

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

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

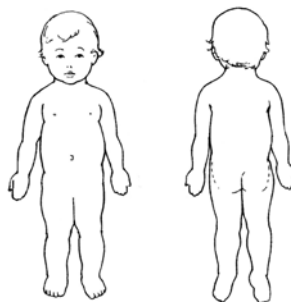
**PARENTS COMPLETE THIS PAGE**

**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.

**Body Health** - My child has problems with  Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe any skin markings



**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.*

- 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, 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:*

**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.

**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<sup>1</sup>

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.

<sup>1</sup> 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:

Doctor Signature \_\_\_\_\_ May use stamp
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 <sup>2</sup>											
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr
<b>History:</b>	Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
<b>Measurement:</b>	Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
	Head Circumference	●	●	●	●	●	●	●	●				
	Blood Pressure										●	●	●
<b>Sensory Screen:</b>	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
<b>Developmental Screening</b>		●	●	●	●	●	●	●	●	●	●	●	●
<b>Complete Unclothed Physical Exam</b>		●	●	●	●	●	●	●	●	●	●	●	●
<b>Lab:</b>	Hereditary/Metabolic Screen	● <sup>3</sup>											
	Hematocrit or Hemoglobin					●	→	◆	→	→	→	→	→
	Urinalysis												●
	Lead Test						●		◆	● <sup>4</sup>	◆	◆	◆
	Cholesterol Screen									◆	→	→	→
	TB test <sup>5</sup>						◆	→	→	→	→	→	→
<b>Immunizations:</b>	<i>per Iowa schedule<sup>6</sup></i>	●	●	●	●	●	●	●	●	●	●	●	●
<b>Family Guidance:</b>	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

<sup>2</sup> 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.

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

<sup>4</sup> 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.

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