ASQ-3™ Ages & Stages Questionnaires®

12 Month Questionnaire

11 months 0 days through 12 months 30 days

Please provide the following information. Use black or blue ink only and print legibly when completing this form.

Date ASQ completed: M M D D Y Y Y Y

Baby's information

Baby's first name:

Middle initial:

Baby's last name:

Baby's date of birth: M M D D Y Y Y Y

If baby was born 3 or more weeks prematurely, # of weeks premature:

Baby's gender:
- Male
- Female

Person filling out questionnaire

First name:

Middle initial:

Last name:

Street address:

Relationship to baby:
- Parent
- Guardian
- Teacher
- Child care provider
- Grandparent or other relative
- Foster parent
- Other:

City:

State/Province:

ZIP/Postal code:

Country:

Home telephone number:

Other telephone number:

E-mail address:

Names of people assisting in questionnaire completion:

PROGRAM INFORMATION

Baby ID #:

Age at administration, in months and days: M M D D

Program ID #:

If premature, adjusted age, in months and days: M M D D

Program name:

E101120100

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12 Month Questionnaire

11 months 0 days through 12 months 30 days

On the following pages are questions about activities babies may do. Your baby may have already done some of the activities described here, and there may be some your baby has not begun doing yet. For each item, please fill in the circle that indicates whether your baby is doing the activity regularly, sometimes, or not yet.

Important Points to Remember:

- ☑ Try each activity with your baby before marking a response.
- ☑ Make completing this questionnaire a game that is fun for you and your baby.
- ☑ Make sure your baby is rested and fed.
- ☑ Please return this questionnaire by ______________.

Notes:

____

____

____

____

COMMUNICATION

	YES	SOMETIMES	NOT YET	
1. Does your baby make two similar sounds, such as "ba-ba," "da-da," or "ga-ga"? *(The sounds do not need to mean anything.)*	○	○	○	___
2. If you ask your baby to, does he play at least one nursery game even if you don't show him the activity yourself (such as "bye-bye," "Peekaboo," "clap your hands," "So Big")?	○	○	○	___
3. Does your baby follow one simple command, such as "Come here," "Give it to me," or "Put it back," *without* your using gestures?	○	○	○	___
4. Does your baby say three words, such as "Mama," "Dada," and "Baba"? *(A "word" is a sound or sounds your baby says consistently to mean someone or something.)*	○	○	○	___
5. When you ask, "Where is the ball (hat, shoe, etc.)?" does your baby look at the object? *(Make sure the object is present. Mark "yes" if she knows one object.)*	○	○	○	___
6. When your baby wants something, does he tell you by *pointing* to it?	○	○	○	___

COMMUNICATION TOTAL ___

GROSS MOTOR

	YES	SOMETIMES	NOT YET	
1. While holding onto furniture, does your baby bend down and pick up a toy from the floor and then return to a standing position?	○	○	○	___
2. While holding onto furniture, does your baby lower herself with control (without falling or flopping down)?	○	○	○	___
3. Does your baby walk beside furniture while holding on with only one hand?	○	○	○	___

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GROSS MOTOR (continued)

	YES	SOMETIMES	NOT YET	
4. If you hold both hands just to balance your baby, does he take several steps without tripping or falling? *(If your baby already walks alone, mark "yes" for this item.)*	○	○	○	___
5. When you hold *one hand* just to balance your baby, does she take several steps forward? *(If your baby already walks alone, mark "yes" for this item.)*	○	○	○	___
6. Does your baby stand up in the middle of the floor by himself and take several steps forward?	○	○	○	___
			GROSS MOTOR TOTAL	___

FINE MOTOR

	YES	SOMETIMES	NOT YET	
1. After one or two tries, does your baby pick up a piece of string with his first finger and thumb? *(The string may be attached to a toy.)*	○	○	○	___
2. Does your baby pick up a crumb or Cheerio with the *tips* of her thumb and a finger? She may rest her arm or hand on the table while doing it.	○	○	○	___
3. Does your baby put a small toy down, without dropping it, and then take his hand off the toy?	○	○	○	___
4. Without resting her arm or hand on the table, does your baby pick up a crumb or Cheerio with the *tips* of her thumb and a finger?	○	○	○	___ *
5. Does your baby throw a small ball with a forward arm motion? *(If he simply drops the ball, mark "not yet" for this item.)*	○	○	○	___
6. Does your baby help turn the pages of a book? *(You may lift a page for him to grasp.)*	○	○	○	___
			FINE MOTOR TOTAL	___

