



Certificate of Child Health Examination

Please complete this request for a health history form. If the request is for a State of Illinois Child Medical Examination form, Town & Country Pediatrics can provide it for you. All other program specific forms should be provided by you.

If your child has not been seen within the last 12 months for a check-up, you will be asked to complete a visit before the form can be finished.

Please allow up to 10 business days to complete your child's form.

Please complete the information below, sign and date where indicated. By signing this form, you also acknowledge and agree that you are the legal guardian/parent of the patient named above, and have authority to make healthcare and other decisions on behalf of this patient. As a legal guardian/parent, you are also authorized to have access to Protected Health Information (PHI) of the patient, in accordance with federal and state laws.

PATIENT INFORMATION		
Last Name:	First Name:	DOB:

PARENT/GUARDIAN		
Last Name:	First Name:	
Address:		City:
State:	Zip Code:	Preferred Contact Number:

FORM TYPE				
<input type="checkbox"/> State of IL Health	<input type="checkbox"/> IHSA	<input type="checkbox"/> Medication	<input type="checkbox"/> Allergy	<input type="checkbox"/> Camp
<input type="checkbox"/> Other, description:				

ANY PERTINENT CHANGES TO YOUR CHILD'S HEALTH SINCE YOUR CHILD'S LAST PHYSICAL?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes, explain:

HAS YOUR CHILD EVER HAD A POSITIVE COVID TEST?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes, if checked specify date: _____

DELIVERY METHOD <i>choose one method</i>			
<input type="checkbox"/> MyChart <i>(Quickest delivery option)</i>	<input type="checkbox"/> Mail <i>(Enter Address below)</i>	<input type="checkbox"/> Pick Up <i>(Select location below)</i>	<input type="checkbox"/> Email <i>*(Enter Address below)</i>
Pick Up Location: <input type="checkbox"/> Halsted Location <input type="checkbox"/> Skokie Location <input type="checkbox"/> Glenview Location			
Mailing Address:			
Email Address:			

NAME OF LEGAL GUARDIAN: _____

SIGNATURE OF LEGAL GUARDIAN: _____

RELATIONSHIP: _____ DATE: _____ TIME: _____

*By checking this box, I agree to receive email communication that may contain protected health information. I understand that email transmissions cannot be guaranteed to be delivered, secured or error-free despite best efforts of sender. Sender does not accept liability for errors resulting from transmission.

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