Welcome to D105 Preschool / Bienvenidos al Prescolar del D105

A physical exam and immunizations are required for your student's entry into Preschool. They must be completed within 30 days of beginning school and can be dated as early as one year before entry. Don't wait! You can start getting these done now. Turn them in to the nursing office or Preschool staff as soon as they are completed.

Current Physical Examination:

*Physical must have documentation of all up-to-date immunizations. Parents, make sure to fill out the Health History section on the top of the back page.

*BMI (body mass index), Blood Pressure, Diabetes Screening, and Lead Risk Questionnaire sections must be completed by the doctor's office. (Check these before you leave the medical office.)

Estimados Padres,
Para entrar al prescolar, se requiere un examen físico junto con las vacunas actualizadas. Este tiene que estar completo en los primeros 30 días del primer día de entrada a clases, puede tener fecha de un par de meses. A si es que no espere! Usted puede completar este requisito ahora y entregarlo a la oficina prescolar o a la enfermería de la escuela tan pronto lo tenga completo.

Examen Físico Actualizado:

*Padres, el examen físico tiene que estar documentado al día con las vacunas actuales. Asegúrese, de contestar las pregustas de la sección marcada HISTORIA de SALUD en la forma del físico que se encuentra arriba, firma y fecha.

*Esta sección de preguntas tiene que ser completadas por el medico (Por Favor asegúrese, que esta parte en la forma físico sea completa antes de salir del consultorio médico.)

BMI (Índice de masa corporal), Alta Presión, Prueba de Diabetes, y el cuestionario de Riesgo de Plomo.

State of Illinois
Certificate of Child Health Examination

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	Race/Ethnicity	School /Grade Level/ID#

Address (Street, City, Zip Code) | Parent/Guardian | Telephone # Home | Work

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.

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 Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Comments:

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**

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.

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

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

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

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**
HEAD CIRCUMFERENCE if <2-3 years old HEIGHT WEIGHT BMI 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 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.)
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
Hemoglobin or Hematocrit		
Urinalysis		

			Sickle Cell (when indicated)		
			Developmental Screening Tool		

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: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ 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**

Nombre del Estudiante			Fecha de Nacimiento	Sexo	Escuela	Grado / Núm. De Ident.
Apellido	Nombre	Inicial	Mes / Día / Año			

HISTORIAL DE SALUD **PARA SER COMPLETADO Y FIRMADO POR EL PADRE / TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD**

ALERGIAS (Alimentos, drogas, insectos, otro)				**MEDICINAS** (Anote todas las recetadas o tomadas con regularidad.)			
¿Diagnosis de Asma? ¿Niño(a) despierta tosiendo en la noche?	Sí Sí	No No	Indique Severidad	¿Pérdida de las Funciones de uno de los pares de Órganos? (Ojos /Oídos / Riñones / Testículos)	Sí	No	
¿Defectos de Nacimiento?	Sí	No		¿Hospitalizaciones? ¿Cuándo? ¿Para Qué?	Sí	No	
¿Retrasos del Desarrollo?	Sí	No					
¿Problemas De La Sangre? Hemofilia, Glóbulos Falciformes, Otro Explique	Sí	No		¿Cirugía? (Anótelas Todas) ¿Cuándo? ¿Para Qué?	Sí	No	
¿Diabetes?	Sí	No		¿Heridas Graves o Enfermedad?	Sí	No	
¿Herida de la Cabeza / golpe / desmayo?	Sí	No		¿Prueba positiva de la piel para el TB (Pasado o Presente)?	Sí *	No	*Si contestó sí, referencia al departamento de salud local
¿Convulsiones? ¿Cómo Se Manifiestan?	Sí	No		¿Enfermedad de TB (Pasado o Presente)?	Sí *	No	
¿Problemas Cardiacos / Falta de Respiración?	Sí	No		¿Uso de Tabaco (Tipo, Frecuencia)?	Sí	No	
¿Soplo Cardiaco / Presión Arterial Alta?	Sí	No		¿Uso de Alcohol / Drogas?	Sí	No	
¿Mareos O Dolor De Pecho Al Hacer Ejercicio?	Sí	No		¿Historial Familiar de Muerte Repentina antes de los 50 años? (¿Causa?)	Sí	No	
¿Problemas con los Ojos / Visión? Lentes • Lentes de Contacto • Último Examen _____ ¿Otras Preocupaciones? (bizco, párpados caídos, entrecerrar los ojos, dificultad cuando lee)				Dental • • Ganchos • • Puente • • Placas Otro ¿Otras Preocupaciones?			
¿Problemas de Audición?	Sí	No		La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.			
¿Problemas de los huesos / Articulaciones / Heridas / Escoliosis?				**Firma del Padre / Tutor**			Fecha