

School & Sport Physicals offered by the Whiteside County Health Department

(Illinois Requires: Kindergarten, 6th grade, 9th grade Freshman and all Sports)



Eastland High School

June 24, 2026

8:30 - 3:30

Cost for Sports Physical \$35. Cost for School Physical \$50. (Cash, credit card, insurance, Medicare, & Medicaid). Please have all forms completely filled out indicating which physical you are requesting and consent form signed by a legal guardian prior to arrival. Children under 14 years of age must be accompanied by a parent or legal guardian, or with parent/guardian signed consent the child may be accompanied by an adult 18 or older. Children 14-17 do not need to be accompanied by an adult, but must have parent/guardian signed consent form. **NO EXCEPTIONS.** Immunizations will not be given at the event. If your child is due for immunizations, dental, or vision you can call to schedule that appointment at the Health Department. Please call the **Whiteside County Health Department at 815-626-2230 EXT: 1241 or 1215 (no walk-ins).** We hope to see you there!



State of Illinois

Certificate of Child Health Examination

Student's Name Last First Middle			Birth Date (Mo/Day/Yr)	Sex	Race/Ethnicity	School/Grade Level/ID#
Street Address City ZIP Code			Parent/Guardian		Telephone (home/work)	
HEALTH HISTORY: MUST 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)	
Child wakes during night coughing?		☐ Yes ☐ No			☐ Yes ☐ No	
Birth Defects?		☐ Yes ☐ No			Hospitalization? When? What for?	
Developmental delay?		☐ Yes ☐ No			☐ Yes ☐ No	
Blood disorder? Hemophilia, Sickle Cell, Other? Explain.		☐ Yes ☐ No			Surgery? (List all) When? What for?	
Diabetes?		☐ Yes ☐ No			☐ Yes ☐ No	
Head Injury/Concussion/Passed out?		☐ Yes ☐ No			Serious Injury or Illness?	
Seizures? What are they like?		☐ Yes ☐ No			☐ Yes* ☐ No	
Heart problem/Shortness of breath?		☐ Yes ☐ No			TB skin test positive (past/present)?	
Heart murmur/High blood pressure?		☐ Yes ☐ No			☐ Yes* ☐ No	
Dizziness or chest pain with exercise?		☐ Yes ☐ No			Tobacco use (type, frequency)?	
					☐ Yes ☐ No	
					Alcohol/Drug use?	
					☐ Yes ☐ No	
					Family history of sudden death before age 50? (Cause?)	
					☐ Yes ☐ No	
Eye/Vision problems? ☐ Glasses ☐ Contacts Last exam by eye doctor			☐ Dental ☐ Braces ☐ Bridge ☐ Plate ☐ Other			
Other concerns? (Crossed eyes, drooping lids, squinting, difficulty reading)			Additional Information:			
Ear/Hearing problems? ☐ Yes ☐ No			Information may be shared with appropriate personnel for health and educational purposes.			
Bone/Joint problem/Injury/scoliosis? ☐ Yes ☐ No			Parent/Guardian Signature: _____ Date: _____			
IMMUNIZATIONS: To be completed by health care provider. The mo/day/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						
Varicella (Chickenpox)						
Meningococcal Conjugate						
RECOMMENDED, BUT NOT REQUIRED Vaccine/Dose				Comments:		
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 _____	

Student's Name Last First Middle			Birth Date (Mo/Day/Yr)	Sex	School	Grade Level/ID#																																																																																																																		
Certificates of Religious Exemption to Immunizations or Physician Medical Statement of Medical Contraindication are reviewed and <i>Maintained</i> by the School Authority.																																																																																																																								
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.																																																																																																																								
Physician Statements of Immunity MUST be submitted to IDPH for review.																																																																																																																								
Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____																																																																																																																								
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 ☐ 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 aged 6 months through 5 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																																																																																																																								
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WHITESIDE
 COUNTY
HEALTH
DEPARTMENT

Main Office: 1800 W. 2nd St.
Rock Falls, IL 61071
Phone: 815-626-2230
Fax: 815-626-2231

Environmental Office: 18819 Lincoln Rd.
Morrison, IL 61270
Phone: 815-772-7411
Fax: 815-772-4723

Consent to Treat a Minor (14 years of Age and Under)
Without a Parent or Guardian Present