**If Fine Motor Item 4 is marked "yes" or "sometimes," mark Fine Motor Item 2 "yes."*

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PROBLEM SOLVING

	YES	SOMETIMES	NOT YET	
1. When holding a small toy in each hand, does your baby clap the toys together (like "Pat-a-cake")?	○	○	○	___
2. Does your baby poke at or try to get a crumb or Cheerio that is inside a clear bottle (such as a plastic soda-pop bottle or baby bottle)?	○	○	○	___
3. After watching you hide a small toy under a piece of paper or cloth, does your baby find it? *(Be sure the toy is completely hidden.)*	○	○	○	___
4. If you put a small toy into a bowl or box, does your baby copy you by putting in a toy, although she may not let go of it? *(If she already lets go of the toy into a bowl or box, mark "yes" for this item.)*	○	○	○	___
5. Does your baby drop two small toys, one after the other, into a container like a bowl or box? *(You may show him how to do it.)*	○	○	○	___ *
6. After you scribble back and forth on paper with a crayon (or a pencil or pen), does your baby copy you by scribbling? *(If she already scribbles on her own, mark "yes" for this item.)*	○	○	○	___

PROBLEM SOLVING TOTAL ___

**If Problem Solving Item 5 is marked "yes" or "sometimes," mark Problem Solving Item 4 "yes."*

PERSONAL-SOCIAL

	YES	SOMETIMES	NOT YET	
1. When you hold out your hand and ask for his toy, does your baby offer it to you even if he doesn't let go of it? *(If he already lets go of the toy into your hand, mark "yes" for this item.)*	○	○	○	___
2. When you dress your baby, does she push her arm through a sleeve once her arm is started in the hole of the sleeve?	○	○	○	___
3. When you hold out your hand and ask for his toy, does your baby let go of it into your hand?	○	○	○	___
4. When you dress your baby, does she lift her foot for her shoe, sock, or pant leg?	○	○	○	___
5. Does your baby roll or throw a ball back to you so that you can return it to him?	○	○	○	___
6. Does your baby play with a doll or stuffed animal by hugging it?	○	○	○	___

PERSONAL-SOCIAL TOTAL ___

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OVERALL

Parents and providers may use the space below for additional comments.

1. Does your baby use both hands and both legs equally well? If no, explain: ◯ YES ◯ NO

2. Does your baby play with sounds or seem to make words? If no, explain: ◯ YES ◯ NO

3. When your baby is standing, are her feet flat on the surface most of the time? If no, explain: ◯ YES ◯ NO

4. Do you have concerns that your baby is too quiet or does not make sounds like other babies do? If yes, explain: ◯ YES ◯ NO

5. Does either parent have a family history of childhood deafness or hearing impairment? If yes, explain: ◯ YES ◯ NO

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OVERALL *(continued)*

6. Do you have concerns about your baby's vision? If yes, explain: ◯ YES ◯ NO

7. Has your baby had any medical problems in the last several months? If yes, explain: ◯ YES ◯ NO

8. Do you have any concerns about your baby's behavior? If yes, explain: ◯ YES ◯ NO

9. Does anything about your baby worry you? If yes, explain: ◯ YES ◯ NO

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12 Month ASQ-3 Information Summary

11 months 0 days through 12 months 30 days

Baby's name: ______________________ Date ASQ completed: ______________________

Baby's ID #: ______________________ Date of birth: ______________________

Administering program/provider: ______________________ Was age adjusted for prematurity when selecting questionnaire? ◯ Yes ◯ No

1. SCORE AND TRANSFER TOTALS TO CHART BELOW: See *ASQ-3 User's Guide* for details, including how to adjust scores if item responses are missing. Score each item (YES = 10, SOMETIMES = 5, NOT YET = 0). Add item scores, and record each area total. In the chart below, transfer the total scores, and fill in the circles corresponding with the total scores.

