

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS complete this page.

Child's name		Child's birthdate	Name of center, provider, or preschool
			Telephone #
Parent 1 name		Parent 2 name	
Child home address #1			Telephone # 1
Child home address #2			Telephone #2
Where parent # 1 works	Work address	Home phone #	
		Work #	
		Pager #	
		Cellular #	
		Home email	
		Work email	
Where parent # 2 works	Work address	Home phone #	
		Work #	
		Pager #	
		Cellular #	
		Home email	
		Work email	

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parents/guardian. During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.

Parent/Guardian Signature: _____ Date _____

Alternate emergency contact person's name: _____ Relationship to child: _____ Phone number: _____

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone #	Does your child have health insurance? Yes, Company _____ ID #
Child's dentist's name	Dentist Telephone # 1	Does your child have dental insurance? Yes, Company _____ ID#
Dentist's Address	After hours telephone #	NO, we do not have health insurance. NO, we do not have dental insurance.
Other health care specialist name	Telephone #	<input type="checkbox"/> Please help us find health or dental insurance.
Type of specialty		

Child Name: _____

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS complete this page.

Tell us about your child's health. Place an X in the box if the sentence applies to your child. Check *all* that apply to your child.

Growth

I am concerned about my child's growth.

Appetite

I am concerned about my child's eating / feeding habits or appetite.

Rest -

I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child

has had a serious illness, surgery, or injury. *Please describe.*

Physical Activity - My child

must restrict physical activity. *Please describe.*

Development and Learning

I am concerned about my child's behavior, development, or learning. *Please describe:*

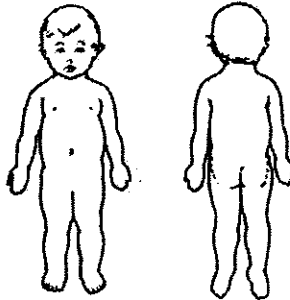
Medication - My child takes medication.

List meds taken at home, preschool, or in child care. List the name, time medication taken, and the reason medication prescribed.

Body Health - My child has problems with

Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe any skin markings



Eyes \ vision, glasses

Ears \ hearing, hearing aides or device, earaches, tubes in ears

Nose problems, nosebleeds, runny nose

Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring

Frequent sore throats or tonsillitis

Breathing problems, asthma, cough, croup

Heart, heart murmur

Stomach aches, upset stomach, colic, spitting up

Using toilet, toilet training, urinating

Bones, muscles, movement, pain with moving

Mobility, uses assistive equipment

Nervous system, headaches, seizures, or nervous habits (like twitches)

Needs special equipment. *Please describe:*

Allergy - My child has allergies (food, medicine, fabric, inhalants, insects, animals, etc.). Please describe.

Parent or child care provider questions or concerns to ask health care provider:

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROVIDERS complete this page¹

Date of Exam:

Height or Length:

Weight

Head Circumference (for children under 2 yr.):

Body Mass Index (for children over 2 yr.):

Blood Pressure (start @ age 3 yr.):

Hgb. or Hct.: (start @ 1 yr.)

Blood Lead Level: (start @ 1 yr.)

Exam Results (*n = normal limits*) otherwise describe

HEENT

Teeth

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Sensory and Developmental Screening

Vision Right eye _____ Left eye _____

Hearing Right ear _____ Left ear _____

Tympanometry (attach results)

Developmental Screening results:

Personal-Social

Fine Motor-Adaptive

Language

Gross Motor

Developmental Referral Made Today: Yes No

Birthdate:

Age today:

Date of Last Dental Exam:

Dental Referral Made Today: Yes No

Vaccines given today:

DtaP/DTP/Td

HEP B

HIB

Influenza

MMR

Pneumococcal

Polio

Varicella

Other

TB testing (for high risk child only)

Referrals made today:

Referred to *hawk-i* today 1-800-257-8563

Physician authorizes the child may receive the following medications while at child care: (include over-the-counter and prescribed):

Medication Name

Dosage

Diaper crème:

Pain reliever:

Sunscreen:

Cough medication

¹ Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROVIDER COMPLETES THIS SECTION -- Assessment Statement:

The child may participate in developmentally appropriate child care/preschool with **NO** health-related restrictions.

The child may participate in developmentally appropriate child care/preschool **with these restrictions**: Describe all restrictions:

Health Provider (may use stamp)

Name: print name: _____

Signature _____

Provider's Type (circle) MD DO PA ARNP

Health Care Provider Address:

Health Care Provider Telephone:

Additional Comments from the Health Care Provider

Health Provider's Guide to Iowa Recommendations for Preventive Pediatric Health Care

Health Provider's Guide		AGE ²											
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr
History:	Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Measurement:	Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
	Head Circumference	●	●	●	●	●	●	●	●	●			
	Blood Pressure										●	●	●
Sensory Screen:	Vision	S	S	S	S	S	S	S	S	S	O	O	O
	Hearing	O	S	S	S	S	S	S	S	S	S	O	O
Developmental Screening		●	●	●	●	●	●	●	●	●	●	●	●
Complete Unclothed Physical Exam		●	●	●	●	●	●	●	●	●	●	●	●
Lab:	Hereditary/Metabolic Screen	● ³											
	Hematocrit or Hemoglobin					●	→	◆	→	→	→	→	→
	Urinalysis												●
	Lead Test						●		◆	◆	◆	◆	◆
	Cholesterol Screen									◆	→	→	→
	TB test ⁵						◆	→	→	→	→	→	→
Immunizations:	<i>per Iowa schedule⁶</i>	●	●	●	●	●	●	●	●	●	●	●	●
Family Guidance:	Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Tricycle Helmet Counseling									●	●	●	●
	Sleep Position Counseling	●	●	●	●	●	●						
	Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●

Key: ● = to be performed

◆ = to be performed for at-risk children

→ = Range in which the task may be completed

S = Subjective, by history

O = Objective, by standard testing

² If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

³ All newborns should receive metabolic screening (e.g. Thyroid, hemoglobinopathies, PKU, galactosemia) during neonatal period.

⁴ Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk.

Lead program 1-800-242-2026.

⁵ TB testing for only at-risk children, Iowa TB program 1-800-383-3826. ⁶ Iowa Immunization program 1-800-831-6293.