

## State of Hlinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES CFS 600
Rev 12/2011

Student's Name								Birth D	ate		Sex	Race	/Ethnic	ity	Scho	ol/Gra	le Leve	I/ID#
Last	First		•		Midd	ile		Month/Da	ay/Year									
Address Stre	et		itv	Z	in Code			Parent/Gua			Telep	hone# H	lome	•		Work		
IMMUNIZATIONS	To be c	omplete	d by he	alth care	provid	er. Note	the mo/	da/yr for	ге е е е гу	lose adn	ninistere	l. The d	lay and r	nonth is	require	d if you	cannot	
determine if the vaccine attached explaining the	was give medica	n <i>after</i> : l reason	the mini for the	mum in contra	terval o indicat	rage. If	a specif	ic vacci	ne is m	edically	contrair	ndicate	d, a sep	arate w	ritten st	atemen	t must l	e i
Vaccine / Dose		1			2			3			4			5			6	
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DTP or DTaP																		
	Td or Pediatric		⊐DT	□Tdap□Td□DT			□Tdap□Td□DT			□Tdap□Td□DT		□Tdap□Td□DT		□DT	□Tda	ърЦТd	TOL	
DT (Check specific type)						1												
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Polio (Check specific		N D	OPV		PV 🗆	OPV		PV 🗆	OPV	ПΙ	PV 🗆 (	OPV		PV 🗆	OPV		PV 🗆	OPV
type)							İ											
Hib Haemophilus							<u> </u>				<u> </u>		<u> </u>		*			
influenza type b																		
Hepatitis B (HB)											-						<del></del>	
Varicella (Chickenpox)										CON	MMEN.	TS:	<del></del>					
MMR Combined Measles Mumps, Rubella																		
	7	Measle	c.	Rubella				Mumps										
Single Antigen Vaccines							14xumps			ĺ								
						·												
Pneumococcal													Ī					
Conjugate Other/Specify		<u> </u>			<u> </u>		ļ			ļ			ļ		1	ļ		
Meningococcal,			·		+	<del></del>			-,	<u> </u>		,			·			
Hepatitis A, HPV, Influenza										-								
Health care provider (	MD. DO	, APN.	PA. scl	ool hea	I Ith pro	l fessiona	L healfl	ı officia	) D verify	ing aho	ve imm	unizatio	on histo	רע ותוופו	t sion h	low 1	faddin	r detec
to the above immunizat	ion histo	ry section	on, put y	our initi	ials by c	late(s) ar	nd sign l	nere.)	, ,	g	.,				. 2.6 0	2011	- acon,	5 unios
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ALTERNATIVE P.  1. Clinical diagnosis is						. +/												
•	-										iter July 1,	, 2002, m	nust be co	nfirmed.	by labora	tory evid	ence_)	
*MEASLES (Rubeola 2 History of varicella	(chicke	DA YR	MUN isease is	IPS Mo	DA Cableify	YR V	ARICE hy heal	th care	DA C	YR r. schoo	Physic	ian's S	ignatur sional o	e r healt	officie	1		
Person signing below is ve	rifying th	at the par	ent/guard	lian's de:	scription	of varice	lla distas	e history	is indicat	ive of pa	st infection	n and is	accepting	such his	tory as d	cumentz	tion of d	isease.
Date of Disease			Signa					F-1700	Title			<u> </u>			Date	>		
3. Laboratory confirm Lab Results	12ПОП (С	neck o	ае) Ш	Measle Date	S MO	□Mun DA		□Rub	еца	ШHе	patitis !	В	□Vari (Attach		f lab re	sult)		
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Date						-							1						
Agel Grade																			Code: P=Pass
	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 G/C=
Hearing																			Glasses/Contacts

	- Colombia de la Colo					В	irth Date	s	ex	School			Grade Level/I
Last	F	rirst		М	liddle		Month/Day/ Year				***************************************		
HEALTH HISTORY	TC	D BE COMPI	ETEI	O AND SI	GNED BY	PARENT/G	UARDIAN AND VERI	FIED BY	Y HŒA	LTH CAF	E PR	OVIDER	
ALLERGIES (Food, drug, i	nsect, other)	o de la compansión de la c				en ingen eine Erichte bei erzeich der Steine Gereichte der Steine Gereichte der Steine Gereichte der Steine Ge	MEDICATION (List	tall prescrit	bed or tal	cen on a regul	ar basis.	)	
Diagnosis of asthma? Child wakes during night	coughing	? Yes Yes	No No			•	Loss of function of o organs? (eye/ear/kidr	-		Yes	No		
Birth defects?		Yes	No				Hospitalizations?			Yes	No		
Developmental delay?		Yes	No			***************************************	When? What for?						
Blood disorders? Hemopl Sickle Cell, Other? Expl	nilia, ain.	Yes	No				Surgery? (List all.) When? What for?			Yes	Νo		
Diabetes?		Yes	No				Serious injury or illne	ess?		Yes	No		
Head injury/Concussion/I	Passed out	? Yes	No	1			TB skin test positive	(past/pre	sent)?	Yes*	No		efer to local health
Seizures? What are they	like?	Yes	No				TB disease (past or pr	resent)?		Yes*	No	departm	ent
Heart problem/Shortness	of breath?	Yes	No				Tobacco use (type, fr	equency)	?	Yes	No		
Heart murmur/High blood	l pressure	7 Yes	No				Alcohol/Drug use?			Yes	No		
Dizziness or chest pain was exercise?	ith	Yes	No				Family history of sud- before age 50? (Caus		1	Yes .	No		
Eye/Vision problems?		isses 🗆 Conta				octor	Dental ☐ Brace:	s □• <del>I</del>	Bridge	□ • Plate	e Oth	er	
Other concerns? (crossed	eye, droopîr		g, diffi No	culty readi	ng)	-	Information may be share	ed with an	DEDULIA+	e personnel f	or heal	h and educ	ational purposes
Ear/Hearing problems?		Yes					Parent/Guardian		propriac	personner i	or near	n and conc	anonai piu poses,
Bone/Joint problem/injury	//scoliosis	? Yes	No				Signature					D	ate
PHYSICAL EXAMINATE HEAD CIRCUMFERENCE	NATION E if < 2-3 y	REQUIRE	ME	VIS E	Entire sec HEIGH		to be completed by WEIGHT	MD/D	O/AP	N/PA BMI			Ъ/Р
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