Area	Cutoff	Total Score	0	5	10	15	20	25	30	35	40	45	50	55	60
Communication	15.64														
Gross Motor	21.49														
Fine Motor	34.50														
Problem Solving	27.32														
Personal-Social	21.73														

2. TRANSFER OVERALL RESPONSES: Bolded uppercase responses require follow-up. See *ASQ-3 User's Guide*, Chapter 6.

1. Uses both hands and both legs equally well? Yes **NO**
   Comments:
2. Plays with sounds or seems to make words? Yes **NO**
   Comments:
3. Feet are flat on the surface most of the time? Yes **NO**
   Comments:
4. Concerns about not making sounds? **YES** No
   Comments:
5. Family history of hearing impairment? **YES** No
   Comments:
6. Concerns about vision? **YES** No
   Comments:
7. Any medical problems? **YES** No
   Comments:
8. Concerns about behavior? **YES** No
   Comments:
9. Other concerns? **YES** No
   Comments:

3. ASQ SCORE INTERPRETATION AND RECOMMENDATION FOR FOLLOW-UP: You must consider total area scores, overall responses, and other considerations, such as opportunities to practice skills, to determine appropriate follow-up.

If the baby's total score is in the ☐ area, it is above the cutoff, and the baby's development appears to be on schedule.
If the baby's total score is in the ▒ area, it is close to the cutoff. Provide learning activities and monitor.
If the baby's total score is in the ■ area, it is below the cutoff. Further assessment with a professional may be needed.

4. FOLLOW-UP ACTION TAKEN: Check all that apply.

_____ Provide activities and rescreen in _____ months.

_____ Share results with primary health care provider.

_____ Refer for (circle all that apply) hearing, vision, and/or behavioral screening.

_____ Refer to primary health care provider or other community agency (specify reason): ______________________.

_____ Refer to early intervention/early childhood special education.

_____ No further action taken at this time

_____ Other (specify): ______________________

5. OPTIONAL: Transfer item responses (Y = YES, S = SOMETIMES, N = NOT YET, X = response missing).

	1	2	3	4	5	6
Communication						
Gross Motor						
Fine Motor						
Problem Solving						
Personal-Social						

