Los exámenes físicos de 9 grado deben entregarse el 1 de Julio y deben tener fecha despues del 16/8/2023. ¿Preguntas? Por favor llame al (630) 795-8480.

State of Illinois

# Certificate of Child Health Examination

Los padres DEBEN completar esta sección y firmar.

| Student's Name | | | Birth Date (Mo/Day/Yr) | Sex | Race/Ethnicity | School/Grade Level/ID# |
|---|---|---|---|---|---|---|
| Last | First | Middle | | | | |
| Street Address | City | ZIP Code | Parent/Guardian | | | Telephone (home/work) |

**HISTORIAL DE SALUD: DEBE SER COMPLETADO Y FIRMADO POR EL PADRE/TUTOR Y VERIFICADO POR EL PROVEEDOR DE ATENCIÓN MÉDICA.**

| ALERGIAS (Alimentos, drogas, insectos, otro) | ☐ Sí ☐ No | Anote todas las alergias: | MEDICAMENTOS (Recetados o tomados con regularidad) | ☐ Sí ☐ No | Anote todos los medicamentos: |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| ¿Tiene diagnóstico de asthma? | ☐ Sí ☐ No | | ¿Tiene pérdida de funciones en uno de los órganos?(Ojos/Oídos/Riñones/Testículos) | ☐ Sí ☐ No | |
| ¿Despierta el niño tosiendo en la noche? | ☐ Sí ☐ No | | ¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué? | ☐ Sí ☐ No | |
| ¿Tiene defectos de nacimiento? | ☐ Sí ☐ No | | | | |
| ¿Tiene retrasos del desarrollo? | ☐ Sí ☐ No | | ¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué? | ☐ Sí ☐ No | |
| ¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro. Explique. | ☐ Sí ☐ No | | ¿Ha tenido heridas graves o enfermedades? | ☐ Sí ☐ No | |
| ¿Tiene diabetes? | ☐ Sí ☐ No | | ¿Prueba positiva de TB (Pasado o Presente)? | ☐ Sí* ☐ No | *Si contestó sí, refiera al departamento de salud local |
| ¿Tiene heridas en la cabeza/golpe/desmayo? | ☐ Sí ☐ No | | ¿Enfermedad de TB (Pasado o Presente)? | ☐ Sí* ☐ No | |
| ¿Tiene convulsiones? Cómo se manifiestan? | ☐ Sí ☐ No | | ¿Usa tabaco (tipo, frecuencia)? | ☐ Sí ☐ No | |
| ¿Tiene problemas cardiacos/Dificultad para respirar? | ☐ Sí ☐ No | | ¿Toma alcohol/drogas? | ☐ Sí ☐ No | |
| ¿Tiene soplo en el corazón/presión arterial alta? | ☐ Sí ☐ No | | ¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa? | ☐ Sí ☐ No | |
| ¿Tiene mareos o dolor de pecho al hacer ejercicios? | ☐ Sí ☐ No | | ☐ Dental ☐ Frenos ☐ Puente ☐ Placas ☐ Otro | | |
| ¿Problemas con los ojos/visión? ____ ☐ Lentes ☐ Lentes de Contacto Último examen ____ | | | **Información Adicional:** | | |
| ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee) ____ | | | La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación. | | |
| ¿Tiene problemas de los oídos/no oye bien? | ☐ Sí ☐ No | | | | |
| ¿Tiene problemas de los huesos/articulaciones/heridas/ escoliosis? | ☐ Sí ☐ No | | Firma del Padre/ Tutor: ____ | Fecha: ____ | |

