

State of Illinois Certificate of Child Health Examination

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

DCFS

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A History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Serson 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 Laboratory confirmation (check one) Date Mo DA YR VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN Attach copy of lab result) VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN Attach copy of lab result Attach copy of lab result Code: P = Pass F = Fail F =															med by I	aboratory	evidenc	e.)	
Acte of Disease Code: Cod	. History of varicella	(chicken	pox) dis	ease is ac	centabl	e if veri	fied by	health a	are prov	vider e	chool h	aalth nee	faccion	al am b	ealth of	ficial.			
Laboratory confirmation (check one)		niying tha	t the pare			otion of v	aricella d	isease his	story is inc	licative	of past in	fection and	l is accep	oting suc	h history	as docum	entation	of disea	se.
AB Results Date MO DA YR (Attach copy of lab result) VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN ate ge/ ge/ rade R L R L R L R L R L R L R L R L R L R		ation (c)	eck one			П	Aumne.				Monot	:4:- D	Пх			Date			
ge/ rade R L R L R L R L R L R L R L R L R L R L									Kubella		лерат	itis B				result)			
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Glasses/Contact					_		+-	+-	+	-	-		-	-		-	G/C =		ota

				Birth Date	rth Date Sex S			Grade Level/ ID			
Last		irst	Middle	Month/Day/ Year							
HEALTH HISTORY		BE COMPLETE	D AND SIGNED BY PARENT	I/GUARDIAN AND VERIFIEI							
ALLERGIES (Food, drug, i	nsect, other)	-		MEDICATION (List all pro		taken on a regular b	asis.)				
Diagnosis of asthma? Child wakes during night	coughing		0	Loss of function of one of organs? (eye/ear/kidney/to		Yes	No				
Birth defects?		Yes No	0		Hospitalizations? When? What for?						
Developmental delay?	1.0	Yes No	0	when? what for?							
Blood disorders? Hemopl Sickle Cell, Other? Expl		Yes No		Surgery? (List all.) When? What for?		Yes 1	No				
Diabetes?	and the fact of the	Yes No		Serious injury or illness?	Yes 1	No	- 1111111				
Head injury/Concussion/I	Passed out	? Yes No		TB skin test positive (past	present)?	? Yes* 1		fer to local health			
Seizures? What are they	like?	Yes No	Year of the second of the seco	TB disease (past or presen	t)?	Yes* 1	No departmen	at.			
Heart problem/Shortness	of breath?	Yes No		Tobacco use (type, freque	ncy)?	Yes 1	No				
Heart murmur/High blood	d pressure	Yes No		Alcohol/Drug use?		Yes 1	No				
Dizziness or chest pain we exercise?	îth	Yes No		Family history of sudden of before age 50? (Cause?)	leath	Yes 1	No				
Eye/Vision problems? Other concerns? (crossed of	Gla eye, droopir	sses Contacts In glids, squinting, diff	Last exam by eye doctor ficulty reading)	Dental Braces I	-						
Ear/Hearing problems?		Yes No	0		Information may be shared with appropriate personnel for health and educational purposes.						
Bone/Joint problem/injury	/scoliosis	Yes No		Parent/Guardian Signature			Date				
PHYSICAL EXAMIN HEAD CIRCUMFERENCE			NTS Entire section belo	ow to be completed by MI WEIGHT	/DO/A	PN/PA BMI	1	B/P			
DIABETES SCREENING	G (NOT RE	QUIRED FOR DAY C	ARE) BMI>85% age/sex	Yes□ No□ And any two	of the fol	llowing: Fam	ily History Y	es □ No □			
				ars enrolled in licensed or publ							
and/or kindergarten. (Bloc	od test req	uired if resides in	Chicago or high risk zip code.)	ans emotion in need sea of publi	c school	operated day t	are, prescrioo	i, nursery school			
Questionnaire Administe	red? Yes	□ No □ Blo	od Test Indicated? Yes 🗆 1	No □ Blood Test Date		Resi	alt	1018.90			
TB SKIN OR BLOOD TI	EST Reco	mmended only for c	hildren in high-risk groups includir	ng children immunosuppressed due	o HIV inf	fection or other c	onditions, frequ	ent travel to or born			
in high prevalence countries or	those expos	sed to adults in high-	risk categories. See CDC guideline	es. No test needed		formed 🗆	-	es and a second			
Skin Test: Date Res Blood Test: Date Re			Result: Positive □ Negativ Result: Positive □ Negativ	######################################		_		14.19			
LAB TESTS (Recommended)	Date	Results			Date		Results			
Hemoglobin or Hematocri	it			Sickle Cell (when indica	ited)						
Urinalysis				Developmental Screenin	g Tool			1000			
SYSTEM REVIEW	Normal	Comments/Follo	w-up/Needs	No	mal Co	mments/Follo	w-up/Needs	arma chin ili			
Skin				Endocrine	T. U.	ti de la	The state of the s	OCCUPATION OF THE PARTY OF			
Ears				Gastrointestinal							
Eyes			Amblyopia Yes□ N	o□ Genito-Urinary			LMP				
Nose			3 XXX - 31 - 111	Neurological				Stocker			
Throat		1		Musculoskeletal		7.74	4 4	33 22 1			
Mouth/Dental	H 10%			Spinal Exam			1-00102	PERSONAL PROPERTY.			
Cardiovascular/HTN				Nutritional status			- Control				
Respiratory	34.4	10 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	☐ Diagnosis of Asthma	Mental Health							
	medicatio	on (e.g. Short Actin	ng Beta Agonist)	Other	\top						
NEEDS/MODIFICATION		e.g. inhaled cortic		DIETADVALIDA							
	•	•		DIETARY Needs/Restrict							
pur transfer of the process of the	Carriella	per la la la company de la com	Carried and Carried Control of Control of Carried C	arrhythmia, pacemaker, prosthetic d	evice, den	tal bridge, false	eeth, athletic su	pport/cup			
f you would like to discuss this	student's h	ealth with school or	ne school should know about this s school health personnel, check title	: Nurse Teacher							
Yes 🗆 No 🗆 If yes, plea	ase describe	i.		res, asthma, insect sting, food, pean				rt problem)?			
On the basis of the examination PHYSICAL EDUCATION			*** *	(If No or Modifie ERSCHOLASTIC SPORTS	d please a	-		Limited			
rint Name				ature				ate			
ddress				Phone							