P101120700

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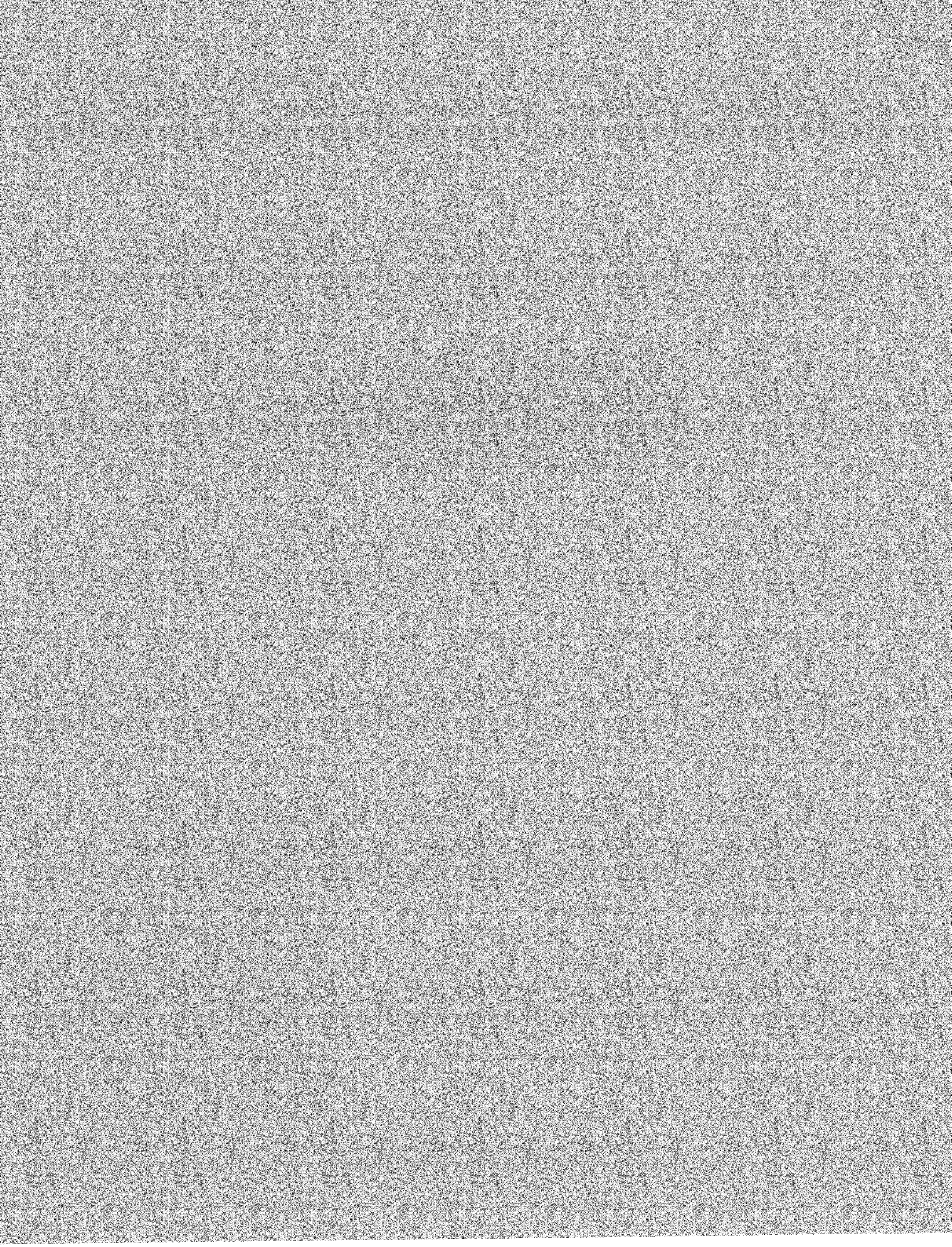

Ages & Stages Questionnaires®: Social-Emotional
A Parent-Completed, Child-Monitoring System for Social-Emotional Behaviors
By **Jane Squires, Diane Bricker, & Elizabeth Twombly**
with assistance from **Suzanne Yockelson, Maura Schoen Davis, & Younghee Kim**
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ASQ:SE™

12 Month/1 Year Questionnaire

(For children ages 9 through 14 months)

Important Points to Remember:

☑ Please return this questionnaire by ______________________ .

☑ If you have any questions or concerns about your child or about this questionnaire, please call: ______________________ .

☑ Thank you and please look forward to filling out another ASQ:SE questionnaire in ______ months.

ASQ:SE™

Ages & Stages Questionnaires®: Social-Emotional
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12 Month/1 Year ASQ:SE Questionnaire

(For children ages 9 through 14 months)

Please provide the following information.

Child's name: ______________________________

Child's date of birth: ______________________________

Today's date: ______________________________

Person filling out this questionnaire: ______________________________

What is your relationship to the child? ______________________________

Your telephone: ______________________________

Your mailing address: ______________________________

____

City: ______________________________

State: ______________________________ ZIP code: ______________________________

List people assisting in questionnaire completion: ______________________________

____

Administering program or provider: ______________________________

ASQ:SE™

Please read each question carefully and
1. Check the box ❑ that best describes your child's behavior *and*
2. Check the circle ❍ if this behavior is a concern

	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
1. Does your baby laugh or smile at you and other family members?	❑ z	❑ v	❑ x	❍
2. Does your baby look for you when a stranger approaches?	❑ z	❑ v	❑ x	❍
3. Does your baby like to play near and be with family members and friends?	❑ z	❑ v	❑ x	❍
4. Does your baby like to be picked up and held?	❑ z	❑ v	❑ x	❍
5. When upset, can your baby calm down within a half hour?	❑ z	❑ v	❑ x	❍
6. Does your baby stiffen and arch her back when picked up?	❑ x	❑ v	❑ z	❍
7. Does your baby like to play games like Peekaboo?	❑ z	❑ v	❑ x	❍
8. Is your baby's body relaxed?	❑ z	❑ v	❑ x	❍
9. Does your baby cry, scream, or have tantrums for long periods of time?	❑ x	❑ v	❑ z	❍

