



Minimum Immunization Requirements Entering a Child Care Facility or School in Illinois, Fall-2017
Footnotes for Further Guidance

Vaccine Requirement ¹	Child Care Facility, Preschool, Early Childhood, Pre-Kindergarten Programs	Kindergarten through 12th Grade		Minimum Intervals Allowed Between Doses and Other Options for Proof of Immunity ²
		First Entry into School (Kindergarten or First Grade)	Other Grades	
DTP/DTaP/ or Tdap, Td (Diphtheria, Tetanus, Pertussis)	Three doses of DTP or DTaP by 1 year of age. One additional booster dose by 2nd birthday	Four or more doses of DTP/DTaP with the last dose qualifying as a booster and received on or after the 4th birthday	Three or more doses of DTP/DTaP or Td; with the last dose qualifying as a booster if received on or after the 4th birthday For Students entering 6th thru 12th grades: One dose of Tdap	Minimum interval between series doses: 4 weeks (28 days) Between series and booster: 6 months No proof of immunity allowed
Polio	Two doses by 1 year of age. One additional dose by 2nd birthday	Four or more doses of the same type of Polio vaccine with the last dose qualifying as a booster and received on or after the 4th birthday. (progressive requirement)	Three or more doses of Polio with the last dose qualifying as a booster and received on or after the 4th birthday. If the series is given in any combination of polio vaccine types, four or more doses are required with the last being a booster on or after the 4th birthday.	Minimum interval between series doses: 4 weeks (28 days) For Grade K: 6 month interval between three dose series and booster; booster must be on or after 4th birthday No proof of immunity allowed
Measles	One dose on or after the 1st birthday	Two doses of Measles Vaccine , the first dose must have been received on or after the 1st birthday and the second dose no less than 4 weeks (28 days) later.		Laboratory evidence of measles immunity or Certified physician verification* of measles disease by date of illness *Cases diagnosed after 7/1/2002 must include lab evidence of infection.
Rubella	One dose on or after the 1st birthday	Two doses of Rubella Vaccine , the first dose must have been received on or after the 1st birthday and the second dose no less than 4 weeks (28 days) later.		Laboratory evidence of rubella immunity, History of disease is not acceptable proof of immunity to rubella.
Mumps	One dose on or after the 1st birthday	Two doses of Mumps Vaccine , the 1st dose must have been received on or after the first birthday and the second dose no less than 4 weeks (28 days) later.		Laboratory evidence of mumps immunity or Certified physician verification of mumps disease by date of illness.
Haemophilus influenzae type b	Refer to ACIP Hib series schedule for Children 24-59 mos. Children without series must have one dose after 15 mos. of age	Not required after the 5th birthday (60 months of age)		Refer to ACIP Hib series schedule No proof of immunity allowed

1. Students attending ungraded school programs must comply in accordance with grade equivalent.

2. Within ACIP recommendations, vaccine doses given up to four days before minimum interval or age can be counted as valid. However, this does not apply to intervals between live vaccines. Live vaccines shall not be given fewer than 28 days after receipt of a prior live vaccine.



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Pneumococcal Conjugate Vaccine (PCV 13)	Refer to ACIP PCV series schedule for Children 24-59 mos. Children without series must have one dose after 24 months of age.	Not required after the 5th birthday (60 months of age)		Refer to ACIP PCV series schedule No proof of immunity allowed
Hepatitis B	Three doses for all children Third dose must have been administered on or after 6 months of age (168 days)	No Requirements	For Students entering grades 6 thru 12: Three doses hepatitis B vaccine administered at recommended intervals. Two doses Adult Recombivax-HB vaccine for ages 11 to 15.	Minimum intervals between doses: First & Second - at least 4 weeks (28 days) Second & Third - at least 2 months (56 days) First & Third - at least 4 months (112 days) Adult Recombivax-HB two doses separated by 4 months (112 days)
Varicella (progressive requirement)	One dose on or after 1st birthday	Two doses of Varicella; The first dose must have been received on or after the 1st birthday and the second dose no less than 4 weeks (28 days) later.	One dose of Varicella on or after the 1st birthday for Students entering grades 4 & 5 Two doses of Varicella for Students entering grades 2, 3, 6, 7, 8, 9, 10, 11 & 12.	Minimum intervals for administration: The first dose must have been received on after the 1st birthday and the second dose no less than 4 weeks (28 days) later. Statement from physician or health care provider verifying disease history OR Laboratory evidence of varicella immunity
Meningococcal Conjugate Vaccine (progressive requirement)	No Requirements	No Requirements	Applies to Students entering grades 6, 7, 8, & 12 beginning 2017-2018 school year One dose of Meningococcal Conjugate vaccine for entry to grade 6, 7, & 8 Two doses of Meningococcal Conjugate vaccine at entry to 12th grade	Minimum intervals for administration: The first dose received on or after the 11th birthday; second dose on or after the 16th birthday. An interval of least eight weeks after the first dose. Only one dose is required if the first dose was received at 16 years of age or older. No proof of immunity allowed.

