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

PLEASE PRINT

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

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 (Rubeola)												
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 (identify)		

*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

IL 482-0933