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				**Comments:**		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
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**

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 No Yes 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						
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			
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						

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		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			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**

Illinois Department of Public Health

Childhood Lead Risk Assessment Questionnaire

ALL CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE MUST BE ASSESSED FOR LEAD POISONING (410 ILCS 45/6.2)

Name _____ Today's Date_____

Age _____ Birthdate _____ ZIP Code _____

Respond to the following questions by circling the appropriate answer.	**R E S P O N S E**

1. Is this child eligible for or enrolled in Medicaid, Head Start, All Kids or WIC? Yes No Don't Know
2. Does this child have a sibling with a blood lead level of10 mcg/dL or higher? Yes No Don't Know
3. Does this child live in or regularly visit a home built before 1978? Yes No Don't Know
4. In the past year, has this child been exposed to repairs, repainting or renovation of a home built before 1978? Yes No Don't Know
5. Is this child a refugee or an adoptee from any foreign country? Yes No Don't Know
6. Has this child ever been to Mexico, Central or South America, Asian countries (i.e., China or India), or any country where exposure to lead from certain items could have occurred (for example, cosmetics, home remedies, folk medicines or glazed pottery)? Yes No Don't Know
7. Does this child live with someone who has a job or a hobby that may involve lead (for example, jewelry making, building renovation or repair, bridge construction, plumbing, furniture refinishing, or work with automobile batteries or radiators, lead solder, leaded glass, lead shots, bullets or lead fishing sinkers)? Yes No Don't Know
8. At any time, has this child lived near a factory where lead is used (for example, a lead smelter or a paint factory)? Yes No Don't Know
9. Does this child reside in a high-risk ZIP code area? Yes No Don't Know

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A blood lead test should be performed on children:

- with any "Yes" or "Don't Know" response
- living in a high-risk ZIP code area

All Medicaid-eligible children should have a blood lead test at 12 months of age and at 24 months of age. If a Medicaid-eligible child between 36 months and 72 months of age has not been previously tested, a blood lead test should be performed.

If there is any "Yes" or "Don't Know" response; **and**

- there has been no change in the child's living conditions; **and**
- the child has proof of two consecutive blood lead test results (documented below) that are each less than 10 mcg/dL (with one test at age 2 or older), a blood lead test is not needed at this time.

Test 1: Blood Lead Result_____mcg/dL Date _____ Test 2: Blood Lead Result_____mcg/dL Date _____

If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.

_____ _____

Signature of Doctor/Nurse Date

Illinois Lead Program
866-909-3572 or 217-782-3517
TTY (hearing impaired use only) 800-547-0466

Illinois Department of Public Health
Guidelines for Blood Lead Screening and Lead Risk Assessment

- **Blood lead screening** is defined as obtaining a blood lead test. **Lead risk assessment** is defined as evaluation of potential for exposures to lead based on questionnaire responses.

- **It is always appropriate to obtain a diagnostic blood lead test when a child is symptomatic or potential exposure to lead has been identified, regardless of child's age.**

- Illinois has defined ZIP code areas at high risk and low risk for lead exposure based on housing age and poverty rates. Review the list of ZIP codes and determine status of ZIP codes in your area.

- In Illinois, all children from **low-income families** (i.e., Medicaid-eligible children) should receive a blood lead test at ages 12 and 24 months, even if they live in a low-risk ZIP code area. If the child is 3 through 6 years old and has not been tested, a blood lead test is required.

Childhood Lead Risk Assessment Questionnaire

- Complete the Childhood Lead Risk Assessment Questionnaire during a health care visit at ages 12 and 24 months.
    - If responses to all the questions are "NO," re-evaluate at every well child visit or more often if deemed necessary.
    - If any response is "YES" or "DON'T KNOW," obtain a blood lead test
- Consider evaluating children before 12 months of age, depending on the area.
- If the child is age 3-6 years ***and***
    1) there is any "YES" or "DON"T KNOW" ***and***
    2) has had two successive blood lead test results that were each less than < 10 mcg/dL with one of these tests at age 2 years or older ***and***
    3) risks of exposure to lead have not changed, **further blood lead tests are not necessary.**
- If the child is 1) 3-6 years, ***and*** 2) all answers to the Childhood Lead Risk Assessment Questionnaire are "NO," ***and*** 3) risks of exposure to lead have not changed, a blood lead test is not necessary.
- If the child is 3-6 years of age and risks of exposures to lead have increased, obtain a blood lead test.
- Continue to use the Childhood Lead Risk Assessment Questionnaire through age 6.