TOTAL POINTS ON PAGE ___

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	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
10. Is your baby able to calm himself down (for example, by sucking on his hand or a pacifier)?	☐ z	☐ v	☐ x	○
11. Is your baby interested in things around her, such as people, toys, and foods?	☐ z	☐ v	☐ x	○
12. Does it take longer than 30 minutes to feed your baby?	☐ x	☐ v	☐ z	○
13. Do you and your baby enjoy mealtimes together?	☐ z	☐ v	☐ x	○
14. Does your baby have any eating problems, such as gagging, vomiting, or ______________________ ? (You may write in another problem.)	☐ x	☐ v	☐ z	○
15. Does your baby have trouble falling asleep at naptime or at night?	☐ x	☐ v	☐ z	○
16. Does your baby make babbling sounds? For example, does he put sounds together, like "ba-ba-ba-ba" or "na-na-na-na"? (If your child often babbles, mark "most of the time.")	☐ z	☐ v	☐ x	○
17. Does your baby sleep at least 10 hours in a 24-hour period?	☐ z	☐ v	☐ x	○

TOTAL POINTS ON PAGE ___

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	MOST OF THE TIME	SOMETIMES	RARELY OR NEVER	CHECK IF THIS IS A CONCERN
18. Does your baby get constipated or have diarrhea?	☐ X	☐ V	☐ Z	○
19. Does your baby let you know when she is hungry, hurt, or tired?	☐ Z	☐ V	☐ X	○
20. When you talk to your baby, does he turn his head, look, or smile?	☐ Z	☐ V	☐ X	○
21. Does your baby try to hurt other children, adults, or animals (for example, by kicking or biting)?	☐ X	☐ V	☐ Z	○
22. Has anyone expressed concerns about your baby's behaviors? If you checked "sometimes" or "most of the time," please explain:	☐ X	☐ V	☐ Z	○

____

____

____

____

23. Do you have concerns about your baby's eating or sleeping behaviors? If so, please explain:

____

____

____

____

TOTAL POINTS ON PAGE ___

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24. Is there anything that worries you about your baby? If so, please explain:

____

____

____

____

25. What things do you enjoy most about your baby?

____

____

____

____

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12 Month/1 Year ASQ:SE Information Summary

Child's name: ______________________ Child's date of birth: ______________________

Person filling out the ASQ:SE: ______________________ Relationship to child: ______________________

Mailing address: ______________________ City: __________ State: __________ ZIP: __________

Telephone: ______________________ Assisting in ASQ:SE completion: ______________________

Today's date: ______________________ Administering program/provider: ______________________

SCORING GUIDELINES

1. Make sure the parent has answered all questions and has checked the concern column as necessary. If all questions have been answered, go to Step 2. If not all questions have been answered, you should first try to contact the parent to obtain answers or, if necessary, calculate an average score (see pages 39 and 41 of *The ASQ:SE User's Guide*).
2. Review any parent comments. If there are no comments, go to Step 3. If a parent has written in a response, see the section titled "Parent Comments" on pages 39, 41, and 42 of *The ASQ:SE User's Guide* to determine if the response indicates a behavior that may be of concern.
3. Using the following point system:

Z (for zero) next to the checked box	= 0 points
V (for Roman numeral V) next to the checked box	= 5 points
X (for Roman numeral X) next to the checked box	= 10 points
Checked concern	= 5 points

Add together:

Total points on page 3	= _____
Total points on page 4	= _____
Total points on page 5	= _____
Child's total score	= _____

SCORE INTERPRETATION

1. *Review questionnaires*
   Review the parent's answers to questions. Give special consideration to any individual questions that score 10 or 15 points and any written or verbal comments that the parent shares. Offer guidance, support, and information to families, and refer if necessary, as indicated by score and referral considerations.
2. *Transfer child's total score*
   In the table below, enter the child's total score (transfer total score from above).

