

School-Age Child – Parent Statement of Health

PARENT/GUARDIAN Complete this page.

Child's name: _____

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

Date of child's last physical exam: _____

Date of last dental appointment: _____

- Growth.** I am concerned about my child's growth.
- Appetite.** I am concerned about my 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.
- Will play only with one or two other children.
- Prefers to play alone.
- Fights with other children.
- I am concerned about my child's play activity with other children.

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:

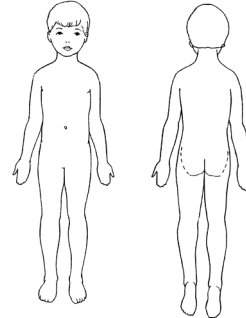
- Allergy.** My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.)

List allergies:

- Special Needs Care Plan.** My child has a special needs care plan. (IEP, Asthma Action Plan, Food Allergy Action Plan, etc.) Please discuss with your health care provider.

- Body Health.** My child has problems with skin, hair, fingernails or toenails.

Describe skin marks, birthmarks or scars. Show us where these skin marks are located using the drawing below.



- Eyes\vision, glasses or contact lenses
- Ears\hearing, hearing assistive aids or device, earache, tubes in ears
- Nose problems, nosebleeds
- Mouth, teeth, gums, tongue, sores in mouth or on lips, breathes through mouth
- Frequent sore throats or tonsillitis
- Breathing problems, asthma, cough
- Heart problems or heart murmur
- Stomach aches or upset stomach
- Trouble using toilet or wetting accidents
- Hard stools, constipation, diarrhea, watery stools
- Bones, muscles, movement, pain when moving
- Mobility, child uses assistive equipment
- Nervous system, headaches, seizures or nervous habits (like twitches or tics)
- Females – difficult monthly periods**

Please describe:

- Medication.** My child takes medication. **Parents:** Please review the child care program's policies about the use of medication at child care.

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

- Yes No **Child has EpiPen, inhaler or other emergency medication.**

Parent signature (required)

Date

School-Age Child – Parent Statement of Health

Health professional complete this page

Date of exam: _____

Height: _____ Weight: _____

Body Mass Index: _____

There are weight concerns.

Referral made to: _____

Blood pressure: _____

Laboratory Screening

Blood lead level: Date: _____

Venous Capillary (for child under age 6 years)

Results: _____

Hgb or Hct: _____

Urinalysis: _____

TB testing (high-risk child only): _____

Sensory Screening

Vision acuity: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry: Right ear _____ Left ear _____

Exam Results *(n = normal limits; otherwise describe)*

Skin: _____

HEENT: _____

Teeth/oral health: _____

Date of dentist exam: _____ or None to date

Dental referral made today: Yes No

Heart: _____

Lungs: _____

Stomach/abdomen: _____

Genitalia: _____

Extremities, joints, muscles, spine: _____

Neurological: _____

Psychosocial/behavioral assessment (depression screening starting at age 11): _____

Allergies

Environmental: _____

Medication: _____

Food: _____

Insects: _____

Other: _____

Health care provider comments:

Child's name: _____

Date of birth: _____ Age: _____

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

Medication

Health provider authorizes the child to receive the following medications while at child care or school. (Include over-the-counter and prescribed.)

Medication Name	Dosage
<input type="checkbox"/> Fever/pain reliever	_____
<input type="checkbox"/> Sunscreen	_____
<input type="checkbox"/> Cough medication	_____
<input type="checkbox"/> Other (list all): _____	_____
_____	_____
_____	_____

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 **fully participate** with **NO** health-related restrictions.

The child has the following **health-related restrictions** to participation (please specify):

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

Signature: _____
May use stamp.

Check the provider type:

MD DO PA ARNP

Address: _____

Telephone: _____