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– starting at age 24 mo. _____

Head Circumference- age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr:_____

Hgb or Hct- @ 12 mo: _____

Lead Risk Assessment:_____

Blood Lead Level: date_____ results _____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe

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

Date of Dental exam _____

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

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Health Care Provider comments:

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Immunization: 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: Health professional authorizes the child may receive the following medications while at the child care facility: (include *over-the-counter* and *prescribed*)

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 restrictions*** (see comments).

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

May use stamp

Signature _____
Circle the Provider Credential Type: MD DO PA ARNP
Address: Telephone:

[1] 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