PARENTS/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:

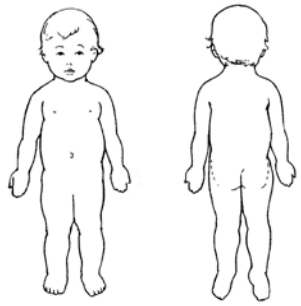
☐ **Allergies**. My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.)

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 aids or device, earaches, 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:

Infant, Toddler, Preschool Age – Child Health Form

Health professional complete this page

Child's name:_____

Birthdate:_____ **Age today:**_____

Date of exam:_____

Height/length:_____ Weight:_____

BMI (start at age 24 months):_____

Head circumference (age 2 years and under):_____

Blood pressure (start at age 3 years):_____

Hgb or Hct (at 12 months):_____

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

n = normal limits; otherwise describe

Developmental screening results:_____

Autism screening results:_____

Psychosocial/behavioral results:_____

Developmental referral made today: ☐ Yes ☐ No

Heart:_____

Lungs:_____

Stomach/abdomen:_____

Genitalia:_____

Extremities, joints, muscles, spine:_____

Skin, lymph nodes:_____

Neurological:_____

Health care provider comments:

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

Allergies

Environmental:_____

Medication:_____

Food:_____

Insects:_____

Other:_____

Immunizations 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 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 ***with restrictions*** (see comments).

☐ The child has a special needs care plan. Type of plan:_____ (please attach)

Signature:_____

May use stamp.

Check the provider credential type:

☐ MD ☐ DO ☐ PA ☐ ARNP

Address:_____

Telephone:_____