

Infant, Toddler, Preschool Age – Child Health Exam Form

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PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name		Child's birthdate	Name of center, provider, or preschool
			Telephone #
Parent 1 name		Parent 2 name	
Child home address #1			Telephone # 1
Child home address #2			Telephone #2
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 parent/guardian. ☐ YES ☐ NO

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: _____ Date _____

Alternate emergency contact person's name: _____ **Phone number:** _____

Relationship to child: _____ **Cellular number:** _____

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone #	Does child have health insurance? <input type="checkbox"/> Yes, Company _____ ID #
Child's dentist's name	Dentist Telephone # 1	Does child have dental insurance? <input type="checkbox"/> Yes, Company _____ ID#
Dentist's Address	After hours telephone #	<input type="checkbox"/> NO, we do not have health insurance. <input type="checkbox"/> NO, we do not have dental insurance.
Other health care specialist name	Telephone #	<input type="checkbox"/> Please help us find health or dental insurance.
Type of specialty		

This consent will be in effect beginning (date) _____ and be annually updated by the parent/ legal guardian

Signature Parent/Guardian _____ Date _____
 Update: _____ Date: _____
 Update: _____ Date: _____

Signature Parent/Guardian _____ Date _____
 Update: _____ Date: _____
 Update: _____ Date: _____

PARENTS COMPLETE THIS PAGE

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

☐ 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:

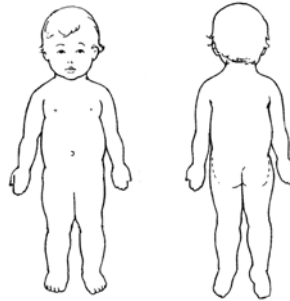
☐ **Medication** - My child takes medication. List the name, time medication taken, and the reason medication prescribed.

Child's Name: _____

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 aides or device, ear-aches, 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:*

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

Please describe:

Parent questions or comments for the health care provider:

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HEALTH PROFESSIONAL COMPLETE THIS PAGE¹

Child's Name: _____

Birthdate: _____ Age today: _____

Date of Exam: _____

Height/Length: _____

Weight: _____

Head Circumference—for children age 2 yr and **under**: _____

Blood Pressure—start @ age 3 yr: _____

Hgb or Hct—anytime between 6-9 mo: _____

Blood Lead Level—start @ 12 mo: _____

Sensory Screening:

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry (may attach results) _____

Developmental Screening²:

Developmental screening results: _____

Autism screening results: _____

Psychosocial/behavioral results _____

Developmental Referral Made Today: ☐ Yes ☐ No

Exam Results: (n = normal limits) otherwise describe

HEENT

Oral/Teeth

Oral Health/Dental Referral Made Today: ☐ Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Space is available on [back page](#) for detailed comments or instructions pertaining to enrollment at child care or preschool.

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

² Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.

Allergies

Environmental: _____

Medication: _____

Food: _____

Insects: _____

Other: _____

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td

MMR

Hepatitis B

Pneumococcal

HIB

Varicella

Polio

Other

Influenza

TB testing (only for high-risk child)

Medication: Health professional authorizes the child may receive the following medications while at child care or preschool: (include over-the-counter and prescribed)

Medication Name

Dosage

☐ Cough medication

☐ Diaper crème:

☐ Fever or Pain reliever:

☐ Sunscreen:

☐ Other

Other Medication should be listed with written instructions for use in child care.

Referrals made:

☐ Referred to **hawk-i** today 1-800-257-8563

☐ Other: _____

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 the following restrictions:**

May use stamp

Signature _____

Circle the Provider Credential Type: MD DO PA ARNP

Address: _____

Telephone: _____

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Health Care Provider comments or instructions:

Child's name: _____

Iowa Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care³

Health Provider's Guide		AGE ⁴											
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr
History:	Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Physical Exam		●	●	●	●	●	●	●	●	●	●	●	●
Measurement:	Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
	Head Circumference	●	●	●	●	●	●	●	●	●			
	Blood Pressure												
Nutrition	Assess/Educate	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health Assessment⁵		●	●	●	●	●	●	●	●	●	●	●	●
Development and Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●
	Developmental Screening					●			●		●		
	Autism Screening								●	●			
	Developmental Surveillance	●	●	●	●		●	●		●		●	●
	Psychosocial/behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screen:	Vision	S	S	S	S	S	S	S	S	S	O	O	O
	Hearing ⁶	S	S	S	S	S	S	S	S	S	S	O	O
Immunizations:	<i>per Iowa schedule⁷</i>	●	●	●	●	●	●	●	●	●	●	●	●
Lab:	Hemoglobinopathy/Metabolic Screen	● ⁸											
	Hematocrit or Hemoglobin					● →		◆					→
	Urinalysis												●
	Lead Test						●		◆	● ⁹	◆	◆	◆
	Cholesterol Screen									◆			→
	TB test ¹⁰						◆						→
Family Guidance:	Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Tricycle Helmet Counseling									●	●	●	●
	Sleep Position Counseling	●	●	●	●	●	●						
	Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr

Key: ● = to be performed

◆ = to be performed for high-risk children

→ = Range in which the task may be completed

S = Subjective, by history

O = Objective, by standard testing

³ The periodicity schedule was revised July 2009 by the Iowa Medicaid EPSDT program. http://www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp

⁴ 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.

⁵ Oral Health Assessment consists of dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; and dental referral based on risk assessment. http://www.idph.state.ia.us/hpcdp/oral_health.asp or toll-free: 866-528-4020.

⁶ Infants born in Iowa should have record of results from newborn hearing screening. <http://www.idph.state.ia.us/iaehdi/default.asp> or toll-free 800-383-3826.

⁷ Iowa Immunization program 1-800-831-6293.

⁸ All newborns should receive metabolic screening during neonatal period. www.idph.state.ia.us/genetics

⁹ Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk.

¹⁰ TB testing for only at-risk children, Iowa TB program 1-800-972-2026.

¹⁰ TB testing for only at-risk children, Iowa TB program 1-800-383-3826.