For children living in Chicago:

- A blood lead test for children age 3 and younger should be obtained at 6, 12, 18, 24 and 36 months **OR** at 9, 15, 24 and 36 months.
- Children 4 through 6 years of age with prior blood lead levels <10 mcg/dL should have an annual risk assessment. A blood lead test should be performed if risk increases or if the child exhibits persistent oral behaviors.

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High-Risk ZIP Codes for Pediatric Blood Lead Poisoning

Adams	62567	**Effingham**	62367	**Knox**	62526	61466	62976	60942
62301	62570	None	62373	61401	62537	61476	62992	60960
62320	**Clark**	**Fayette**	62379	61410	62551	61486	**Putnam**	60963
62324	62420	62458	62380	61414	**Macoupin**	**Monroe**	61336	61810
62339	62442	62880	**Hardin**	61436	62009	None	61340	61831
62346	62474	62885	62919	61439	62033	**Montgomery**	61363	61832
62348	62477	**Ford**	62982	61458	62069	62015	**Randolph**	61833
62349	62478	60919	**Henderson**	61467	62085	62019	62217	61844
62365	**Clay**	60933	61418	61474	62088	62032	62242	61848
Alexander	62824	60936	61425	61485	62093	62049	62272	61857
62914	62879	60946	61454	61489	62626	62051	**Richland**	61865
62988	**Clinton**	60952	61460	61572	62630	62056	62419	61870
Bond	62219	60957	61469	**Lake**	62640	62075	62425	61876
62273	**Coles**	60959	61471	60040	62649	62077	**Rock Island**	61883
Boone	61931	60962	61480	**LaSalle**	62672	62089	61201	**Wabash**
61038	61938	61773	**Henry**	60470	62674	62091	61236	62410
Brown	61943	**Franklin**	61234	60518	62685	62094	61239	62852
62353	62469	62812	61235	60531	62686	62538	61259	62863
62375	**Cook**	62819	61238	61301	62690	**Morgan**	61265	**Warren**
62378	All Chicago	62822	61274	61316	**Madison**	62601	61279	61412
Bureau	ZIP Codes	62825	61413	61321	62002	62628	**St. Clair**	61417
61312	60043	62874	61419	61325	62048	62631	62201	61423
61314	60104	62884	61434	61332	62058	62692	62203	61435
61315	60153	62891	61443	61334	62060	62695	62204	61447
61322	60201	62896	61468	61342	62084	**Moultrie**	62205	61453
61323	60202	62983	61490	61348	62090	61937	62220	61462
61328	60301	62999	**Iroquois**	61354	62095	**Ogle**	62289	61473
61329	60302	**Fulton**	60911	61358	**Marion**	61007	**Saline**	61478
61330	60304	61415	60912	61364	None	61030	62930	**Washington**
61337	60305	61427	60924	61370	**Marshall**	61047	62946	62214
61338	60402	61431	60926	61372	61369	61049	**Sangamon**	62803
61344	60406	61432	60930	**Lawrence**	61377	61054	62625	**Wayne**
61345	60456	61441	60931	62439	61424	61064	62689	62446
61346	60501	61477	60938	62460	61537	61091	62703	62823
61349	60513	61482	60945	62466	61541	**Peoria**	**Schuyler**	62843
61359	60534	61484	60951	**Lee**	**Mason**	61451	61452	62886
61361	60546	61501	60953	60553	62617	61529	62319	**White**
61362	60804	61519	60955	61006	62633	61539	62344	62820
61368	**Crawford**	61520	60966	61031	62644	61552	62624	62821
61374	62433	61524	60967	61042	62655	61602	62639	62835
61376	62449	61531	60968	61310	62664	61603	**Scott**	62844
61379	62451	61542	60973	61318	62682	61604	62621	62887
Calhoun	**Cumberland**	61543	**Jackson**	61324	**Massac**	61605	62663	**Whiteside**
62006	62428	61544	62927	61331	62953	61606	62694	61037
62013	**DeWitt**	61563	62940	61353	**McDonough**	**Perry**	**Shelby**	61243
62036	61727	**Gallatin**	62950	61378	61411	62832	62438	61251
62070	61735	62934	**Jasper**	**Livingston**	61416	62997	62534	61261
Carroll	61749	**Greene**	62432	60420	61420	**Piatt**	62553	61270
61014	61750	62016	62434	60460	61422	61813	**Stark**	61277
61051	61777	62027	62459	60920	61438	61830	61421	61283
61053	61778	62044	62475	60921	61440	61839	61426	**Will**
61074	61882	62050	62480	60929	61470	61855	61449	60432
61078	**DeKalb**	62054	**Jefferson**	60934	61475	61929	61479	60433
Cass	60111	62078	62883	61311	62374	61936	61483	60436
62611	60129	62081	**Jersey**	61313	**McHenry**	**Pike**	61491	**Williamson**
62618	60146	62082	62030	61333	60034	62312	**Stephenson**	62921
62627	60550	62092	62063	61740	**McLean**	62314	61018	62948
62691	**Douglas**	**Grundy**	**Jo Daviess**	61741	61701	62323	61032	62949
Champaign	61930	60437	61028	61743	61720	62340	61039	62951
61815	61941	60474	61075	61769	61722	62343	61044	**Winnebago**
61816	61942	**Hamilton**	61085	61775	61724	62345	61050	61077
61845	**DuPage**	62817	61087	**Logan**	61728	62352	61060	61101
61849	60519	62828	**Johnson**	62512	61730	62355	61062	61102
61851	**Edgar**	62829	62908	62518	61731	62356	61067	61103
61852	61917	62859	62923	62519	61737	62357	61089	61104
61862	61924	**Hancock**	**Kane**	62548	61770	62361	**Tazewell**	**Woodford**
61872	61932	61450	60120	62543	**Menard**	62362	61564	61516
Christian	61933	62311	60505	62635	62642	62363	61721	61545
62083	61940	62313	**Kankakee**	62643	62673	62366	61734	61570
62510	61944	62316	60901	62666	62688	62370	**Union**	61760
62517	61949	62318	60910	62671	**Mercer**	**Pope**	62905	61771
62540	**Edwards**	62321	60917	**Macon**	61231	None	62906	
62546	62476	62330	60954	62514	61260	**Pulaski**	62920	
62555	62806	62334	60969	62521	61263	62956	62926	
62556	62815	62336	**Kendall**	62522	61276	62963	**Vermilion**	
62557	62818	62354	None	62523	61465	62964	60932	