Questionnaire interval	Cutoff score	Child's ASQ:SE score
12 months/1 year	48	

3. *Referral criteria*
   Compare the child's total score with the cutoff in the table above. If the child's score falls above the cutoff and the factors in Step 4 have been considered, refer the child for a mental health evaluation.
4. *Referral considerations*
   It is always important to look at assessment information in the context of other factors influencing a child's life. Consider the following variables prior to making referrals for a mental health evaluation. Refer to pages 44–46 in *The ASQ:SE User's Guide* for additional guidance related to these factors and for suggestions for follow-up.
   - Setting/time factors
     (e.g., Is the child's behavior the same at home as at school?)
   - Development factors
     (e.g., Is the child's behavior related to a developmental stage or a developmental delay?, Have there been any stressful events in the child's life recently?)
   - Health factors
     (e.g., Is the child's behavior related to health or biological factors?)
   - Family/cultural factors
     (e.g., Is the child's behavior acceptable given cultural or family context?)

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PEDIATRIC TB RISK ASSESSMENT FORM

Physician/ Health Provider:	Phone:	Date:

Child's Name: ______________________________ Date of Birth: _____/_____/_____

Address: ______________________ City: ______________ State: ______ County: __________

Sex: ❐ Male ❐ Female Hispanic: ❐ No ❐ Yes Race: ❐ White ❐ Black ❐ Asian ❐ Am. Indian/Nat. Alaskan ❐ Other _______

US Born: ❐ Yes ❐ No If no, US Date of Arrival: _____/_____/_____ Country of Birth: ____________________

Parent/Guardian: ______________________________ Phone: ________________

TB RISK FACTORS:

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue) or an abnormal chest X-ray?	❐ Yes ❐ No	If yes, name of symptoms: ____________________
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB?	❐ Yes ❐ No	
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East?	❐ Yes ❐ No	If yes, in what country was the child born: ______________
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East for more than one month?	❐ Yes ❐ No	If yes, in what country did the child travel to: ______________
5. Have any members of the child's household come to the United States from another country?	❐ Yes ❐ No	If yes, name of country: ________
6. Is the child exposed to a person who: • Is currently in jail or who has been in jail in the past 5 years? • Has HIV? • Is homeless? • Lives in a group home? • Uses illegal drugs? • Is a migrant farm worker?	❐ Yes ❐ No	If yes, name the risk factors the child is exposed to: ____________________ ____________________
7. Is the child/teen in jail or ever been in jail?	❐ Yes ❐ No	If yes, name of jail: __________
8. Does the child have any history of immunosuppressive disease or take medications that might cause immunosuppression?	❐ Yes ❐ No	If yes, name of disease or medications: ______________

If yes, to any of the above, the child has an increased risk of TB infection and should have a TST/IGRA.

All children with a positive TST/IGRA result must have a medical evaluation, including a chest X-ray. Treatment for latent TB infection should be initiated if the chest X-ray is normal and there are no signs of active TB. ***If testing was done, please attach or enter results on next page.***

MEDICAL INFORMATION:

Primary Reason for Evaluation: ❒ Contact Investigation ❒ Targeted Testing ❒ Immigration Exam ❒ Incidental Abnormal CXR/CT ❒ Incidental Lab Result ❒ Other: ____________________

Symptomatic: ❒ No ❒ Yes If Yes, ONSET date: _____/_____/_____

Symptoms: ❒ Cough ❒ Hemoptysis ❒ Fever ❒ Night Sweats ❒ Weight Loss of _____lbs. ❒ Other: ____________________

Tuberculin Skin Test (TST/Mantoux/PPD) **Date Given:** _____/_____/_____ **Date Read:** _____/_____/_____	**Induration:** ______ **mm** **Impression:** ❒ Negative ❒ Positive
Interferon Gamma Release Assay (IGRA) **Date:** _____/_____/_____	**Impression:** ❒ Negative ❒ Positive ❒ Indeterminate
Chest X-ray (required with positive TST or IGRA) **Date:** _____/_____/_____	**Impression:** ❒ Normal ❒ Abnormal findings
❒ **LTBI treatment** (Rx and start date): Rx:__________________ Date: _____/_____/_____ ❒ **Contraindications to INH or rifampin for LTBI**	❒ **Prior TB/LTBI treatment** (Rx and duration): Rx: ________________________ ________mm ❒ **Offered but refused LTBI treatment**

ADDITIONAL COMMENTS:

____

____

____

____

RECOMMENDATIONS:

____

____

____

____

Health Provider Signature: ______________________________ **Date Completed:** ____/____/____

State of Illinois
Illinois Department of Public Health

Childhood Lead Risk Questionnaire

STATE LAW REQUIRES:

All children 6 years of age or younger must be evaluated for lead exposure.
All children must be assessed for risk of lead exposure and tested if necessary for enrollment into daycare, preschool, and kindergarten.

