



## State of Illinois Certificate of Child Health Examination

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#											
Last		First		Middle		Month/Day/Year												
Address				Parent/Guardian		Telephone # Home Work												
<b>IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.</b>																		
REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
Polio (Check specific type)	<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV			<input type="checkbox"/> IPV <input type="checkbox"/> OPV		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps, Rubella										<b>Comments:</b> * indicates invalid dose								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
<b>RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose</b>																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		
Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.																		
Signature				Title				Date										
Signature				Title				Date										
<b>ALTERNATIVE PROOF OF IMMUNITY</b>																		
1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result. <b>*MEASLES (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR</b>																		
2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies 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 _____																		
3. Laboratory Evidence of Immunity (check one) <input type="checkbox"/> Measles* <input type="checkbox"/> Mumps** <input type="checkbox"/> Rubella <input type="checkbox"/> Varicella Attach copy of lab result.																		
*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence. **All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.																		
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____ Physician Statements of Immunity MUST be submitted to IDPH for review.																		

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

Last			First			Middle			Birth Date Month/Day/Year			Sex	School			Grade Level/ ID	
<b>HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER</b>																	
<b>ALLERGIES</b> (Food, drug, insect, other)			Yes	No	List:			<b>MEDICATION</b> (Prescribed or taken on a regular basis)			Yes	No	List:				
Diagnosis of asthma?			Yes	No				Loss of function of one of paired organs? (eye/ear/kidney/testicle)			Yes	No					
Child wakes during night coughing?			Yes	No				Hospitalizations? When? What for?			Yes	No					
Birth defects?			Yes	No				Surgery? (List all.) When? What for?			Yes	No					
Developmental delay?			Yes	No				Serious injury or illness?			Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.			Yes	No				TB skin test positive (past/present)?			Yes*	No				*If yes, refer to local health department.	
Diabetes?			Yes	No				TB disease (past or present)?			Yes*	No					
Head injury/Concussion/Passed out?			Yes	No				Tobacco use (type, frequency)?			Yes	No					
Seizures? What are they like?			Yes	No				Alcohol/Drug use?			Yes	No					
Heart problem/Shortness of breath?			Yes	No				Family history of sudden death before age 50? (Cause?)			Yes	No					
Heart murmur/High blood pressure?			Yes	No				Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other									
Dizziness or chest pain with exercise?			Yes	No				Information may be shared with appropriate personnel for health and educational purposes.									
Eye/Vision problems? <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor <input type="checkbox"/>									Parent/Guardian Signature						Date		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)																	
Ear/Hearing problems?			Yes	No													
Bone/Joint problem/injury/scoliosis?			Yes	No													
<b>PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA</b>																	
HEAD CIRCUMFERENCE if < 2-3 years old			HEIGHT			WEIGHT			BMI			BMI PERCENTILE			B/P		
<b>DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI&gt;85% age/sex</b> Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: <b>Family History</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Ethnic Minority</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Signs of Insulin Resistance</b> (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> <b>At Risk</b> Yes <input type="checkbox"/> No <input type="checkbox"/>																	
<b>LEAD RISK QUESTIONNAIRE:</b> 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 required if resides in Chicago or high risk zip code.) <b>Questionnaire Administered?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Indicated?</b> Yes <input type="checkbox"/> No <input type="checkbox"/> <b>Blood Test Date</b> _____ <b>Result</b> _____																	
<b>TB SKIN OR BLOOD TEST</b> Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. <a href="http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm">http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm</a> . <b>No test needed</b> <input type="checkbox"/> <b>Test performed</b> <input type="checkbox"/> <b>Skin Test: Date Read</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>mm</b> _____ <b>Blood Test: Date Reported</b> _____ <b>Result: Positive</b> <input type="checkbox"/> <b>Negative</b> <input type="checkbox"/> <b>Value</b> _____																	
<b>LAB TESTS (Recommended)</b>			Date			Results			Date			Results					
Hemoglobin or Hematocrit									Sickle Cell (when indicated)								
Urinalysis									Developmental Screening Tool								
<b>SYSTEM REVIEW</b>		Normal	<b>Comments/Follow-up/Needs</b>					Normal		<b>Comments/Follow-up/Needs</b>							
Skin								Endocrine									
Ears			Screening Result:					Gastrointestinal									
Eyes			Screening Result:					Genito-Urinary		LMP							
Nose								Neurological									
Throat								Musculoskeletal									
Mouth/Dental								Spinal Exam									
Cardiovascular/HTN								Nutritional status									
Respiratory			<input type="checkbox"/> Diagnosis of Asthma					Mental Health									
Currently Prescribed Asthma Medication:								Other									
<input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist)																	
<input type="checkbox"/> Controller medication (e.g. inhaled corticosteroid)																	
<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 support/cup																	
<b>MENTAL HEALTH/OTHER</b> 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: <input type="checkbox"/> Nurse <input type="checkbox"/> Teacher <input type="checkbox"/> Counselor <input type="checkbox"/> 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.)																	
<b>PHYSICAL EDUCATION</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>						<b>INTERSCHOLASTIC SPORTS</b> Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>											
Print Name						(MD,DO, APN, PA) Signature						Date					
Address						Phone											