State of Illinois
Certificate of Child Health Examination

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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				**Comments:**		
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Signature **Title** **Date**

Signature **Title** **Date**

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

HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)	Sí No	Anótelas todas:		MEDICINAS (Anote todas las recetadas o tomadas con regularidad)	Sí No		
¿Tiene diagnóstico de asthma? ¿Despierta el niño tosiendo en la noche?	Sí No			¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí No		
¿Tiene defectos de nacimiento?	Sí No			¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	Sí No		
¿Tiene retrasos del desarrollo?	Sí No						
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí No			¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	Sí No		
¿Tiene diabetes?	Sí No			¿Ha tenido heridas graves o enfermedades?	Sí No		
¿Tiene heridas en la cabeza/golpe/desmayo?	Sí No			¿Prueba positiva de TB (Pasado o Presente)?	Sí No	*Si contestó sí, refiera al departamento de salud local	
¿Tiene convulsiones? Cómo se manifiestan?	Sí No			¿Enfermedad de TB (Pasado o Presente)?	Sí No		
¿Tiene problemas cardiacos/No respira bien?	Sí No			¿Usa tabaco (tipo, frecuencia)?	Sí No		
¿Tiene soplo en el corazón/presión arterial alta?	Sí No			¿Toma alcohol/drogas?	Sí No		
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí No			¿Historial de familiares 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, parpadear, dificultad cuando lee)				Dental ☐ Ganchos ☐ Puente ☐ Placas Otro			
¿Tiene problemas de los oídos/no oye bien?	Sí No			La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.			
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	Sí No			**Firma del Padre/Tutor**		**Fecha**	

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		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			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**

Departamento de Salud Pública de Illinois
Cuestionario de Asesoramiento Infantil de Riesgo por el Plomo

Todos los Niños (as) de 6 meses a 6 años deben ser sometidos a un asesoramiento por Envenenamiento de Plomo.