Complete the Childhood Lead Risk Questionnaire during a well-child or health care visit for children ages 12 and 24 months of age (at minimum) and once a year at annual well-child-visits at ages 3, 4, 5, and 6 years.

- If responses to all the questions are "NO," re-evaluate at next age referenced above or more often if deemed necessary.
- If any response is "YES" or "DON'T KNOW," a blood lead test *must* be obtained.
- If there are any "YES" or "DON"T KNOW" answers ***and***
  - ✓ previous blood lead testing was done at 12 and 24 months of age with a result of 4.9 µg/dL or less OR if not performed at 12 and 24 months, a blood lead test was performed at 3, 4, 5, or 6 years of age with a result of 4.9 µg/dL or less, and
  - ✓ there has been no change in address of the child's home/residential building, child care facility, school, or other frequently visited facilities and
  - ✓ risks of exposure to lead have not changed, further blood lead tests are not necessary.

Child's name ______________________________ Today's date ______________

Age ________ Birthdate ________________ ZIP Code ________________

Respond to the following questions by circling the appropriate answer.

		RESPONSE		
1.	Does this child reside or regularly visit a home/residential building, child-care setting, school or other facility built before 1978 or in a high risk ZIP code area? (see reverse side of page for high risk ZIP code area list)	Yes	No	Don't Know
2.	Is this child eligible for or enrolled in Medicaid, All Kids, Head Start, WIC, or any HFS medical program? ***All Medicaid-eligible children and children enrolled in HFS medical programs shall have a blood lead test at 12 and at 24 months of age. If a Medicaid-eligible child or HFS medical program enrolled child between 36 months and 72 months of age has not been previously tested, a blood lead test shall be performed.	Yes	No	Don't Know
3.	Does this child have a sibling with a confirmed blood lead level of 5 µg/dL or higher?	Yes	No	Don't Know
4.	In the past year, has this child been exposed to repairs, repainting, or renovation of a building/home built before 1978?	Yes	No	Don't Know
5.	Is this child a refugee, adoptee, or recent visitor of any foreign country?	Yes	No	Don't Know
6.	Is this child frequently exposed to imported items (such as, ayurvedic medicine, folk medicines, cosmetics, toys, glazed pottery, spices or other food items, sindoor, or kumkum)?	Yes	No	Don't Know
7.	Does this child live with someone who has a job or a hobby that may involve lead (for example; jewelry making, building renovation, bridge construction, plumbing, furniture refinishing, work with automobile batteries or radiators, lead solder, leaded glass, bullets, lead fishing sinkers, or recycling facility work)?	Yes	No	Don't Know
8.	If the child is younger than 12 months of age, did the child's mother have a past confirmed blood lead level of 5 µg/dL or higher?	Yes	No	Don't Know
9.	Has the water in your home/residential building, child-care setting, school, or other regularly visited facility been tested and had a confirmed level of lead (5 ppb or higher)?	Yes	No	Don't Know
10.	Does your child live near an active lead smelter, battery recycling plant, or another industry likely to release lead, or does your child live near a heavily-traveled road where soil and dust may be contaminated with lead?	Yes	No	Don't Know

*****ALL blood lead test results MUST be submitted to the Illinois Lead Program.**
Fax: 217-557-1188 Phone: 866-909-3572

______________________________ ______________
Signature of Doctor/Nurse *Date*

Illinois Lead Program 866-909-3572 or 217-782-3517 email: dph.lead@illinois.gov
TTY (hearing impaired use only) 800-547-0466

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State of Illinois
Illinois Department of Public Health

