IDPH
ILLINOIS DEPARTMENT OF PUBLIC HEALTH

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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		First Entry into School (Kindergarten or 1st Grade)	**Other Grades**	
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 Last First Middle	**Birth Date** Month/Day/Year	**Sex**	**Race/Ethnicity**	**School /Grade Level/ID#**
Address Street City Zip Code	Parent/Guardian	Telephone # Home		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** MO DA YR	**DOSE 2** MO DA YR	**DOSE 3** MO DA YR	**DOSE 4** MO DA YR	**DOSE 5** MO DA YR	**DOSE 6** 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	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ 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**

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.

Apellido	Nombre	Inicial	Fecha de Nacimiento Mes / Día / Año	Sexo	Escuela	Grado/Núm. de Ident.

HISTORIAL MÉDICO- PARA SER COMPLETADO Y FIRMADO POR PADRES/TUTOR Y VERIFICADO POR EL PROVEEDOR DE CUIDADO DE SALUD

ALERGIAS (Alimentos, drogas, insectos, otro)	Sí No	Anótelas todas:	MEDICINAS (Anote todas las recetadas o tomadas con regularidad)	Sí No	
¿Tiene diagnóstico de asthma? ¿Despierta el niño tosiendo en la noche?	Sí No		¿Tiene pérdida de funciones en uno de los órganos? (Ojos/Oídos/Riñones/Testículos)	Sí No	
¿Tiene defectos de nacimiento?	Sí No		¿Ha sido hospitalizado? ¿Cuándo? ¿Para qué?	Sí No	
¿Tiene retrasos del desarrollo?	Sí No				
¿Tiene problemas de la sangre? Hemofilia, Glóbulos Falciformes (Sickle Cell), Otro	Sí No		¿Ha tenido alguna cirugía?(anótelas todas) ¿Cuándo? ¿Para qué?	Sí No	
¿Tiene diabetes?	Sí No		¿Ha tenido heridas graves o enfermedades?	Sí No	
¿Tiene heridas en la cabeza/golpe/desmayo?	Sí No		¿Prueba positiva de TB (Pasado o Presente)?	Sí No	*Si contestó sí, refiera al departamento de salud local
¿Tiene convulsiones? Cómo se manifiestan?	Sí No		¿Enfermedad de TB (Pasado o Presente)?	Sí No	
¿Tiene problemas cardiacos/No respira bien?	Sí No		¿Usa tabaco (tipo, frecuencia)?	Sí No	
¿Tiene soplo en el corazón/presión arterial alta?	Sí No		¿Toma alcohol/drogas?	Sí No	
¿Tiene mareos o dolor de pecho al hacer ejercicios?	Sí No		¿Historial de familiares de muerte repentina antes de los 50 años? ¿Causa?	Sí No	
¿Problemas con los ojos/visión? _____ Lentes ☐ Lentes de Contacto ☐ Último examen _____ ¿Otras Preocupaciones? (bizco, párpados caídos, parpadear, dificultad cuando lee)			Dental ☐ Ganchos ☐ Puente ☐ Placas Otro		
¿Tiene problemas de los oídos/no oye bien?	Sí No		La información en este formulario se puede compartir con el personal apropiado para propósitos de salud y educación.		
¿Tiene problemas de los huesos/articulaciones/heridas/escoliosis?	Sí No		**Firma del Padre/Tutor**		**Fecha**

PHYSICAL EXAMINATION REQUIREMENTS

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

HEAD CIRCUMFERENCE if < 2-3 years old **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. (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**		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 Agonist) ☐ 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**