

**Infant, Toddler, Preschool Age** (including Kindergarten entry)  
**Child Health Form**

**HEALTH PROFESSIONAL COMPLETE PAGE**

OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)

**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 @ 1 yr. & 2 yr.: 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

**Allergies**

Environmental:

Medication:

Food:

Insects:

Other:

**Child Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Immunization and TB Testing:** (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

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

Health provider authorizes the child may receive the following at child care: (include over-the-counter medications)

	<u>Name</u>	<u>Dosage</u>
<input type="checkbox"/> Diaper cream/ointment:		
<input type="checkbox"/> Fever or Pain reliever:		
<input type="checkbox"/> Sunscreen:		
<input type="checkbox"/> Other		

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at <https://hhs.iowa.gov/hcci/products>

**Additional Referrals made:**

☐ \_\_\_\_\_

☐ \_\_\_\_\_

**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 complete and give to parent for child care templates at <https://hhs.iowa.gov/hcci/products>)

Comments:

May use stamp

**Signature** \_\_\_\_\_

Circle Provider Type: MD DO PA ARNP Chiropractor

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) [https://downloads.aap.org/AAP/PDF/periodicity\\_schedule.pdf?\\_ga=2.153767288.1525543973.1674849857-346854326.1661880588](https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767288.1525543973.1674849857-346854326.1661880588)

**PARENT/GUARDIAN** (COMPLETE THIS PAGE ANNUALLY) **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.).

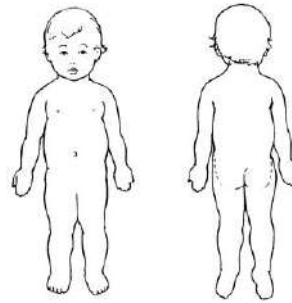
Please describe:

☐ **Special Needs Care Plan** - My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

☐ **Body Health** - My child has skin problems, birthmarks, Mongolian spots, etc.

Map and describe color/shape of skin markings

birthmarks, scars, moles



- ☐ Eyes \ vision, glasses
- ☐ Ears \ hearing, hearing aids 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
- ☐ Nervous System, headaches, seizures
- ☐ 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.
- ☐ Needs special equipment.

List equipment:

☐ **Medication<sup>1</sup>** - My child takes medication.

<u>Medication Name</u>	<u>Time Given</u>	<u>Reason for Medication</u>

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at <https://hhs.iowa.gov/hcci/products>

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

Parent/Guardian Signature (required) \_\_\_\_\_ Date: \_\_\_\_\_

<sup>1</sup> Please review the child care program's policies about the use of medication at child care.