Pediatric Lead Poisoning High-Risk ZIP Code Areas

Adams
62301
62320
62324
62339
62346
62348
62349
62365

Alexander
62914
62988

Bond
62273

Boone
61038

Brown
62353
62375
62378

Bureau
61312
61314
61315
61322
61323
61328
61329
61330
61337
61338
61344
61345
61346
61349
61359
61361
61362
61368
61374
61376
61379

Calhoun
62006
62013
62036
62070

Carroll
61014
61051
61053
61074
61078

Cass
62611
62618
62627
62691

Champaign
61815
61816
61845
61849
61851
61852
61862
61872

Christian
62083
62510
62517
62540
62546
62555
62556
62557
62567
62570

Clark
62420
62442
62474
62477
62478

Clay
62824
62879

Clinton
62219

Coles
61931
61938
61943
62469

Cook
All Chicago ZIP Codes
60043
60104
60153
60201
60202
60301
60302
60304
60305
60402
60406
60456
60501
60513
60534
60546
60804

Crawford
62433
62449
62451

Cumberland
62428

DeWitt
61727
61735
61749
61750
61777
61778
61882

DeKalb
60111
60129
60146
60550

Douglas
61930
61941
61942

DuPage
60519

Edgar
61917
61924
61932
61933
61940
61944
61949

Edwards
62476
62806
62815
62818

Effingham
None

Fayette
62458
62880
62885

Ford
60919
60933
60936
60946
60952
60957
60959
60962
61773

Franklin
62812
62819
62822
62825
62874
62884
62891
62896
62983
62999

Fulton
61415
61427
61431
61432
61441
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61501
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61543
61544
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Gallatin
62934

Greene
62016
62027
62044
62050
62054
62078
62081
62082
62092

Grundy
60437
60474

Hamilton
62817
62828
62829
62859

Hancock
61450
62311
62313
62316
62318
62321
62330
62334
62336
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62367
62373
62379
62380

Hardin
62919
62982

Henderson
61418
61425
61454
61460
61469
61471
61480

Henry
61234
61235
61238
61274
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61434
61443
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61490

Iroquois
60911
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Jackson
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62940
62950

Jasper
62432
62434
62459
62475
62480

Jefferson
62883

Jersey
62030
62063

Jo Daviess
61028
61075
61085
61087

Johnson
62908
62923

Kane
60120
60505

Kankakee
60901
60910
60917
60954
60969

Kendall
None

Knox
61401
61410
61414
61436
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61458
61467
61474
61485
61489
61572

Lake
60040

LaSalle
60470
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61301
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Lawrence
62439
62460
62466

Lee
60553
61006
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Livingston
60420
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Logan
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62643
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62671

Macon
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Macoupin
62009
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62069
62085
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62093
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62649
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62674
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62686
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Madison
62002
62048
62058
62060
62084
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62095

Marion
None

Marshall
61369
61377
61424
61537
61541

Mason
62617
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62644
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Massac
62953

McDonough
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62374

McHenry
60034

McLean
61701
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61770

Menard
62642
62673
62688

Mercer
61231
61260
61263
61276
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61466
61476
61486

Monroe
None

Montgomery
62015
62019
62032
62049
62051
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62094
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Morgan
62601
62628
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62695

Moultrie
61937

Ogle
61007
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Peoria
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Perry
62832
62997

Piatt
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61929
61936

Pike
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62323
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62343
62345
62352
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62356
62357
62361
62362
62363
62366
62370

Pope
None

Pulaski
62956
62963
62964
62976
62992

Putnam
61336
61340
61363

Randolph
62217
62242
62272

Richland
62419
62425

Rock Island
61201
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St. Clair
62201
62203
62204
62205
62220
62289

Saline
62930
62946

Sangamon
62625
62689
62703

Schuyler
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62319
62344
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Scott
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62694

Shelby
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Stark
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Stephenson
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Tazewell
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Union
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Vermilion
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Wabash
62410
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Warren
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61473
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Washington
62214
62803

Wayne
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62843
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White
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62821
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62887

Whiteside
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Will
60432
60433
60436

Williamson
62921
62948
62949
62951

Winnebago
61077
61101
61102
61103
61104

Woodford
61516
61545
61570
61760

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