



**State of Illinois**  
**Certificate of Child Health Examination**

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES  
CFS 800  
Rev 12/2011



<b>Student's Name</b>			<b>Birth Date</b>	<b>Sex</b>	<b>Race/Ethnicity</b>	<b>School /Grade Level/ID#</b>
Last	First	Middle	Month/Day/Year			
<b>Address</b>			<b>Parent/Guardian</b>	<b>Telephone # Home</b>	<b>Work</b>	
Street			City	Zip Code		

**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		2		3		4		5		6	
	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
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												
Hepatitis B (HB)												
Varicella (Chickenpox)												
MMR Combined Measles Mumps Rubella												
Single Antigen Vaccines	Measles		Rubella		Mumps							
Pneumococcal Conjugate												
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza												

**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.)

<b>Signature</b>	<b>Title</b>	<b>Date</b>
<b>Signature</b>	<b>Title</b>	<b>Date</b>

**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
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3. Laboratory confirmation (check one) Measles Mumps Rubella Hepatitis B Varicella  
Lab Results Date MO DA YR (Attach copy of lab result)

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN													
Date													Code: P = Pass F = Fail U = Unable to test R = Referred G/C = Glasses/Contacts
Age/Grade	R	L	R	L	R	L	R	L	R	L	R	L	
Vision													
Hearing													

