ACADEMICS FAITH

FINE ARTS COMMUNITY

ST. NICHOLAS OF TOLENTINE

"A Place Where Students Flourish and Talents Flow "

Dear Parent,

Attached is the Medical Form for your child. Please make sure the form is completely filled out before returning it to school.

PARENT: Fill out the top of the first page and also the medical history part on the second page, you also need to fill out the top of the second page. After you fill out the medical history please sign in the appropriate box.

PHYSICIAN: The physician/health care provider must sign in two places, - under the immunization record on the first page, and at the bottom of the second page under the physical exam.

IMMUNIZATION DATES MUST INCLUDE MONTH, DAY AND YEAR, MUST BE COMPLETE AND UP TO DATE.

THIS FORM MUST BE RETURNED TO SCHOOL BY AUGUST 15TH.

Queridos Padres de Familia:

Adjunto encontrara la forma medica para su hijo. Por favor asegurese de llenarla completamente antes que su hijo(a) regrese a la escuela.

PADRES: Llenar la parte de arriba de la primera hoja, tambien la historia clinica que se encuentra en la segunda hoja en la parte de arriba. Despues de llenarlo, favor de firmar en el lugar correcto.

DOCTOR: El doctor o su proveedor de salud debera firmar en dos lugares, uno es abajo de el record de vacunacion que se encuentra en la primera hoja, y en la parte de abajo de la segunda hoja donde se encuentra los resultados del examen fisico.

LAS VACUNAS DEBERAN MOSTRAR LA FECHA EN QUE SE APLICARON (mes, dia y ano), TODO ESTO DEBERA ESTAR ACTUALIZADO.

ESTA FORMA DEBERA SER REGRESADA LA ESCUELA PARA EL DIA DE 15TH DE AGOSTO.

3741 W. 62nd Street Chicago IL 60629 Telephone (773) 735-0772 Fax (773) 735-5414
www.stnicksschool.com

STATE OF ILLINOIS
DEPARTMENT OF HUMAN SERVICES
CERTIFICATE OF CHILD HEALTH EXAMINATION

Please Print

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

Address (Street, City, ZIP code) | Parent/Guardian | Telephone # Home / Work

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 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 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)	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐PPV23	☐PCV7 ☐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

																							Code:
Date																							P = Pass
Age/Grade																							F = Fail
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	U = Unable to test
Vision																							R = Referred
Hearing																							G/C = Glasses/ Contacts

Printed by Authority of the State of Illinois

(Complete Both Sides)

IL444-4737 (R-01-05)

Student's Name (Last / First / Middle)	Birth Date (Month/Day/Year)	Sex	School	Grade Level/ EC

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					
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	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			
				Other concerns?			
Ear/Hearing problems?	Yes	No		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 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 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☐ No☐ Objective screening Yes☐ No☐ Result_____ Amblyopia Yes☐ No☐ Referred to Opthalmologist/Optometrist Yes☐ No☐			Genito-Urinary		LMP
			Neurological		
Nose			Musculoskeletal		
Throat			Spinal examination		
Mouth/Dental			Nutritional status		
Cardiovascular/HTN			Mental Health		
Respiratory					

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)