



## **IDPH School Health Program & Child Health Exam Update**

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# IDPH Vision & Mission

**Vision:** Communities of Illinois will achieve and maintain optimal health and safety

**Mission:** Protect the health and wellness of the people in Illinois through the prevention, health promotion, regulation, and the control of disease and injury



# Office of Women's Health and Family Health Services & School Health Program

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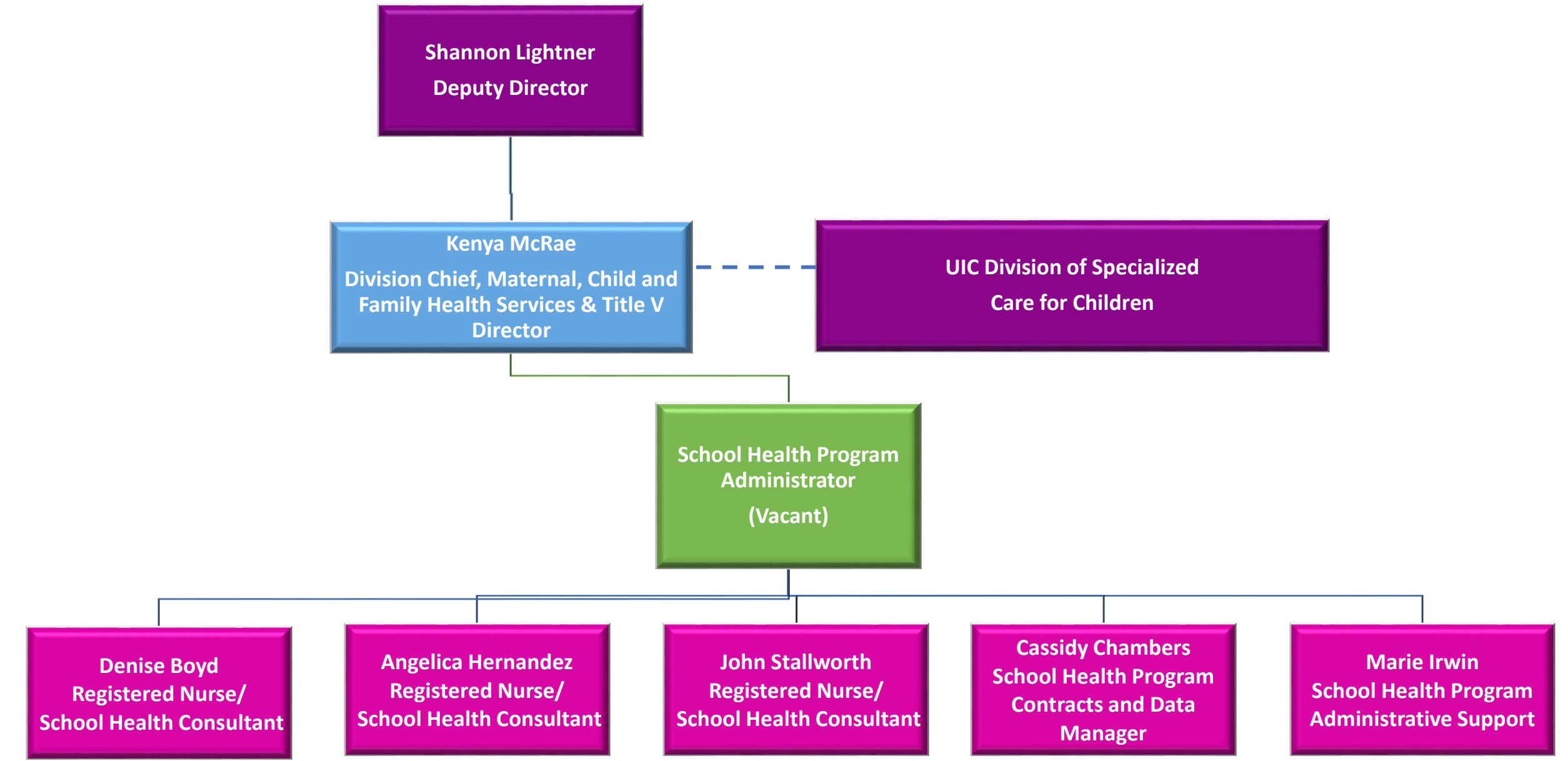
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# School Health Centers and Grant Program

- Purpose: Improves the overall physical and emotional health of students
  - Promotes healthy lifestyles
  - Provides available and accessible preventative health care
  - Identifies risk-taking behaviors and appropriate anticipatory guidance, treatment and referral

- IDPH monitors **63** School Health Centers across Illinois
- Provides funding support to **39** agencies that operate school health centers

## Programs and Activities (Engaging School Nurses)

- Annual School Health Days (Fall)
- Critical Issues (Spring)
- Maintain Child and Student Health Examination and Immunization Code (*in collaboration with other IDPH offices*)
- Child Health Exam Form

A dark blue, irregularly shaped graphic with a splatter effect, containing white text. The graphic is centered on a white background and has a rough, hand-painted appearance with some lighter blue and white splatters around its edges.

