

Please Print

<b>Student's Name</b>	<b>Birth Date</b>	<b>Sex</b>	<b>Grade Level</b>	<b>ID #</b>
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Address code	Street	City	ZIP	Parent/ Guardian	Telephone # Home:	Work
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**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			2			3			4			5			6		
	MO	DA	YR	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)	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23	<input type="checkbox"/> PCV7	<input type="checkbox"/> PPV23
Check specific type (PCV7, PPV23)      Date																		
Other (Specify: Hepatitis A, meningococcal, etc.)																		

Comments:

Health care provider (MD, APN, PA, school health professional, health official) verifying above immunization history must sign below.

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

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.)

**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**

This section to be completed by IDPH certified screening personnel, if pre-existing approved IDPH form is not available.  
Pre-school - annually beginning at age 3; School age - during school year at required grade levels.

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

Printed by Authority of the State of Illinois (over)

<b>Student's Name</b> Last First Middle	<b>Birth Date</b> Month Day Year	Sex	School	<b>Grade Level/ ID #</b>
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER					
	Circle one	Comments		Circle one	Comments
Diagnosis of Asthma? Wheeze/Cough During or After Play?	Yes <input type="radio"/> No <input type="radio"/>	Indicate Severity:	Loss of Function of One of Paired Organs? (Eye/Ear/Kidney/Testicle)	Yes <input type="radio"/> No <input type="radio"/>	
Birth Defects?	Yes <input type="radio"/> No <input type="radio"/>		Hospitalizations? When? What for?	Yes <input type="radio"/> No <input type="radio"/>	
Developmental Delay?	Yes <input type="radio"/> No <input type="radio"/>				
Blood Disorders? Hemophilia, Sickle Cell, Other? Explain	Yes <input type="radio"/> No <input type="radio"/>		Surgery? (List All) When? What For?	Yes <input type="radio"/> No <input type="radio"/>	
Diabetes?	Yes <input type="radio"/> No <input type="radio"/>		Serious Injury or Illness?	Yes <input type="radio"/> No <input type="radio"/>	
Head Injury/Concussion/Passed Out?	Yes <input type="radio"/> No <input type="radio"/>		TB Skin Test Positive (Past or Present)?	Yes* <input type="radio"/> No <input type="radio"/>	* Refer positive response to the local health department.
Seizures? What are they like?	Yes <input type="radio"/> No <input type="radio"/>		TB Disease (Past or Present)?	Yes* <input type="radio"/> No <input type="radio"/>	
Heart Problem/Shortness of Breath?	Yes <input type="radio"/> No <input type="radio"/>		Tobacco Use (Type, Frequency)?	Yes <input type="radio"/> No <input type="radio"/>	
Heart Murmur/High Blood Pressure?	Yes <input type="radio"/> No <input type="radio"/>		Alcohol/Drug Use?	Yes <input type="radio"/> No <input type="radio"/>	
Dizziness or Chest Pain With Exercise?	Yes <input type="radio"/> No <input type="radio"/>		Family History of Sudden Death Before Age 50? (Cause?)	Yes <input type="radio"/> No <input type="radio"/>	
Bone/Joint Problems/Injury? Scoliosis?	Yes <input type="radio"/> No <input type="radio"/>		Dental • Braces • Bridge • Plate • Other		
			Other Concerns?		
Ear/Hearing Problems?	Yes <input type="radio"/> No <input type="radio"/>		<b>Information on this form may be shared with appropriate personnel for health and educational purposes.</b>		
Eye/Vision Problems? Glasses    Contacts    Last Exam _____ Other Concerns?					
			<b>Parent/Guardian Signature</b>	<b>Date</b>	

TO BE COMPLETED BY MD/APN/PA (* INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES OR SELECTED SCHOOLS AND PROGRAMS)					
Strongly Recommended Tests	Date	Results		Date	Results
Hemoglobin * or			Urinalysis		
Hematocrit *			Sickle Cell * (as needed)		
Lead Questionnaire* Completed? Yes <input type="radio"/> No <input type="radio"/> Date _____ Blood Test Indicated? Yes <input type="radio"/> No <input type="radio"/> Blood Test Performed? Yes <input type="radio"/> No <input type="radio"/>					
TB Skin Test Recommended only for children in high-risk groups: includes 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. <b>Date Read</b> / / <b>Result</b> mm					
PHYSICAL EXAMINATION REQUIREMENTS		HEIGHT	WEIGHT	B/P	HEART RATE
	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin				Endocrine	
Ears				Gastrointestinal	
Eyes				Genito-Urinary	LMP
Nose				Neurological	
Throat				Musculoskeletal	
Mouth/Dental				Spinal Examination	
Cardiovascular/EIN				Nutritional Status	
Respiratory				Mental Health	
<b>ALLERGIES</b> (Food, drug, insect, other)			<b>MEDICATION</b> (List all prescribed or taken on a regular basis.)		
<b>NEEDS/MODIFICATIONS</b> required in the school setting			<b>DIETARY</b> Needs/Restrictions		
<b>SPECIAL INSTRUCTIONS/DEVICES</b> e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic supporter/cup					
<b>MENTAL HEALTH/OTHER:</b> Is there anything else that you think 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					
<b>EMERGENCY ACTION</b> 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 <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/> INTERSCHOLASTIC SPORTS (for one year) Yes <input type="checkbox"/> No <input type="checkbox"/> Limited <input type="checkbox"/>					
Physician/Advanced Practice Nurse/Physician Assistant performing examination					
Print Name		Signature		Date	
Address			Phone		