

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		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.														
BIRTH WEIGHT (Circle yes or no) Comments		DOSE			1			2			3			4		
		MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR			
Birth Complication	Yes No	Diphtheria, Pertussis & Tetanus (DTP/DTaP)														
Premature	Yes No	Diphtheria and Tetanus (DT) or (Td)														
Birth Defects	Yes No	Polio (TOPV or IPV)														
Abnormal Newborn Blood Test	Yes No	Haemophilus influenzae type b (Hib)														
TB/TB Contact	Yes No	Comb. Measles/Mumps/Rubella (MMR)														
Serious Illness/Injury	Yes No	Measles (Rubella)														
Hospitalization	Yes No	Rubella (3 day or German Measles)														
Hearing/Ear Problem	Yes No	Mumps														
Vision/Eye Problem	Yes No	Hepatitis B														
Speech/Feeding Problem	Yes No	Other (e.g., Varicella)														
Allergies (list)																
Medications (list)																

**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	Developmental Screening Tests		
Hemoglobin* or Hematocrit*			DDSTII		
Urinalysis			PDQ		
Sickle Cell* (as needed)			Other (identify)		
Lead Questionnaire and/or Blood Test*			*Mandated for state licensed child care facilities or approved schools and programs.		

**PHYSICAL EXAMINATION REQUIREMENTS**

	(Normal)	Comments/Follow-up		(Normal)	Comments/Follow-up
General Appearance			Gastrointestinal		
Skin			Genito-Urinary		
Ears			Neurological		
Eyes			Musculoskeletal		
Nose			Nutritional Status		
Throat			Other		
Mouth/Dental			Summary of child's health		
Cardiovascular					
Respiratory					

**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	Startles with loud noise	YES	NO
Corneal light reflexes symmetrical	YES	NO	Turns to soft sound	YES	NO
Red reflex present bilaterally	YES	NO	Follows whispered direction	YES	NO
Follows face, light, small toy	YES	NO			
OTHER TEST (identify)			OTHER TEST (identify)		

PHYSICIAN'S NAME (print) \_\_\_\_\_ PHYSICIAN'S SIGNATURE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_ DATE \_\_\_\_\_

PHYSICIAN'S SUMMARY OF HEALTH PROBLEMS, CONDITIONS OR DEVELOPMENTAL DISCREPANCIES THAT MAY AFFECT THE CHILD'S EDUCATIONAL OR ACTIVITIES PROGRAM

---

---

---

---

---

---

---

CHECK BOX IF PHYSICIAN'S DETERMINATION IS THAT A TB TEST IS **NOT** NECESSARY FOR THIS CHILD

NEED FOR ENVIRONMENTAL ADJUSTMENT OR ACTIVITIES TO BE LIMITED

---

---

---

---

---

---

---

PARTICIPATION IN GROSS MOTOR ACTIVITIES IS APPROVED WITH THE FOLLOWING TYPES OF ACTIVITY TO BE EXCLUDED (IF ANY)

---

---

---

---

---

---

---

TO BE COMPLETED BY PARENT/GUARDIAN OR CHILD CARE FACILITY:

NAME OF FACILITY OR LICENSEE \_\_\_\_\_

ADDRESS \_\_\_\_\_

\_\_\_\_\_