Source: Child and Student Health Examination and Immunization Code/Part 665

Prepared by Illinois Department of Public Health, Immunization Section April, 2017



State of Illinois Certificate of Child Health Examination

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				Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for every 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.

REQUIRED Vaccine / Dose	DOSE 1			DOSE 2			DOSE 3			DOSE 4			DOSE 5			DOSE 6		
	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR	MO	DA	YR
DTP or DTaP																		
Tdap; Td or Pediatric DT (Check specific type)	<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT			<input type="checkbox"/> Tdap <input type="checkbox"/> Td <input type="checkbox"/> DT		
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		
Hib Haemophilus influenza type b																		
Pneumococcal Conjugate																		
Hepatitis B																		
MMR Measles Mumps. Rubella										Comments:								
Varicella (Chickenpox)																		
Meningococcal conjugate (MCV4)																		
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose																		
Hepatitis A																		
HPV																		
Influenza																		
Other: Specify Immunization Administered/Dates																		

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 (Rubeola) MO DA YR **MUMPS MO DA YR HEPATITIS B MO DA YR VARICELLA MO DA YR**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official. Person signing below verifies 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
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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, 2013, must be confirmed by laboratory evidence.

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

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and Maintained by the School Authority.

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

ALLERGIES (Food, drug, insect, other)	Yes No	List:	MEDICATION (Prescribed or taken on a regular basis.)	Yes No	List:
Diagnosis of asthma?		Yes No	Loss of function of one of paired organs? (eye/ear/kidney/testicle)		Yes No
Child wakes during night coughing?		Yes No	Hospitalizations?		Yes No
Birth defects?		Yes No	When? What for?		
Developmental delay?		Yes No	Surgery? (List all.)		Yes No
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.		Yes No	When? What for?		
Diabetes?		Yes No	Serious injury or illness?		Yes No
Head injury/Concussion/Passed out?		Yes No	TB skin test positive (past/present)?	Yes*	No
Seizures? What are they like?		Yes No	TB disease (past or present)?	Yes*	No
Heart problem/Shortness of breath?		Yes No	Tobacco use (type, frequency)?	Yes	No
Heart murmur/High blood pressure?		Yes No	Alcohol/Drug use?	Yes	No
Dizziness or chest pain with exercise?		Yes No	Family history of sudden death before age 50? (Cause?)	Yes	No
Eye/Vision problems? _____ Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Last exam by eye doctor _____			Dental <input type="checkbox"/> Braces <input type="checkbox"/> Bridge <input type="checkbox"/> Plate <input type="checkbox"/> Other		
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			Information may be shared with appropriate personnel for health and educational purposes.		
Ear/Hearing problems?		Yes No	Parent/Guardian		
Bone/Joint problem/injury/scoliosis?		Yes No	Signature		
			Date		

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA

HEAD CIRCUMFERENCE if < 2-3 years old	HEIGHT	WEIGHT	BMI	BMI PERCENTILE	B/P
DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes <input type="checkbox"/> No <input type="checkbox"/> And any two of the following: Family History Yes <input type="checkbox"/> No <input type="checkbox"/> Ethnic Minority Yes <input type="checkbox"/> No <input type="checkbox"/> Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes <input type="checkbox"/> No <input type="checkbox"/> At Risk Yes <input type="checkbox"/> No <input type="checkbox"/>					

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** _____

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.

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		Screening Result:		Gastrointestinal
Eyes		Screening Result:		Genito-Urinary
Nose				Neurological
Throat				Musculoskeletal
Mouth/Dental				Spinal Exam
Cardiovascular/HTN				Nutritional status
Respiratory		<input type="checkbox"/> Diagnosis of Asthma		Mental Health
Currently Prescribed Asthma Medication: <input type="checkbox"/> Quick-relief medication (e.g. Short Acting Beta Agonist) <input type="checkbox"/> 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

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. _____

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 No **Modified** **INTERSCHOLASTIC SPORTS** Yes No **Modified**

Print Name _____ **(MD,DO, APN, PA) Signature** _____ **Date** _____

Address _____ **Phone** _____