

Dear Parent/Guardian of the child entering Kindergarten in the fall of 2011
It is required by Illinois State Law that every child entering Kindergarten have a complete health physical form dated 2011. Kindergarteners must show proof of having received the following immunizations prior to entering Kindergarten:

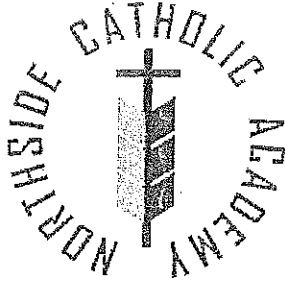
1. DPT: four or more doses, with the last dose being a booster having been received on or after the 4th birthday.
2. OPV: three or more doses, with the last dose being a booster having been received on or after the 4th birthday.
3. MMR: two doses of Measles, one dose on or after 1st birthday and the second dose no less than 4 weeks after the first dose, and one each of Mumps and Rubella.
4. VARICELLA: one dose on or after the 1st birthday
5. TB: dated 2011, if indicated
6. Lead test.

Children who have not received the physical examination as required are considered to be in non-compliance with state law, whether or not they have received the required immunizations.

This form must be completed and signed by the physician and parent. Please return the form to the school office on or before the first day of school, Fall 2011.

Your child will not be allowed to attend the first day of school without a completed and signed health form.

Heather Garcia RN
School Health Record Coordinator



Estimado Padre/Pariente de un niño entrando Kinder in el otoño del año 2011

Es requerido por ley estatal que cada niño entrando Kinder tiene una forma documentando un físico de salud del año 2011.

Uno niño del Kinder tiene que documentar de haber recibido las siguientes vacunas:

1. "DPT": cuatro o más dosis, la última dosis siendo una inyección secundaria recibido después del 4 cumpleaños.
2. "OPV": tres o más dosis, la última dosis siendo una inyección secundaria recibido después del 4 cumpleaños.
3. "MMR": dos dosis de sarampión, la primera dosis siendo después de 12 meses de edad, una dosis de papera y una de rubéola.
4. "VARICELLA": uno dosis.
5. "TB": marcado con el año 2011
6. Prueba de plomo.

Niños que no han recibido los físicos requeridos serán considerados no en conformidad con la ley estatal, si han recibido las vacunas o no.

Esta forma tiene que ser completado y firmado por el médico y el padre del niño. Para que su niño será aceptado el primer día de clases del año escolar 2011 es necesario entregar esta forma a la oficina de la escuela en o antes del primer día de clases. Les agradecemos su respuesta puntual.

HEATHER GARCIA RN
El Programa Escolar de Salud



**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			Parent/ Guardian	Telephone # Home	Work
Street	City	ZIP code			

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)																			Comments	
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)																				
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: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade															
	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)

Student's Name Last First Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID #
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HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)			MEDICATION (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma?	Yes	No	Indicate Severity	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night coughing	Yes	No		Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Developmental delay?	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No			Serious injury or illness?	Yes
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	Diabetes?	TB skin test positive (past/present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No			TB disease (past or present)?	Yes*
Seizures? What are they like?	Yes	No	Heart problem/Shortness of breath?	Tobacco use (type, frequency)?	Yes	No
Heart murmur/High blood pressure?	Yes	No			Alcohol/Drug use?	Yes
Dizziness or chest pain with exercise?	Yes	No	Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)	Family history of sudden death before age 50? (Cause?)	Yes	No
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other	*If yes, refer to local health department.
Ear/Hearing problems?	Yes	No	Bone/Joint problem/injury/scoliosis?	Information may be shared with appropriate personnel for health and educational purposes. Parent/Guardian Signature _____ Date _____		
Bone/Joint problem/injury/scoliosis?	Yes	No				

Entire section below to be completed by MD/DO/APN/PA (*INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES)

PHYSICAL EXAMINATION REQUIREMENTS	HEIGHT	WEIGHT	BMI	B/P
DIABETES SCREENING BMD>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/>				
Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>				

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 Indicated? Yes No **Blood Test Date** _____ **Blood Test Result** _____ (Blood test required in Chicago and other high risk zip codes.)

TB SKIN TEST 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. **Date Read** / / **Result** _____ mm

LAB TESTS *INDICATES TESTING MANDATED FOR STATE LICENSED CHILD CARE FACILITIES	Date	Results	Date	Results
Hemoglobin * or Hematocrit *			Sickle Cell * (as indicated)	
Urinalysis			Other	

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs	Normal	Comments/Follow-up/Needs
Skin			Endocrine	
Ears			Gastrointestinal	
Eyes	Normal Yes <input type="checkbox"/> No <input type="checkbox"/> Amblyopia Yes <input type="checkbox"/> No <input type="checkbox"/>	Objective screening Yes <input type="checkbox"/> No <input type="checkbox"/> Referred to Ophthalmologist/Optomtrist Yes <input type="checkbox"/> No <input type="checkbox"/>	Genito-Urinary	LMP
Nose			Neurological	
Throat			Musculoskeletal	
Mouth/Dental			Spinal examination	
Cardiovascular/HTN			Nutritional status	
Respiratory			Mental Health	

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** (for one year) Yes No Limited

Physician/Advanced Practice Nurse/Physician Assistant performing examination

Print Name	Signature	Date
Address	Phone	

(Complete both sides)