



State of Illinois
Certificate of ChcD(IldhcD(q 31.32 635.04 546.6 30.6 re W n BT /TT1 1 Tf -0

Haemophilus
influenza type b

| | | | | | | | | | | | | | | | | |
|------|--|--|-------|--|--|--------|--|--|-------------------------------|--|--|-----|--------|--|-----------------|--|
| Last | | | First | | | Middle | | | Birth Date Month/Day/ Year | | | Sex | School | | Grade Level/ ID | |
|------|--|--|-------|--|--|--------|--|--|-------------------------------|--|--|-----|--------|--|-----------------|--|

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 | | | | | | | | | | |
| Birth defects? | | Yes | No | | | | | | | | | | |