Let's talk more about  
the Child Health Exam  
Form

# Who needs a Physical Exam?

## Section 665.140 Timetable for Examinations

- The examination shall be conducted **within one year before the following**:
  - Entering school (this includes nursery school, special education, Head Start or other pre-kindergarten programs operated by elementary school systems or secondary level school units or institutions of higher learning; and students transferring into Illinois from outside of the state or country);
  - Entering kindergarten or first grade;
  - Entering the sixth grade;
  - Entering the ninth grade.
- For students attending school programs where grade levels are not assigned,
  - Examinations shall be completed before the date of entering and within one year prior to the school years in which the child will be **5, 11, and 15 years of age**.

# Exam (special situations)

- **(Left & Returned to Illinois)** A child who was enrolled in an Illinois school, left the state and then returned to Illinois at a later time would only be required to obtain a new physical at the required grade levels, K, 6 and 9.
- **(Repeating Grades)** If the student repeats a grade on the examination interval (K, 6th, or 9th) and has complied with the exam requirement, the student is not required to take the exam again.
- **(From Another Country)** - regardless of the duration of stay, examinations shall be completed within one year before the date of entering the school and at other intervals as required by the Code
  - If not on the Illinois form, it must include all the elements the State of Illinois requires.
  - Once enrolled, the same health exams, screenings and services required as all students.

**NOTE:** *The Child Health Examination Code (Section 665.140d) states the school has the option of requiring a new physical at anytime they have concerns about a child's health.*



# Accepting a non-Illinois Child Health Examination Form for a student coming from out of state

For transfer students from out of the state or country, or from a federal Head Start program:

- **ACCEPTABLE** - A health form that is **comparable to the Illinois requirements; however, only at the time of first entry** into an Illinois school.
  - Must be completed within one year prior to the date of entry into an Illinois school.
- **NOT ACCEPTABLE** - A letter or correspondence from a physician or other health care provider merely stating that an examination was conducted.



# Appropriate Form

<http://dph.illinois.gov/sites/default/files/forms/certificate-of-child-health-examination-03032017.pdf>

Health examinations shall be reported on the Certificate of Child Health Examination form that the Department of Public Health and the Illinois State Board of Education prescribe for statewide use.



## State of Illinois Certificate of Child Health Examination

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

**IMMUNIZATIONS:** To be completed by health care provider. The month/year for most 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.

DOSE #	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5	DOSE 6
Vaccine / Dose	MO DA YE	MO DA YE	MO DA YE	MO DA YE	MO DA YE	MO DA YE
DTaP or DTaP-IPV						
Tdap, Td or Pediatric DT (specify specific type)						
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
MH (Meningococcal influenza type 1)						
Phenomenical Conjugate						
Hepatitis B						
MMR (Measles Mumps Rubella)						
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify immunization administered						

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 (Rubella) MO DA YE \*\*MUMPS MO DA YE HEPATITIS MO DA YE VARICELLA MO DA YE

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below certifies 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, 2003, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Lab & Physician Signature: \_\_\_\_\_  
Physician Statements of Immunity MUST be submitted to IDPH for review.

Last First Middle Initial		Birth Date Month/Day/Year	Sex	School	Grade Level (21)
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**HEALTH HISTORY** TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

<b>ALLERGIES</b> Food/Drug, reaction	Yes No	<b>Medication</b> (prescription or regular use)	Yes No
Degrees of asthma?	Yes No	Use of bronchodilator or spacer?	Yes No
Child asthmatic during night coughing?	Yes No	Wheezing/Chronic/Recurrent/Intermittent?	Yes No
Child-diabetic?	Yes No	Hypertension?	Yes No
Developmental delay?	Yes No	What? What day?	Yes No
Head disorders? Menorhagia, Stable Cell, Ocular, Epilepsy	Yes No	Fragility? (Use all)	Yes No
Deafness?	Yes No	Stroke injury or illness?	Yes No
Head injury/Concussion/Head out?	Yes No	Thyroid disease (past or present)?	Yes? No?
Seizures? What are they like?	Yes No	Thyroid disease (past or present)?	Yes? No?
Head problems/Obstruction of nasal?	Yes No	Tuberculosis (Type, frequency)?	Yes No
Head trauma/High blood pressure?	Yes No	Abuse? (Drug use)?	Yes No
Diabetes or other pain with insulin?	Yes No	Family history of multiple health problems before age 50? (Cause)?	Yes No
Eye/Vision problems? _____ Glasses _____ Contact _____ Last exam by eye doctor _____	Details _____ Vision _____ Bridge _____ Plate Glass _____	Other concerns? (current eye, dropping, difficulty reading)	
Ear/hearing problems?	Yes No	Information only to assist with appropriate placement for braille and electronic papers	
Heart/lung problems/asthma/cystic fibrosis?	Yes No	Signature _____ Date _____	

