Infant, Toddler, Preschool Age – Child Health Exam Form

**PARENTS COMPLETE PAGES 1 and 2 – child information**

<table>
<thead>
<tr>
<th>Child’s name</th>
<th>Child’s birthdate</th>
<th>Name of center, provider, or preschool Telephone #</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parent 1 name</strong></td>
<td><strong>Parent 2 name</strong></td>
<td><strong>Telephone # 1</strong></td>
</tr>
<tr>
<td><strong>Child home address #1</strong></td>
<td></td>
<td><strong>Telephone # 2</strong></td>
</tr>
<tr>
<td><strong>Child home address #2</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Where parent # 1 works** | **Work address** | **Home phone #**
| | | **Work #**
| | | **Pager #**
| | | **Cellular #**
| | | **Home email**
| | | **Work email** |
| **Where parent # 2 works** | **Work address** | **Home phone #**
| | | **Work #**
| | | **Pager #**
| | | **Cellular #**
| | | **Home email**
| | | **Work email** |

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parents/guardian. During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.

| Parent/Guardian Signature: ____________________________________________ Date _______________ |
| Alternate emergency contact person’s name: ____________________________ Relationship to child: ____________ Phone number: ____________________________ |

| Child’s doctor’s name | Doctor telephone # 1 | Hospital choice |
| Doctor’s address | After hours telephone # | Does your child have health insurance?  □ Yes, Company _____________ ID # |
| Child’s dentist’s name | Dentist Telephone # 1 | Does your child have dental insurance?  □ Yes, Company _____________ ID# |
| Dentist’s Address | After hours telephone # | □ NO, we do not have health insurance. □ NO, we do not have dental insurance. |
| Other health care specialist name | Telephone # | □ Please help us find health or dental insurance. |

Order additional health forms from Healthy Child Care Iowa 1-800-369-2229. Jan. 2008
**Parents Complete This Page**

**Child’s Name:** ___________________________

**Parents:** 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 doctor 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 has had a serious illness, surgery, or injury. **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:**

### Body Health
- □ My child has problems with:
  - Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.
  - Map and describe any skin markings

- □ 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, colic, spitting up
- □ Using toilet, toilet training, urinating
- □ Bones, muscles, movement, pain with moving
- □ Mobility, uses assistive equipment
- □ Nervous system, headaches, seizures, or nervous habits (like twitches)
- □ Needs special equipment. **Please describe:**

### Medication
- □ My child takes medication. List meds taken at home, preschool, or in child care. List the name, time medication taken, and the reason medication prescribed.

### Allergies
- □ My child has allergies (food, medicine, fabric, inhalants, insects, animals, etc.). **Please describe.**

Parent questions or comments for the health care provider:
Child’s Name:  
Birthdate:  Age today:  
Date of Exam:  
Height or Length:  
Weight  
Head Circumference (for children under 2 yr.):  
Body Mass Index (for children over 2 yr.):  
Blood Pressure (start @ age 3 yr.):  
Hgb. or Hct.: (start @ 1 yr.)  
Blood Lead Level: (start @ 1 yr.)  
Sensory Screening:  
Vision Right eye ________  Left eye _________  
Hearing Right ear ________  Left ear _________  
Tympanometry (attach results)  
Developmental Screening:  
Personal-Social  
Fine Motor-Adaptive  
Language  
Gross Motor  
Developmental Referral Made Today: □Yes □No  
Exam Results: (n = normal limits) otherwise describe  
HEENT  
Oral/Teeth  
Date of Last Dental Exam:  
Dental Referral Made Today: □Yes □No  
Heart  
Lungs  
Stomach/Abdomen  
Genitalia  
Extremities, Joints, Muscles, Spine  
Skin, Lymph Nodes  
Neurological  

Immunization: Doctor may attach a copy of Iowa Department of Public Health Immunization Certificate  
DtaP/DTP/Td  
Hepatitis B  
HIB  
Influenza  
MMR  
Pneumococcal  
Polio  
Varicella  
Other  
TB testing (for high risk child only)  
Medication: Physician authorizes the child may receive the following medications while at child care: (include over-the-counter and prescribed)  
Medication Name  Dosage  
Diaper crème:  
Pain reliever:  
Sunscreen:  
Cough medication  
Other Medication should be listed with written instructions for use in child care.  

Referrals made:  
□ Referred to hawk-i today  1-800-257-8563  
Health Provider Assessment Statement:  
□ The child may participate in developmentally appropriate child care/preschool with NO health-related restrictions.  
□ The child may participate in developmentally appropriate child care/preschool with these restrictions:  

Space is available on back page for detailed physician comments or instructions.  

1 Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org
<table>
<thead>
<tr>
<th>Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care</th>
</tr>
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<tbody>
<tr>
<td><strong>Health Provider's Guide</strong></td>
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<tr>
<td></td>
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<tr>
<td>History:</td>
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<tr>
<td>Initial and Interval</td>
</tr>
<tr>
<td>Measurement:</td>
</tr>
<tr>
<td>Height/ Weight</td>
</tr>
<tr>
<td>Head Circumference</td>
</tr>
<tr>
<td>Blood Pressure</td>
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<tr>
<td>Sensory Screen:</td>
</tr>
<tr>
<td>Vision</td>
</tr>
<tr>
<td>Hearing</td>
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<tr>
<td>Developmental Screening</td>
</tr>
<tr>
<td>Complete Unclothed Physical Exam</td>
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<tr>
<td>Lab:</td>
</tr>
<tr>
<td>Hereditary/Metabolic Screen</td>
</tr>
<tr>
<td>Hematocrit or Hemoglobin</td>
</tr>
<tr>
<td>Urinalysis</td>
</tr>
<tr>
<td>Lead Test</td>
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<tr>
<td>Cholesterol Screen</td>
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<tr>
<td>TB test⁵</td>
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<tr>
<td>Immunizations:</td>
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<tr>
<td>Family Guidance:</td>
</tr>
<tr>
<td>Injury Prevention</td>
</tr>
<tr>
<td>Child Car Seat Counseling</td>
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<tr>
<td>Tricycle Helmet Counseling</td>
</tr>
<tr>
<td>Sleep Position Counseling</td>
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<tr>
<td>Nutrition &amp; Physical Activity Counseling</td>
</tr>
<tr>
<td>Violence Prevention</td>
</tr>
<tr>
<td>Child Development Guidance</td>
</tr>
</tbody>
</table>

**Key:**
- ● = to be performed
- S = Subjective, by history
- ◆ = to be performed for at-risk children
- O = Objective, by standard testing
- ➔ = Range in which the task may be completed

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² If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

³ All newborns should receive metabolic screening (e.g. Thyroid, hemoglobinopathies, PKU, galactosemia) during neonatal period.

⁴ Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk. Lead program 1-800-242-2026.

⁵ TB testing for only at-risk children, Iowa TB program 1-800-383-3826. ⁵ Iowa Immunization program 1-800-831-6293.