ILLINOIS DEPARTMENT OF PUBLIC HEALTH
CERTIFICATE OF INFANT AND TODDLER HEALTH EXAMINATION

(Information on this form may be shared with appropriate personnel for health and educational purposes.)

PLEASE PRINT

CHILD'S NAME (Last) (First) (Middle)	BIRTHDATE MO DA YR	SEX	EARLY INTERVENTION PROGRAM	SOCIAL SECURITY #
ADDRESS (Street) (City) (ZIP code)	PARENT/GUARDIAN TELEPHONE # (Home) (Work)			PREFERRED LANGUAGE IN HOME
PARENT OR GUARDIAN	ADDRESS			

HEALTH HISTORY
To be completed by parent or guardian

BIRTH WEIGHT	(Circle yes or no)	Comments
Birth Complication	Yes No	
Premature	Yes No	
Birth Defects	Yes No	
Abnormal Newborn Blood Test	Yes No	
TB/TB Contact	Yes No	
Serious Illness/Injury	Yes No	
Hospitalization	Yes No	
Hearing/Ear Problem	Yes No	
Vision/Eye Problem	Yes No	
Speech/Feeding Problem	Yes No	

Allergies (list) _____

Medications (list) _____

IMMUNIZATIONS
Please provide the month, day and year for every dose administered. The day and month is required if you cannot determine if the vaccine was given prior to the minimum interval or age.

DOSE	1 MO	1 DA	1 YR	2 MO	2 DA	2 YR	3 MO	3 DA	3 YR	4 MO	4 DA	4 YR
Diphtheria, Pertussis & Tetanus (DTP/DTaP)												
Diphtheria and Tetanus (DT) or (Td)												
Polio (TOPV or IPV)												
Haemophilus influenza type b (Hib)												
Comb. Measles/Mumps/Rubella (MMR)												
Measles (Rubeolla)												
Rubella (3 day or German Measles)												
Mumps												
Hepatitis B												
Other (e.g., Varicella												

FAMILY HISTORY

Identify any parents/siblings with disability or chronic illness:

Identify any parents/siblings with developmental delay or school problems:

Parent's or Guardian's Signature: Date

TO BE COMPLETED BY PHYSICIAN

HEAD CIRCUMFERENCE | LENGTH/HEIGHT | WEIGHT

(STRONGLY RECOMMENDED)	Date	Results
Hemoglobin* or Hematocrit*		
Urinalysis		
Sickle Cell* (as needed)		
Lead Questionnaire and/or Blood Test*		

Developmental Screening Tests		
DDSTII		
PDQ		
Other (identity)		

*Mandated for state licensed child care facilities or approved schools and programs

PHYSICAL EXAMINATION REQUIREMENTS

	(Normal)	Comments/Follow-up
General Appearance		
Skin		
Ears		
Eyes		
Nose		
Throat		
Mouth/Dental		
Cardiovascular		
Respiratory		

	(Normal)	Comments/Follow-up
Gastrointestinal		
Genito-Urinary		
Neurological		
Musculoskeletal		
Nutritional Status		
Other		

Summary of child's health

Comments/Recommendations

Refer for specialized medical diagnostic evaluation YES ☐ NO ☐

Needs modification/restriction of Early Intervention Program YES ☐ NO ☐

Specify:

VISION AND HEARING SCREENING DATA

Eyes straight	YES	NO
Corneal light reflexes symmetrical	YES	NO
Red reflex present bilaterally	YES	NO
Follows face, light, small toy	YES	NO
OTHER TEST (identify)		

Startles with loud noise	YES	NO
Turns to soft sound	YES	NO
Follows whispered direction	YES	NO
OTHER TEST (identify)		

PHYSICIAN'S NAME (print)	PHYSICIAN'S SIGNATURE
ADDRESS	PHONE DATE

IL 482-0933

MEDICAL FORM REQUIREMENTS
New three and four/five-year olds only

IF YOUR CHILD WAS ENROLLED AS A 3-YEAR OLD IN OUR PRESCHOOL, YOU DO NOT NEED A NEW MEDICAL FORM

- All required shots must be done **no earlier than six months prior** to the start of preschool (April).
- TB shots must state the **results** on the medical form.
- Although the State recommends all children receive TB and Lead Screenings, you and your physician may choose not to administer these tests.
- **If you and your physician choose to waive the TB and/or Lead tests, this form MUST be signed by both you and your physician and must be attached to your medical form.**

MEDICAL TESTS WAIVER FORM

TB TEST

My physician and I have chosen not to administer the TB test for the Downers Grove Park District Preschool program for my child _____.
(child's name)

_____ _____
Parent Signature Physicians Signature

_____
Date

LEAD SCREENING

My physician and I have chosen not to administer the Lead Screening for the Downers Grove Park District Preschool program for my child _____
(child's name)

_____ _____
Parent Signature Physicians Signature

_____
Date