**PHYSICAL EXAMINATION REQUIREMENTS** Entire section below to be completed by MD/DO/PA/FA  
HEAD CIRCUMFERENCE < 13.2 years old HEIGHT INCH WEIGHT LBS BMI PERCENTILE NP

**HEARING SCREENING** (per department best case) **HDL-OTC** agrees Yes  No  And any two of the following: Family History Yes  No   
Child's Hearing Yes  No  Signs of hearing loss (deafness, dyspraxia, polygenic hearing loss, conductive hearing loss) Yes  No

**LEAD BLOOD LEVEL SCREENING** Required for children age 1 through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Should not be required if resident in Chicago or high-risk zip code).

Questionnaire Administered? Yes  No  Blood Test Indicated? Yes  No  Blood Test Date \_\_\_\_\_ Results \_\_\_\_\_

**TRISKIN OR BLOOD TEST** Recommended only for children in high-risk groups including children immunocompromised due to HIV infection or other conditions, frequent travel to or from a high-prevalence area or those exposed to a high-risk subgroup. See CDC guidelines <http://www.cdc.gov/od/oc/media/pressrel/r061101a.htm>  
No test needed  Test performed  Date Reported \_\_\_\_\_ Results Positive  Negative  Value \_\_\_\_\_  
Blood Test: Date Reported \_\_\_\_\_ Results Positive  Negative  Value \_\_\_\_\_

<b>HEART TESTS</b> (EKG/ECG)	Date _____	Results _____	Date _____	Results _____
Hemoglobin or Hematocrit		Stable Cell (when indicated)		
Urinalysis		Developmental Screening Test		

**SYSTEM REVIEW** Normal  Concerns/Follow up/Needs \_\_\_\_\_

Skin	Normal	Concerns/Follow up/Needs _____
Ears	Normal	Concerns/Follow up/Needs _____
Eyes	Normal	Concerns/Follow up/Needs _____
Nose	Normal	Concerns/Follow up/Needs _____
Throat	Normal	Concerns/Follow up/Needs _____
Mouth/Dental	Normal	Concerns/Follow up/Needs _____
Cardiovascular/HTN	Normal	Concerns/Follow up/Needs _____
Respiratory	Normal	Concerns/Follow up/Needs _____
Neurological	Normal	Concerns/Follow up/Needs _____
Musculoskeletal	Normal	Concerns/Follow up/Needs _____
Splenic Exam	Normal	Concerns/Follow up/Needs _____
Neurological	Normal	Concerns/Follow up/Needs _____
Mental Health	Normal	Concerns/Follow up/Needs _____
Other	Normal	Concerns/Follow up/Needs _____
Other	Normal	Concerns/Follow up/Needs _____

Currently Prescribed Asthma Medication:  
 Quick relief medications (e.g. Short Acting Beta Agonist)  
 Controller medications (e.g. inhaled corticosteroid)

**NEEDS MEDICATION/ADDITIONS** required to the school setting

**SPECIAL INSTRUCTIONS/REMARKS** e.g. safety glasses, please see child provider for orthodontia, excessive antibiotic use, dental bridge, etc with antibiotic requirements.

**MENTAL HEALTH/OTHER:** Is there anything else the school should know about the student?  
If yes, would like to discuss the student's health with school or school health personnel, check this:  Yes  Teacher  Counselor  Principal

**EMERGENCY ACTION:** needed while at school due to child's health condition (e.g. asthma, seizure, heart, blood, parent allergy, hearing problem, diabetes, heart problem)?  
Yes  No  If yes, please describe \_\_\_\_\_

On the basis of the examination on this day, I approve the child's participation in **PHYSICAL EDUCATION** Yes  No  Modified  **INTERCOURLETTIC SPORTS** Yes  No  Modified

Date: Name (MD, DO, APN, PA) Signature \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

11/2015



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(COMPLETE BOTH SIDES)

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- Forms due no later than **October 15<sup>th</sup>** of the school year or by an earlier date of the current school year established by a school district.
- IESA/IHSA sports physical forms **MAY NOT** be used as the required school health exam.
  - If the student is required to have a sports physical in the year that coincides with the child health examination requirement, the Certificate of Child Health Examination may be accepted as proof of examination for interscholastic sports if the statement regarding participation in interscholastic sports is completed by the health care provider.