Date: _____

Patient Name: _____

Patient Date of Birth: _____

Name of Parent/Legal Guardian: _____

Telephone Number of Parent/Legal Guardian: _____

I, _____ consent for _____ to obtain a school/sports
(Parent/Guardian) (Student)
physical in the presence of _____
(Must be 18 years or Older)

Signature (Adult Listed Above)

Date

Signature (Parent/Guardian)

Date

Patient Information (PLEASE PRINT)

Patient Information 1/1/20

PATIENT'S PREFERRED NAME: _____

Legal Name: _____

Date of Birth: _____

Pronoun: He She They Other _____

Patient's SSN: _____ (photo I.D. required) Phone #: _____

Email: _____

What name would you like to be called in the		
Waiting Room	Preferred	Legal
Exam Room	Preferred	Legal
Phone Calls	Preferred	Legal

Address: _____ Apt#: _____ City: _____ State: _____ Zip: _____

Gender Assigned at Birth (circle one): Male/Female

Gender Identity (circle one): Male /Female /Transgender MTF /Transgender FTM/ Decline/Other: _____

Sexual Orientation (circle one): Lesbian/Gay/ Straight/Bi-sexual / Don't Know/ Decline/Other: _____

Ethnicity (circle one): Mexican, Mexican American, or Chicano Puerto Rican Cuban

Another Hispanic, Latino/a, or Spanish Origin Not Hispanic, Latino/a, or Spanish Origin

Race: Asian Indian Chinese Filipino Japanese Korean Vietnamese Native Hawaiian Other Pacific Islander

Guamanian or Chamorro Samoan Black/African American American Indian/Alaska Native White More than one Race

Are you a migrant or seasonal farm worker? Y/N

Are you homeless (e.g. staying with others, in a hotel, in a shelter, living outside, or in a car (Y/N)

Do you require an interpreter? Y/N

Are you a U.S. Veteran? Y/N

Emergency Contact Information

Name: _____ Relationship: _____ Phone #: _____

Guardian/Guarantor Information (To be completed by person responsible for this account)

Person's name responsible for this account (if other than patient listed above): _____

Relationship to patient (circle one): Parent Partner Other: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of birth of person responsible for this account: _____

FINANCIAL AGREEMENT: I hereby assign Whiteside County Community Health Clinic (WCCHC) all my rights, title and interest to reimbursement under any Medicare, Medicaid, or other insurance policies for which benefits may be available for payment of services provided. I sign as an agent, patient, or as "guarantor" that I understand my insurance company will be billed for services I receive at the WCCHC, and that I am directly responsible and agree to pay the WCCHC the balance due of all charges that may not be covered by my insurance. This may include the cost of collection and/or reasonable attorney's fees. I understand that any labs collected by the WCCHC and performed by an outside lab (LabCorp) will be billed separately to my insurance by LabCorp. I give my direct consent and express consent and permission to the clinic or business associates of the clinic to receive account communications, through various means such as 1) any cell, landline, or other phone number that I provide, 2) auto dialer systems, 3) voicemail messages, 4) text messages 5) emergency contact information, 6) pre-recorded forms of voice messaging systems. This information will not be sold.

Name: _____ Signature: _____ Date: _____

Whiteside County Community Health Clinic
Health History

Patient Sticker

Provider History

Physician/NP/PA: _____ Last Visit: _____
Dentist: _____ Last Visit: _____
Optometrist: _____ Last Visit: _____
Therapist: _____ Last Visit: _____

