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 MO	1 DA	1 YR	2 MO	2 DA	2 YR	3 MO	3 DA	3 YR	4 MO	4 DA	4 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 Influenza type b (Hib)												
TB/TB Contact	Yes No		Comb. Measles/Mumps/Rubella (MMR)												
Serious Illness/Injury	Yes No		Measles (Rubeolla)												
Hospitalization	Yes No		Rubella (3 day or German Measles)												
Hearing/Ear Problem	Yes No		Mumps												
Vision/Eye Problem	Yes No														
Speech/Feeding Problem	Yes No														
Allergies (list)			Hepatitis B												
Medications (list)			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	Developmental Screening Tests		
Hemoglobin* or			DDSTII		
Hematocrit*			PDQ		
Urinalysis			Other (identity)		
Sickle Cell* (as needed)			*Mandated for state licensed child care facilities or approved schools and programs		
Lead Questionnaire and/or Blood Test*					

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

IL 482-0933