If the child is 3-6 years of age and risks of exposures to lead have increased, obtain a blood lead test.
- Continue to use the Childhood Lead Risk Assessment Questionnaire through age 6.

For children living in Chicago:
- A blood lead test for children age 3 and younger should be obtained at 6, 12, 18, 24 and 36 months OR at 9, 15, 24 and 36 months.
- Children 4 through 6 years of age with prior blood lead levels <10 mcg/dL should have an annual risk assessment. A blood lead test should be performed if risk increases or if the child exhibits persistent oral behaviors.
<table>
<thead>
<tr>
<th>County</th>
<th>ZIP Codes</th>
<th>County</th>
<th>ZIP Codes</th>
<th>County</th>
<th>ZIP Codes</th>
<th>County</th>
<th>ZIP Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>62567 Effingham, 62367 Knox, 62526 Putnam</td>
<td>Alexander</td>
<td>62286 Knox, 61425 Putnam, 62093 Putnam</td>
<td>Bond</td>
<td>62219 Franklin, 61234 Putnam</td>
<td>Brown</td>
<td>61943 Franklin, 62134 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
<tr>
<td>Bond</td>
<td>62240 Franklin, 61410 Putnam</td>
<td>Boone</td>
<td>61931 Franklin, 61773 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
<td>Calhoun</td>
<td>61543 Franklin, 61324 Putnam</td>
</tr>
</tbody>
</table>