School-Age Child – Parent Statement of Health

Please use an X in the box 🗆 to statements that apply to your child. Date of child's last physical exam:	PARENT/GUARDIAN Complete this page.	Child's name:
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. Illiness/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. Play With Friends. My child: Plays well in groups with other children. Prefers to play alone. Pights with other children. Prefers to play alone. Fights with other children. I am concerned about my child's play activity with other children. 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.) Special Needs Care Plan. My child has a special needs care plan. (IEP, Asthma Action Plan, etc.) Please discuss with your health care provider.	apply to your child.	fingernails or toenails.
Growth. I am concerned about my child's growth.	Date of child's last physical exam:	
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: Please describe: Eyes\vision, glasses or contact lenses	Date of last dental appointment:	
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Illness, surgery or injury.	Rest. My child needs to rest after school.	\
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Please describe:		tubes in ears
breathes through mouth Frequent sore throats or tonsillitis Plays well in groups with other children. Heart problems or heart murmur Yill play only with one or two other children. Heart problems or heart murmur Stomach aches or upset stomach Trouble using toilet or wetting accidents Fights with other children. Hard stools, constipation, diarrhea, watery stools I am concerned about my child's play activity with other children. Mobility, child uses assistive equipment School and Learning. My child: Mobility, child uses assistive equipment Nervous system, headaches, seizures or nervous habits (like twitches or tics) I am concerned about how my child is doing in school. Frequently misses or is late for school. I am concerned about how my child is doing in school. Please describe: Medication. My child takes medication. Parents: Please review the child care program's policies about the use of medication at child care. Medication Name Time Given Reason for Giving Medication Yes		_
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I am concerned about my child's play activity with other children.		☐ Trouble using toilet or wetting accidents
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Plan, Food Allergy Action Plan, etc.) Please discuss with your health care provider.	Special Needs Care Plan. My child has a	·
	special needs care plan. (IEP, Asthma Action Plan, Food Allergy Action Plan, etc.) Please	
		Date

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Date of exam: Height:	Health professional complete this page	Child's name:
Height: Weight: Body Mass Index: Down Department of Public Health Certificate of Immunization Exemption Medical Certificate of Immunization Exemption Medical Laboratory Screening Down Department of Public Health Certificate of Immunization Exemption Medical Laboratory Screening Down Department of Public Health Certificate of Immunization Exemption Medical Laboratory Screening Down Department of Public Health Certificate of Immunization Exemption Medical Lowa Department of Public Health Certificate of Immunization Exemption Medical Lowa Department of Public Health Certificate of Immunization Exemption Medical Lowa Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Down Department of Public Health Certificate of Immunization Exemption Medical Individual Prescription Feligious Medication Standard Prescription Individual Prescription In	Date of exam:	Date of birth: Age:
There are weight concerns. Referral made to :		Immunizations Please attach:
Blood pressure:	There are weight concerns.	
Blood lead level: Date: Venous Capillary (for child under age 6 years) Results: High or Hot: Urinalysis: Sensory Screening Vision acuity: Right ey Left eye Hearing: Right ear Left ear Tympanometry: Right ear Left ear Tympanometry: Right ear Left ear Tympanometry: Right ear Left ear 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: Extremities, joints, muscles, spine: Sensorial starting at age 11): Allergies Environmental: Medication: Medication Health provider authorizes the child to receive the following medications while at child care or school. (Include over-the-counter and prescribed.) Medication Health provider authorizes the child to receive the following medications while at child care or school. (Include over-the-counter and prescribed.) Medication Health provider authorizes the child to receive the following medications while a child care or school. (Include over-the-counter and prescribed.) Medication Health provider authorizes the child to receive the following medications while a child care or school. (Include over-the-counter and prescribed.) Medication Health provider authorizes the child to receive the following medications while a child care or school. (Include over-the-counter and prescribed.) Medication Health provider authorizes the child care or school. (Include over-the-counter of prescribed.) Medication Health provider authorizes the child care or school. (Include over-the-counter of prescribed.) Medication Health provider authorizes the child care or school. (Include over-the-counter of prescribed.) Medication Health provider authorizes the child care or school. (Include over-the-counter of prescribed.) Medication Health provider authorizes the child care of the following medication of prescribed. Medication Health provider authorizes the child care of the following medi		
Venous Capillary (for child under age 6 years) Results:	Laboratory Screening	☐ Iowa Department of Public Health
Results: Hgb or Hct: Hgb or Hct: Hgb or Hct: Urinalysis: B testing (high-risk child only): Sensory Screening Vision acuity: Right eye	Blood lead level: Date:	Certificate of Immunization Exemption Religious
Hgb or Hct: Urinalysis: Stesting (high-risk child only): Sensory Screening Medication Name Dosage Pever/pain reliever Sunscreen Suns	• • •	Medication
Urinalysis: TB testing (high-risk child only): Sensory Screening Vision acuity: Right eye		Health provider authorizes the child to receive the
Medication Name Dosage		
Sensory Screening Vision acuity: Right eye Left eye Hearing: Right ear Left ear Cough medication Tympanometry: Right ear Left ear Other (list all):		
Vision acuity: Right eye		Medication Name Dosage
Hearing: Right ear	•	Fever/pain reliever
Tympanometry: Right ear Left ear Other (list all):		Sunscreen
Other (list all):		Cough medication
Skin:		Other (list all):
HEENT: Teeth/oral health: Teeth/oral health: 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 Health Provider Assessment Statement The child may fully participate with NO health-related restrictions to participation (please specify): Allergies The child has a special needs care plan. Type of plan:	·	
Teeth/oral health:	Skin:	· · · · · · · · · · · · · · · · · · ·
Date of dentist exam: or _ None to date	HEENT:	
Date of dentist exam: or _ None to date		
Dental referral made today:		
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: 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		
Lungs:Stomach/abdomen:		
Genitalia:		
Extremities, joints, muscles, spine:	Stomach/abdomen:	Health Provider Assessment Statement
Neurological: Psychosocial/behavioral assessment (depression screening starting at age 11): Allergies Environmental: Medication: Food: Insects: Other: Health care provider comments: The child has the following health-related restrictions to participation (please specify): Signature: May use stamp. Check the provider type: MD DO PA ARNP Address: Address:	Genitalia:	
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Plan:		restrictions to participation (please specify).
Environmental:	Allergies	· · · · · · · · · · · · · · · · · · ·
Medication: Food: Insects: Other: Health care provider comments: Signature: May use stamp. Check the provider type: MD DO PA ARNP Address:	Environmental:	plan (please attach)
Check the provider type: MD	Medication:	
Check the provider type: MD	Food:	Signature:
Other: MD DO PA ARNP Health care provider comments: Address:		
Address	Other:	
	Health care provider comments:	Address:
		Telephone:

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

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