**IMMUNIZATIONS: To be completed by health care provider. The mo/day/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.**

| REQUIRED Vaccine/Dose | DOSE 1 MO DA YR | DOSE 2 MO DA YR | DOSE 3 MO DA YR | DOSE 4 MO DA YR | DOSE 5 MO DA YR | DOSE 6 MO DA YR |
|---|---|---|---|---|---|---|
| DTP or DTaP | | | | | | |
| **Tdap; Td** or Pediatric **DT** (Check specific type) | ☐ Tdap ☐ Td ☐ DT | ☐ Tdap ☐ Td ☐ DT | ☐ Tdap ☐ Td ☐ DT | ☐ Tdap ☐ Td ☐ DT | ☐ Tdap ☐ Td ☐ DT | ☐ Tdap ☐ Td ☐ DT |
| **Polio** (Check specific type) | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV | ☐ IPV ☐ OPV |
| **Hib Haemophiles Influenza Type B** | | | | | | |
| **Pneumococcal Conjugate** | | | | | | |
| **Hepatitis B** | | | | | | |
| **MMR** Measles, Mumps, Rubella | | | | **Comments:** * indicates invalid dose | | |
| **Varicella** (Chickenpox) | | | | | | |
| **Meningococcal Conjugate** | | | | | | |
| **RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose** | | | | | | |
| **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 ____



Favor de mandar fisicos completos a Ruby Montano: rmontano@csd99.org o por fax: (630) 795-8399

| Student's Name<br>Last First Middle | Birth Date (Mo/Day/Yr) | Sex | School | Grade Level/ID# |
|---|---|---|---|---|
| | | | | |

**Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and *Maintained* by the School Authority.**

**ALTERNATIVE PROOF OF IMMUNITY**

**1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.**

*MEASLES (Rubeola) (MO/DA/YR) ______ **MUMPS (MO/DA/YR) ______ HEPATITIS B (MO/DA/YR) ______ VARICELLA (MO/DA/YR) ______

**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)** ☐ Measles* ☐ Mumps** ☐ Rubella ☐ 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.

Physician Statements of Immunity MUST be submitted to IDPH for review.

**Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature:** ______

**PHYSICAL EXAMINATION REQUIREMENTS** **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old ______ HEIGHT ______ WEIGHT ______ BMI ______ BMI PERCENTILE ______ B/P ______

**DIABETES SCREENING:** (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** ☐ Yes ☐ No And any two of the following: **Family History** ☐ Yes ☐ No

**Ethnic Minority** ☐ Yes ☐ No **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) ☐ Yes ☐ No **At Risk** ☐ Yes ☐ No

**LEAD RISK QUESTIONNAIRE:** Required for children aged 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.)

**Questionnaire Administered?** ☐ Yes ☐ No **Blood Test Indicated?** ☐ Yes ☐ No **Blood Test Date** ______ **Result** ______

**TB SKIN OR BLOOD TEST:** 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. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.

☐ No test needed ☐ Test performed **Skin Test:** Date Read ______ Result: ☐ Positive ☐ Negative mm ______

**Blood Test:** Date Reported ______ Result: ☐ Positive ☐ Negative Value ______

| LAB TESTS (Recommended) | Date | Results | SCREENINGS | Date | Results |
|---|---|---|---|---|---|
| Hemoglobin or Hematocrit | | | Developmental Screening | | ☐ Completed ☐ N/A |
| Urinalysis | | | Social and Emotional Screening | | ☐ Completed ☐ N/A |
| Sickle Cell (when indicated | | | Other: | | |

| SYSTEM REVIEW | Normal | Comments/Follow-up/Needs | | Normal | Comments/Follow-up/Needs |
|---|---|---|---|---|---|
| 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 | ☐ | ☐ Diagnosis of Asthma | Mental Health | ☐ | |
| Currently Prescribed Asthma Medication:<br>☐ Quick-relief medication (e.g., Short Acting Beta Agonist)<br>☐ Controller medication (e.g., inhaled corticosteroid) | | | Other | ☐ | |

**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** ☐ Yes ☐ No ☐ Modified

Print Name ______ ☐ MD ☐ DO ☐ APN ☐ PA Signature ______ Date ______

Address Phone