(410 ILCS 45/6.2)

Nombre del Niño (a) _____ Fecha de hoy_____

Edad del Niño (a) _____ Fecha de Nacimiento _____ Código Postal del Niño (a) _____

Conteste las siguientes preguntas circulando la respuesta adecuada. **Respuesta**

1. ¿Es éste niño elegible para o inscrito en Medicaid, Head Start, All Kids o WIC? Sí No No Sé
2. ¿Tiene éste niño un hermano (a) que tenga algún nivel de plomo en la sangre de 10 mcg/dL o más alto? Sí No No Sé
3. ¿Vive o visita regularmente éste niño (a) alguna casa construida antes de 1978? Sí No No Sé
4. ¿Desde el año pasado, ha sido expuesto éste niño (a) a reparaciones, pintura, o remodelaciones de la casa construida antes de 1978? Sí No No Sé
5. ¿Es éste niño (a) exilado o un niño (a) adoptado de algún país extranjero? Sí No No Sé
6. ¿Estuvo alguna vez este niño en los países de México, América Central o del Sur, Asia (China o India), o cualquier país donde pudo haber estado expuesto a objetos que contienen plomo (por ejemplo, cosméticos, remedios caseros, medicinas tradicionales o cerámica vidriada) Sí No No Sé
7. ¿Vive éste niño con alguna persona que tenga un trabajo o un pasa tiempo “hobby” que incluya plomo (por ejemplo, personas que hacen joyas, renovación o construcción de edificios, construcción de puentes plomería, recabados de muebles, o un trabajo con baterías o radiadores de automóviles, soldadoras de plomo, vidrio de plomo, proyectiles o balas de plomo, o plomadas para pesca)? Sí No No Sé
8. ¿En algún momento, vivió éste niño cerca de una fábrica donde plomo es usado (por ejemplo, una fábrica metalúrgica o fábrica de pintura)? Sí No No Sé
9. ¿Vive éste niño (a) en un código postal de alto riesgo? Sí No No Sé

Un examen de sangre debe ser tomado con niños que:

- respondieron alguna de las preguntas con "Sí" o "No sé"
- viven en un codigo postal de alto riesgo

Todos los niños elegibles para Medicaid deben tomar un examen de sangre a los 12 meses de edad y a 24 meses de edad. Si un nino(a) elegible para Medicaid entre 36 Meses y 72 Meses de edad no a sido examinado previamente, un examen de sangre debe ser tomado.

Si alguna contestación fue "Sí" o "No Sé" y

- no ha ocurrido ningún cambio en sus condiciones de vivienda
- si el niño (a) puede comprovar dos (2) resultados de exámenes de sangre consecutivos siendo cada uno menos de 10 mcg/dL (con un examen a la edad de 2 años o mayor), un examen de sangre no es necesitado ahora.

Examen 1: Resultado del examen de sangre _____mcg/dL Fecha _____
Examen 2: Resultado del examen de sangre _____mcg/dL Fecha _____

Si las respuestas para todas las preguntas fueron "No" revalue en cada visita médica o como sea necesario.

_____ _____

(Signature) Firma del Doctor o Enfermera (Date) Fecha

Programa de Plomo de Illinois
866-909-3572 o 217-782-3517
TTY (Para personaas con problemas auditivos) 800-547-0466
Imprimido por Autoridad del Estado de Illinois
P.O. # 538380 2M 9/07

Códigos Postales de alto riesgo de Envenenamiento de Plomo Infantil en la Sangre

Adams
62301
62320
62324
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62346
62348
62349
62365
Alexander
62914
62988
Bond
62273
Boone
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Brown
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Franklin
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Cook
All Chicago
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