School- Age Child Health Form

HEALTH PROFESSIONAL COMPLETE PAGE

Date of Exam: _____

Height: _____ Weight: _____
BMI: _____
☐ There are weight concerns

☐ Referral made to _____

Blood Pressure: _____
Hgb or Hct: _____

☐ TB testing completed (if high-risk child)
Blood Lead Level (required for school entry)
Date _____ results _____

Sensory Screening:
Vision Acuity: Right eye _____ Left eye _____
Hearing: Right ear_____ Left ear_____
Tympanometry: (may attach results)
Right ear_____ Left ear_____

Exam Results: *(n = normal limits) or describe*
Skin:
HEENT:
Teeth/Oral health:
Date Dental Exam: _____ or ☐ none to date
Dental Referral Made Today ☐ Yes ☐ No
Heart:
Lungs:
Stomach/Abdomen:
Genitalia:
Extremities, Joints, Muscles, Spine:
Neurological:
Developmental Surveillance:
Psychosocial/Behavioral Assessment:
(Depression screening starting at age 12)

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

☐ 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:

PARENT/GUARDIAN (complete annually)

Child's Name: _____

Age: _____

Please use an **X** in the box ☐ for statements that apply to your child.

Date of child's last physical exam: _____
Date of last dental appointment: _____

☐ **Growth** - I am concerned about child's growth.
☐ **Appetite** - I am concerned about child's eating habits.
☐ **Rest** - My child needs to rest after school.

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

Please describe:

☐ **Physical Activity** - My child must restrict physical activity or needs special equipment to be active.

Please describe:

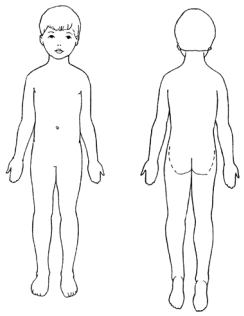
Play with friends - My child
☐ Plays well in groups with other children.
☐ Plays only with one or two children.
☐ Prefers to play alone.
☐ Fights with other children.
☐ I am concerned about my child's play activity with other children.

Please describe:

School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school.

Please describe:

Draw below where your child has marks or scars.



Body Health: My child has
☐ Problems with skin, hair, fingernails/toenails
☐ Eyes/vision, glasses or contact lenses
☐ Ears/hearing, hearing assistive aides or device, earache, tubes in ears
☐ Nose problems, nosebleeds
☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
☐ Breathing problems, asthma, cough
☐ Heart problems or heart murmur
☐ Stomach aches or upset stomach
☐ Trouble using toilet or accidents
☐ Hard stools, constipation, diarrhea, watery stools
☐ Problems with bones, muscles
☐ Mobility difficulties, uses assistive equipment
☐ Nervous system, headaches, seizures, nervous habits, tics
☐ Other special needs

Please describe:

Allergies: _____
☐ No known allergies

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

Medication Name	Time Given	Reason for Medication

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

Parent/Guardian Signature (required) _____ Date: _____