Health History					
Condition	Self	Family History (Mother, Father, Brother, Sister ONLY)	Condition	Self	Family History (Mother, Father, Brother, Sister ONLY)
Anxiety	☐	☐	Cancer: _____	☐	☐
Depression	☐	☐	Radiation Therapy: Head/Neck	☐	☐
ADHD	☐	☐	Sleep Apnea	☐	☐
Bipolar Disorder	☐	☐	Use a CPAP Machine	☐	☐
Schizophrenia	☐	☐	Epilepsy/Seizure Disorder	☐	☐
Autism Spectrum Disorder	☐	☐	High Blood Pressure	☐	☐
Blindness	☐	☐	Stroke: Date: _____	☐	☐
Cerebral Palsy	☐	☐	High Cholesterol	☐	☐
Deafness	☐	☐	Bleeding/Clotting Disorder	☐	☐
Intellectual Disability	☐	☐	Blood Clot in Leg or Lung	☐	☐
Diabetes Type I	☐	☐	HIV/AIDS	☐	☐
Diabetes Type II	☐	☐	Sexually Transmitted Infection	☐	☐
GERD/Acid Reflux	☐	☐	Asthma	☐	☐
Stomach/Intestinal Disorder	☐	☐	COPD/Emphysema/Lung Dis.	☐	☐
Ulcer	☐	☐	Glaucoma	☐	☐
Eating Disorder	☐	☐	Arthritis	☐	☐
Hepatitis Type: _____	☐	☐	Osteoporosis	☐	☐
Other Liver Disease: _____	☐	☐	Urinary Problems	☐	☐
Kidney Disease: _____	☐	☐	Other: _____	☐	☐
Thyroid Disease: _____	☐	☐	Other: _____	☐	☐
Heart Conditions (SELF ONLY)					
Artificial Valve	☐		Rheumatic Heart Disease/Fever	☐	
Previous Infective Endocarditis	☐		Congenital Heart Disease (CHD)	☐	
Heart Transplant	☐		☐ Unrepaired, Cyanotic CHD		
Heart Murmur	☐		☐ Repaired (Completely) in Last 6 Months		
Pacemaker	☐		☐ Repaired CHD with Residual Defects		
Other: _____	☐		Other: _____	☐	
Tobacco/Nicotine Use					
Are you a current tobacco/nicotine user? Yes No If no, continue to the back page.					
How many packs per day do you currently use: Less than 1 pack 1 pack per day 2 packs per day					
Do you currently use smokeless tobacco/nicotine products? Yes No					

Continue to Back

Surgical/Hospitalization/Serious Injury History	
Total Joint Replacement (hip, knee, shoulder, etc) Date(s): _____ Hospital/Location: _____ Any Complications: _____	
Other Surgeries/Hospitalizations/Serious Injury Date(s): _____ Hospital/Location: _____ Any Complications: _____	
Other Surgeries/Hospitalizations/Serious Injury: _____ Date(s): _____ Hospital/Location: _____ Any Complications: _____	
Health Screenings (If Applicable)	
Colorectal Cancer Screening Date: _____ Cervical Cancer Screening Date: _____	Breast Cancer Screening Date: _____ Hgb A1C (Diabetes) Date: _____
Men's Health	
PSA/Rectal Exam: Date: _____	Do you Perform Self Testicular Exams? Yes or No
Women's Health (12 Years Old and Up)	
1 st Menstrual Period – Age: _____ Last Menstrual Period Date: _____ Menopause Year: _____ Are you currently Pregnant: Yes or No Estimated Due Date: _____ OB History: Pregnancies: _____ Living Children: _____ Miscarriages/Abortions: _____ Birth Control: ☐ None ☐ Pills ☐ Other: _____ Do you Perform Self Breast Exams? Yes or No Currently Nursing? Yes or No	
Medication History	
☐ Currently taking, previously taken, or scheduled to begin taking medications for osteoporosis: Alendronate (Fosamax), Ibandronate (Boniva), Risedronate (Actonel), Denosumab (Prolia), or Reclast? ☐ Currently taking or scheduled to begin treatment with IV bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia, multiple myeloma or metastatic cancer? Date treatment began: _____ ☐ Currently taking blood thinners (Coumadin/Warfarin, Plavix, Brilinta, Xarelto, Eliquis, Pradaxa, etc)	
Current Medications	
☐ NONE ☐ Medication List Attached 	
Allergies and Reactions	
☐ NONE 	

I hereby certify that the information provided in this form is complete, true and correct to the best of my knowledge.

Patient/Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____

DOCUMENTED VERIFICATION OF INCOME/FAMILY SIZE

Patient Sticker	Annual Income: _____ Family Size: _____ <u>A Pregnant Woman will Count as Two in the Family</u> Attach copies of proof of income, such as paycheck stubs, income tax returns, etc. (Always make copies, never hand over originals you may need for use later) Sliding Fee: _____
I certify that the information I have provided is correct, to the best of my knowledge. I understand that I will be held responsible for any consequences (e.g. payments, fines, legal action, etc.) resulting from intentionally providing false or misleading information.	
Signature of person responsible for this account: _____ Today's Date _____	
REFUSAL: I certify that I am refusing to provide annual income and family size information to the Whiteside County Community Health Clinic. By signing below, I am acknowledging that by refusing to provide annual income and family size verification, that I will NOT be eligible for discounted services through the Sliding Fee Program. I understand that at any time I can revoke the refusal and provide the WCCHC with verification of income/family size in order to be eligible for discounted services through the Sliding Fee Program.	
Signature of person responsible for this account: _____ Today's Date _____	

