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

HEALTH PROFESSIONAL COMPLETE PAGE

Date of Exam: _____

Height/Length: _____ Weight: _____
BMI - starting at age 24 mo.: _____
Head Circumference age infant to 2 yr._____
Blood Pressure - starting age 3 yr.: _____
Hgb or Hct 12 mo.: _____
☐ TB testing completed (if high-risk child)
Lead Risk Assessment: _____
Blood Lead Level at 1 yr. & 2 yr.
Date _____ results _____

Sensory Screening:
Vison 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: ☐ Yes ☐ No

Exam Results: *(n = normal limits) or describe*
HEENT
Oral/Teeth Date of Dental exam: _____
Oral Health/Dental Referral: ☐ Yes ☐ No
Heart
Lungs
Stomach/Abdomen
Genitalia
Extremities, Joints, Muscles, Spine
Skin, Lymph Nodes
Neurological

Allergies: _____
☐ No known allergies

Child's Name: _____

Date of Birth: _____ Age: _____

Immunization (signed and dated):
check as indicated
☐ HHS Certificate of Immunization
☐ HHS Certificate of Immunization Exemption (Religious or Medical)
☐ HHS Provisional Certificate of Immunization

Health provider authorizes the child to receive the following at child care:

Name and Dosage
☐ Diaper cream/ointment:
☐ Fever or Pain reliever:
☐ Sunscreen:
☐ Other
Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at https://hhs.iowa.gov/programs/programs-and-services/child-care/hcci

Additional Referral made:
_____

Health Provider Assessment Statement:
☐ Child may participate in developmentally appropriate early care with ***NO*** health-related restrictions.
☐ Child may participate in developmentally appropriate early care ***with these restrictions***
_____
☐ The child has a special needs care plan
Type of plan _____
Please complete care plan and give to parent/guardian for child care, templates available at https://hhs.iowa.gov/programs/programs-and-services/child-care/hcci

May use stamp

Signature _____
Circle Provider Type
MD DO PA ARNP Chiropractor
Address: Telephone:

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Child Health Form

PARENT/GUARDIAN (complete annually)

Child's Name: _____
Age: _____

Tell us about your child's health. Please use an **X** in the box ☐ for statements 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 had a serious illness, injury, or surgery.

Please describe:

☐ **Physical Activity** - My child must restrict physical activity.

Please describe:

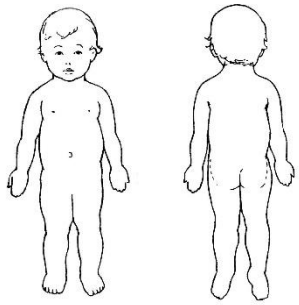
☐ **Development and Learning** - I am concerned about my child's behavior, development, or learning.

Please describe:

☐ **Allergies** - My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.). _____
☐ No known allergies

☐ **Special Needs Care Plan** - My child has a special need and needs a care plan for child care. Please discuss this 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
☐ Problems using toilet, urinating
☐ Toilet training.
☐ Problems with bones, muscles, pain when moving, uses assistive equipment.
☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication or has emergency medication.

Medication Name	Time Given	Reason for Medication

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

Parent/Guardian Signature (required) _____ Date: _____