

CHILD PICKUP

(Use additional sheet of paper if more than 3 people are authorized to pick up child)

I/we authorize _____
Name Address Phone
and/or _____
Name Address Phone
and/or _____
Name Address Phone

to pick up my/our child when I am/we are unavailable.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

TRIPS, EXCURSIONS, AND PUBLIC PARK FACILITIES

I/we authorize _____ to take my/our child on walking trips, special excursions, and to nearby public park facilities. I/we also authorize the child to ride as a passenger in the vehicle owned or leased by the above-named person(s). I/we understand all such trips are under the supervision of the above-named person(s) and that health and safety precautions are taken in compliance with DCFS standards for licensure.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

SWIMMING

I/we consent to my/our child using the swimming pool of _____
Name of Provider

at _____
Address

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

State of Illinois
Department of Children and Family Services

CONSENTS TO DAY CARE PROVIDERS

NAME OF CHILD _____

THESE CONSENTS ARE FOR NON-DCFS WARDS ONLY AND MAY ONLY BE USED FOR DAY CARE SERVICES.

Parent(s) or legal guardian placing the child may sign any or all of the following consents:

EMERGENCY MEDICAL CARE

This authorizes _____
to secure EMERGENCY medical care for my/our child when I/we cannot be immediately reached at the time of emergency. I/we will
be responsible for the emergency medical charges upon receipt of the statement. _____
is the preferred doctor/clinic/hospital.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

ADMINISTER PRESCRIPTION MEDICINE

I/we authorize _____ to administer prescribed medicine to my/our child as
specified in the prescription's directions for administration.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

ADMINISTER OVER-THE-COUNTER MEDICINE
(Administer only in accord with the appropriate standards for licensure)

I/we authorize _____ to administer over-the-counter medicine to my/our
child as specified in written instructions.

Date _____

Signature of parent/guardian

Relationship to child

Date _____

Signature of parent/guardian

Relationship to child

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

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	Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No
Child wakes during the night	Yes	No	Hospitalizations? When? What for?	Yes	No
Birth defects?	Yes	No	Surgery? (List all.) When? What for?	Yes	No
Developmental delay?	Yes	No	Serious injury or illness?	Yes	No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	TB skin test positive (past/present)?	Yes*	No
Diabetes?	Yes	No	TB disease (past or present)?	Yes*	No
Head injury/Concussion/Passed out?	Yes	No	Tobacco use (type, frequency)?	Yes	No
Seizures? What are they like?	Yes	No	Alcohol/Drug use?	Yes	No
Heart problem/Shortness of breath?	Yes	No	Family history of sudden death before age 50? (Cause?)	Yes	No
Heart murmur/High blood pressure?	Yes	No	Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other		
Dizziness or chest pain with exercise?	Yes	No	Information may be shared with appropriate personnel for health and educational purposes.		
Eye/Vision problems? ☐ Glasses ☐ Contacts ☐ Last exam by eye doctor					
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)					
Ear/Hearing problems?	Yes	No	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	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. Questionnaire Administered? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date _____ (Blood test required if resides in Chicago.)				
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. 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			Gastrointestinal	
Eyes		Amblyopia Yes ☐ No ☐	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 Antagonist) ☐ 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

On the basis of the examination on this day, I approve this child's participation in

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. _____ (If No or Modified, please attach explanation.)

PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ INTERSCHOLASTIC SPORTS (for one year) Yes ☐ No ☐ Limited ☐

Print Name	(MD, DO, APN, PA)	Signature	Date
Address	Phone		

(Complete both sides)



State of Illinois
Certificate of Child Health Examination

FOR USE IN DCFS LICENSED
CHILD CARE FACILITIES
CFS 600
Rev 11/2013

Illinois Department of
DCFS
Children & Family Services

Student's Name				Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#	
Last		First		Middle		Month/Day/Year		
Address				Parent/Guardian		Telephone # Home		
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 MO DA YR		2 MO DA YR		3 MO DA YR		4 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	
Polio (Check specific type)	☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV		☐ IPV ☐ OPV	
Hib Haemophilus influenza type b								
Hepatitis B (HB)								
Varicella (Chickenpox)							COMMENTS:	
MMR Combined Measles Mumps Rubella								
Single Antigen Vaccines	Measles		Rubella		Mumps			
Pneumococcal Conjugate								
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza								
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 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 result)				

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