WCCHC Sliding Fee Scale 2026. All income categories are from the 2026 Federal Poverty Guidelines

Family Size	Level 1 Slide	Level 2 Slide	Level 3 Slide	Level 4 Slide	Level 5 Slide	Level 6
1	\$0 \$15,960	\$15,961 \$19,950	\$19,951 \$23,940	\$23,941 \$27,930	\$27,931 \$31,920	\$31,921
2	\$0 \$21,640	\$21,641 \$27,050	\$27,051 \$32,460	\$32,461 \$37,870	\$37,871 \$43,280	\$43,281
3	\$0 \$27,320	\$27,321 \$34,150	\$34,151 \$40,980	\$40,981 \$47,810	\$47,811 \$54,640	\$54,641
4	\$0 \$33,000	\$33,001 \$41,250	\$41,251 \$49,500	\$49,501 \$57,750	\$57,751 \$66,000	\$66,001
5	\$0 \$38,680	\$38,681 \$48,350	\$48,351 \$58,020	\$58,021 \$67,690	\$67,691 \$77,360	\$77,361
6	\$0 \$44,360	\$44,361 \$55,450	\$55,451 \$66,540	\$66,541 \$77,630	\$77,631 \$88,720	\$88,721
7	\$0 \$50,040	\$50,041 \$62,550	\$62,551 \$75,060	\$75,061 \$87,570	\$87,571 \$100,080	\$100,081
8	\$0 \$55,720	\$55,721 \$69,650	\$69,651 \$83,580	\$83,581 \$97,510	\$97,511 \$111,440	\$111,441
For each additional family member	\$5,680	\$7,100	\$8,520	\$9,940	\$11,360	
CHC Target Population	Up to and Including 100% of Poverty	To 125% of Poverty	To 150% of Poverty	To 175% of Poverty	Up to and Including 200%	Over 200% of Poverty

Service Type	Nominal Fees per Visit (Minimum Amount Charged)	Sliding Fees Applied per Visit The percent of the full fee will not slide below the nominal fee				
	Level 1 Slide	Level 2 Slide	Level 3 Slide	Level 4 Slide	Level 5 Slide	Level 6
Medical	\$30	\$35	\$50	\$70	\$90	Full Fee
Behavioral Health						
Dental	Schedule 1: \$35 Schedule 2: \$200	20% of Full Fee	40% of Full Fee	60% of Full Fee	80% of Full Fee	
Oral Surgery	\$400					
Optometry	\$30					

Interviewer's Signature _____

**WHITESIDE COUNTY HEALTH DEPARTMENT & COMMUNITY HEALTH CLINIC
SUMMARY OF NOTICE OF PRIVACY PRACTICES & ACKNOWLEDGEMENT**

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND
HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

YOUR RIGHTS

You have the right to:

- Get a copy of your health and claims record
- Correct your health & claims record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you as your personal representative
- File a complaint if you believe your privacy rights have been violated

YOUR CHOICES

You have some choices in the way that we may share your information:

- Disclosing information to your family and friends (requires written authorization)
- Tell family and friends about your condition
- Provide disaster relief
- Market our services and sell your information (requires written authorization)
- Raise funds
- Disclosing return to work notes to your employer
- Disclosing return to school notes to your school

OUR USES AND DISCLOSURES

We may use & share your information as we:

- Treat you
- Run our organization
- Bill for your health services
- Help with public health and safety issues such as governmentally declared public health emergencies
- Do research
- Comply with the law, such as providing proof of immunity to a school
- Respond to organ & tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions
- Provide you with appointment reminders such as voicemail messages, postcards, texts or letters

We will, under most circumstances, not share any health information regarding Behavioral or Mental Health Services, Substance Abuse(drug/alcohol) Treatment, Physical Assault/Abuse/Neglect, and/or Sexually Transmitted Diseases including HIV/AIDS unless specifically requested by a fully executed Authorization to Release Health Care Information.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy and security of your protected health information.
We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
We must follow the duties and privacy practices described in this notice and give you a copy of it.
We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

I acknowledge that I have been given an opportunity to read this notice and receipt of the notice. I know that I may ask for a copy of the full notice.

I authorize Whiteside County Health Department/CHC to release school physical records, dental records, to my child's School.

Authorization to Release Health Care Information

Patient (or Parent/Guardian) Signature

Date