

## Infant, Toddler, Preschool Age – Child Health Exam Form

### 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
<p><b>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. <input type="checkbox"/> YES <input type="checkbox"/> NO</b></p> <p><b>During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.</b></p>		
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 child have health insurance? <input type="checkbox"/> Yes, Company _____ <b>ID #</b>
Child's dentist's name	Dentist Telephone # 1	Does child have dental insurance? <input type="checkbox"/> Yes, Company _____ <b>ID#</b>
Dentist's Address	After hours telephone #	<input type="checkbox"/> <b>NO, we do not have health insurance.</b> <input type="checkbox"/> <b>NO, we do not have dental insurance.</b> <input type="checkbox"/> <b>Please help us find health or dental insurance.</b>
Other health care specialist name	Telephone #	
Type of specialty		

Child Name:

**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:*

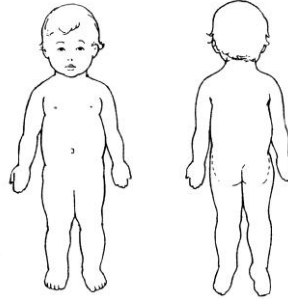
**Medication** - My child takes medication. List the name, time medication taken, and the reason medication prescribed.

**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 (food, medicine, fabric, inhalants, insects, animals, etc.). *Please describe.*

Parent questions or comments for the health care provider:

# Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

## HEALTH PROFESSIONAL COMPLETE THIS PAGE<sup>1</sup>

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 Screening<sup>2</sup>:

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.

<sup>1</sup> 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](http://www.aap.org)

<sup>2</sup> 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.

**Immunization:** 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 (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

### 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: \_\_\_\_\_

## Health Care Provider comments or instructions:

### Iowa Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care<sup>3</sup>

Health Provider's Guide	AGE <sup>4</sup>												
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr	
<b>History:</b> Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●	
<b>Physical Exam</b>	●	●	●	●	●	●	●	●	●	●	●	●	
<b>Measurement:</b> Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●	
Head Circumference	●	●	●	●	●	●	●	●	●				
Blood Pressure											●	●	
<b>Nutrition</b> Assess/Educate	●	●	●	●	●	●	●	●	●	●	●	●	
<b>Oral Health Assessment<sup>5</sup></b>	●	●	●	●	●	●	●	●	●	●	●	●	
<b>Development and Behavioral Assessment</b>	●	●	●	●	●	●	●	●	●	●	●	●	
Developmental Screening					●			●		●			
Autism Screening								●	●				
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	
Psychosocial/behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●	
<b>Sensory Screen:</b> Vision	S	S	S	S	S	S	S	S	S	O	O	O	
Hearing <sup>6</sup>	S	S	S	S	S	S	S	S	S	S	O	O	
<b>Immunizations:</b> <i>per Iowa schedule<sup>7</sup></i>	●	●	●	●	●	●	●	●	●	●	●	●	
<b>Lab:</b> Hemoglobinopathy/Metabolic Screen	● <sup>8</sup>												
Hematocrit or Hemoglobin					● →		◆						
Urinalysis												●	
Lead Test						●		◆	● <sup>9</sup>	◆	◆	◆	
Cholesterol Screen									◆				
TB test <sup>10</sup>						◆							
<b>Family Guidance:</b> 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

<sup>3</sup> 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](http://www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp)

<sup>4</sup> 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.

<sup>5</sup> 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](http://www.idph.state.ia.us/hpcdp/oral_health.asp) or toll-free: 866-528-4020.

<sup>6</sup> 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.

<sup>7</sup> Iowa Immunization program 1-800-831-6293.

<sup>8</sup> All newborns should receive metabolic screening during neonatal period. [www.idph.state.ia.us/genetics](http://www.idph.state.ia.us/genetics)

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

Lead program 1-800-972-2026.

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