Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS COMPLETE PAGES 1 and 2 – child information

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 Type of specialty	Telephone #	☐**Please help us find health or dental insurance.**

Child Name: _____

PARENTS COMPLETE THIS PAGE **Child's Name: _____**

Parents: 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. This will help your doctor plan your child's physical exam.

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.

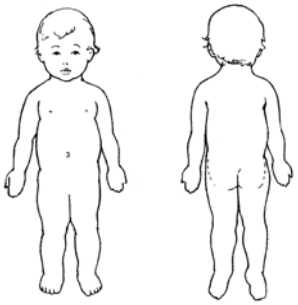
Illness/Surgery/Injury - My child
☐ has had a serious illness, surgery, or injury. *Please describe.*

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*:

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

Parent questions or comments for the health care provider:

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

DOCTORS COMPLETE THIS PAGE[1]

Child's Name:

Birthdate: **Age today:**

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.)

Sensory Screening:

Vision Right eye _____ Left eye _____

Hearing Right ear _____ Left ear _____

Tympanometry (attach results)

Developmental Screening:

Personal-Social

Fine Motor-Adaptive

Language

Gross Motor

Developmental Referral Made Today: □Yes □No

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

HEENT

Oral/Teeth

Date of Last **Dental** Exam: _____
Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Space is available on back page for detailed physician comments or instructions.

[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

Immunization: Doctor may attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td

Hepatitis B

HIB

Influenza

MMR

Pneumococcal

Polio

Varicella

Other

TB testing (for high risk child only)

Medication: 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

Other Medication should be listed with written instructions for use in child care.

Referrals made:

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

Health Provider 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***:

May use stamp

Doctor Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: Telephone:

Health Care Provider comments or instructions:

Health Care Provider -- 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						●		◆	●[4]	◆	◆	◆
Cholesterol Screen									◆	→	→	→
TB test[5]						◆	→	→	→	→	→	→
Immunizations: *per Iowa schedule*[6]	●	●	●	●	●	●	●	●	●	●	●	●
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. [5] . Iowa Immunization program 1-800-831-6293.