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 <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>	<b>INTERSCHOLASTIC SPORTS</b>	Yes <input type="checkbox"/> No <input type="checkbox"/> Modified <input type="checkbox"/>
Print Name	(MD, DO, APN, PA)	Signature	Date
Address		Phone	

# Required Components of Health Examination:

- Immunizations
- Health History
- Physical Examination

Includes:

- Diabetes screening
- Lead risk assessment or testing

# Immunization Section

- The immunization history portion can be signed by a physician, nurse in a physician’s office, school nurse, record keeper in the school, local health agency, etc.
- The verification date must be included.
- A local health department stamp is acceptable for verifying the immunization history portion of the health form. The verification date must be included.

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	



# Parent/Guardian Section

- The health history section of the form is required and must be completed and signed by the parent or legal guardian of the student.
- School nurse should reject the form if incomplete, send it back home to the parent and request that it be completed and returned within a short timeframe.
- If the physician's portion adequately addresses what IDPH requires on the parent portion of the form, the form may be acceptable.
- Consult your district's legal counsel for additional guidance.

# Completing and Signing the Child Health Examination Form

Health examinations, other than dental examinations, eye examinations, and hearing and vision screening, **shall be performed by**, and the Certificate of Child Health Examination shall be signed by,

- **Physician** licensed to practice medicine in all of its branches,
- **Advanced practice nurse** - written collaborative agreement with a collaborating physician that authorizes him/her to perform health examinations, or
- **Physician assistant** - delegated the performance of health examinations by his/her supervising physician.

**NOTE:** A physician is required to review and sign any portion of the Certificate of Child Health Examination completed by anyone other than a physician, APN, or PA performs any part of a health examination. (Section 27-8.1)

# Lead Screening Required

- For children between 1-7 years of age entering a day care center, day care home, preschool, nursery school, kindergarten or other child care facility, including programs ran by a public school district.
- Parent/ legal guardian shall *provide a statement from health care provider that the child has been assessed for risk of lead poisoning or tested or both*, if the child resides in an area defined as high risk by the Department or if the child is potentially at high risk for lead poisoning.
- *Physicians and other health care providers shall also screen children 7+ for lead poisoning in conjunction with the school health examination when, in the medical judgment of the health care provider, the child is potentially at high risk of lead poisoning.* (Section 6.2 of the Lead Poisoning Prevention Act)

## Completion of the section:

**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

If the lead section of the health examination is not completed by the health care provider or nurse, the form is incomplete and cannot be accepted for school enrollment.

# Other Types of Screening

## Diabetes Screening

- Required as part of each mandated health examination.
- Results of the diabetes risk assessment must be documented on the Certificate of Child Health Examination form.

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

## TB Skin or Blood Test

- A tuberculosis skin test screening shall be included as a **required** part of **each** health examination included under this Section if the child resides in an area designated by the Department of Public Health as having a high incidence of tuberculosis.
- The TB Code specifies childcare and pre-school **workers** be tested for TB.
- The recommendation is if there is possibility of exposure to the children, test the staff.

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](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



# Exclusion

It is not the intent of Part 665.240 that any child whose parents comply with the intent of the Act or the School Code, should be excluded from a child care facility or school. A child or student shall be considered in compliance with the law if there is evidence of intent to comply. Evidence may be:

1. A signed statement from a health care provider that he or she has begun, or will begin, the necessary immunization procedures; or
2. The parent's or legal guardian's written consent for the child's participation in a school or other community immunization program.

Any decision by a school to exclude a student for school entrance for failing to comply with the health examination and immunization requirements set forth in this Part shall be done in accordance with Section 27-8.1 of the School Code and applicable Illinois State Board of Education policies or procedures.

# Information about SB 565, Public Act 99-0927 (*Social and Emotional Screening*)

- Requires IDPH to:
  - Develop and implement administrative rules to include an age-appropriate developmental screening and an age-appropriate social and emotional screening as part of the health examination for all school children in Illinois.
  - Revise the Child Health Examination form.
  - Ensure that the required screening is consistent with the ISBE's social and emotional learning standards.
- Doctors are welcome to start doing screenings and schools may *request* that screenings be done; however, schools cannot *require* it. IDPH cannot enforce the requirements of PA 99-0927 until the administrative rules become effective.

NOTE: doctors and schools ***should not*** independently or unilaterally change the Child Health Examination Form in an effort to comply with PA 99-0927 before the administrative rules become effective.

# THANK YOU

*For More Information on the Child Health Examination Code:*

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH

CHAPTER I: DEPARTMENT OF PUBLIC HEALTH

SUBCHAPTER i: MATERNAL AND CHILD HEALTH

**PART 665 CHILD HEALTH EXAMINATION CODE**

<http://www.ilga.gov/commission/jcar/admincode/077/07700665sections.html>

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