# PHYSICIAN MEDICATION ORDER FORM

## St. Libory Consolidated School District #30

811 Darmstadt Street  
St. Libory, Illinois 62282  
Phone: 618-768-4923  
Fax: 618-768-4518

School policy requires that all students who need medication during school hours must do the following:

1. The parent/guardian must sign this consent to administer the medication or present a written physician's order and a signed note from the parent/guardian requesting the administration of the medication.
2. Bring prescription medication in the original prescription bottle, properly labeled by a registered pharmacist as prescribed by law.
3. Bring over-the-counter medication in original containers and include the dosage and time medication is to be given.

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Name of Student: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

### TO BE COMPLETED BY THE PHYSICIAN

Medication, dosage & directions for administration: \_\_\_\_\_

(OR) Health Care Treatment & directions for administration: \_\_\_\_\_

Start Date: \_\_\_\_\_

Intended effect of this medication/treatment: \_\_\_\_\_

Expected side effects, if any: \_\_\_\_\_

Are there any restrictions? \_\_\_\_\_

Other medication student is taking: \_\_\_\_\_

Discontinue/Re-Evaluate/Follow-up Date: \_\_\_\_\_

(circle one)

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

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I give permission for the proper school authorities to obtain medication orders from the physician and to administer the medication as specified to the above named child.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTICE TO ALL PARENTS REGARDING  
CHANGES IN MEDICATION ADMINISTRATION AT SCHOOL  
Effective 8-15-2007

NO MEDICATION, INCLUDING OVER-THE-COUNTER MEDICATION, WILL BE GIVEN  
AT SCHOOL WITHOUT A DOCTOR'S ORDER!

STUDENT'S MAY NOT CARRY MEDICATION OR KEEP MEDICATION IN THEIR  
LOCKERS – IF THE STUDENT BRINGS MEDICATIONS TO SCHOOL THEY SHOULD  
TAKE THEM DIRECTLY TO THE SCHOOL OFFICE.

(See the School for appropriate forms if your child needs to carry an Inhaler or EpiPen)

WHEN SENDING MEDICATION, PLEASE FOLLOW THE RULES LISTED BELOW:

- ALL OVER THE COUNTER MEDICATION MUST BE IN THE ORIGINAL CONTAINER.
- ALL PRESCRIPTION MEDICATION MUST BE IN CONTAINERS LABELED BY THE PHARMACY.
- THE PARENT MUST INCLUDE A SIGNED AND DATED NOTE INDICATING THE TIME THE  
MEDICATION IS TO BE GIVEN.
  - IF NOT ALREADY ON FILE A DOCTOR'S ORDER MUST BE INCLUDED.
- SEND ONE MONTH OR ONE WEEK SUPPLY AT A TIME – MEDICATION WILL NOT BE SENT  
HOME AT THE END OF EACH DAY.

DOCTOR'S ORDERS FOR LONG TERM MEDICATION ARE VALID FOR ONE SCHOOL  
YEAR.

If your child has a chronic problem (ex. headaches, asthma, allergy symptoms, stomach pain etc.) which is relieved by taking over-the-counter and/or prescription medication on an as needed basis please contact the school to make arrangements to obtain an order from the child's physician. The medication can then be kept at school and administered as needed.

If your child is prescribed an antibiotic, cough medication, antihistamine or other short term medication that will need to be administered during the school day have the physician write an order for the school to dispense the prescribed medication at the time the child is examined. If an order is not brought to school or sent with the medication, you will need to come to school and administer the medication yourself.