

Infant, Toddler, Preschool Age – Child Health Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name		Child's birthdate	Child Care Facility _____ Telephone # _____
Parent/Guardian name #1		Parent/Guardian name #2	
Child home address #1		Telephone # 1	
Child home address #2		Telephone #2	
Where parent/guardian # 1 works	Work address	Home phone # Work # Cellular # Home email Work email	
Where parent /guardian # 2 works	Work address	Home phone # Work # Cellular # Home email Work email	
<p>In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care facility is unable to immediately make contact with the parent/guardian. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.</p> <p>Parent/Guardian Signature: _____ Date _____</p> <p>Alternate emergency contact person's name: _____ Phone # _____</p> <p>Relationship to child: _____ Cellular # _____</p>			
Child's doctor's name	Doctor telephone # 1	Hospital choice Phone # _____	
Doctor's address	After hours telephone #	Does child have health insurance? <input type="checkbox"/> Yes, Company _____ ID # _____	
Child's dentist's name (or family's dentist name)	Dentist Telephone # 1	Does child have dental insurance? <input type="checkbox"/> Yes, Company _____ ID# _____	
Dentist's Address	After hours telephone #	<input type="checkbox"/> NO, we do not have health insurance. <input type="checkbox"/> 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: _____

PARENT/GUARDIAN COMPLETE THIS PAGE

Child's Name: _____

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 health care provider 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

☐ had a serious illness, injury, or surgery..

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:

☐ **Allergies**-My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).

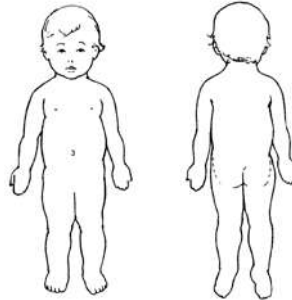
Please describe:

☐ **Special Needs Care Plan** – My child has a special needs care plan (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

Body Health - My child has problems with

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

Map and describe color/shape of skin markings birthmarks, scars, moles



- ☐ Eyes \ vision, glasses
- ☐ Ears \ hearing, hearing aides or device, ear-aches, 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, spitting-up
- ☐ Using toilet, toilet training, urinating
- ☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
- ☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
- ☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

Parent/Guardian questions or comments for the health care provider:

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HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child's Name: _____

Birthdate: _____ **Age today:** _____

Date of Exam: _____

Height/Length: _____ **Weight:** _____

BMI– starting at age 24 mo. _____

Head Circumference– age 2 yr. and under: _____

Blood Pressure–start @ age 3 yr: _____

Hgb or Hct– @ 12 mo: _____

Lead Risk Assessment: _____

Blood Lead Level: date _____ results _____

Sensory Screening:

Vision Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:

(*n = normal limits*) otherwise describe

Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐ Yes ☐ No

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

HEENT

Oral/Teeth

Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐ Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Health Care Provider comments:

Allergies

Environmental: _____

Medication: _____

Food: _____

Insects: _____

Other: _____

Immunization: Please attach:

- ☐ Iowa Department of Public Health
Certificate of Immunization
- ☐ Iowa Department of Public Health
Certificate of Immunization Exemption Medical
- ☐ Iowa Department of Public Health
Certificate of Immunization Exemption Religious.

☐ TB testing completed (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at the child care facility: (include over-the-counter and prescribed)

Medication Name

Dosage

- ☐ Diaper crème:
- ☐ Fever or Pain reliever:
- ☐ Sunscreen:
- ☐ Other

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

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

Health Provider Assessment Statement:

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

☐ The child may participate in developmentally appropriate early care/learning **with restrictions** (see comments).

☐ The child has a special needs care plan

Type of plan _____
(please attach)

May use stamp

Signature _____
Circle the Provider Credential Type: MD DO PA ARNP
Address: _____ **Telephone:** _____

¹ Iowa Child Care Regulations require an admission physical exam report within the previous year and annually. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf