School-Age Child Health Form/Parent Statement of Health

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL[1]

Date of Exam: _____

Height: _____ Weight: _____

Body Mass Index: _____,

☐There are weight concerns

☐Referral made to _____

Blood Pressure: _____

Laboratory Screening:

Blood Lead Level: Date_____ ☐ venous ☐ capillary (for child under age 6 yr.) Results _____

Hgb. / Hct: _____

Urinalysis: _____

Sensory Screening

Vision Acuity: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry: Right ear _____ Left ear _____

Exam Results (*N = normal limits) otherwise describe*

Skin:

HEENT:

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:

Neurological:

Developmental Surveillance:

Psychosocial/Behavioral Assessment: (Depression screening starting at age 12)

Allergies:

Environmental
Medication
Food
Insects
Other

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures March 2021) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

[1] Annual physical for school-age is recommended but not required for child care

Child Name: _____

Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed & signed

☐ TB testing completed (only for high-risk child)

Health provider authorizes the child to receive the following medications while at child care or school
(Including *over-the-counter* and *prescribed*)

Medication Name Dosage

☐Fever/Pain reliever:

☐Sunscreen:

☐Cough medication:

☐Other - list all

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Additional Referrals made:

☐ _____

☐ _____

Health Provider 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 complete and give to parent for child care)

Health Care Provider Comments:

May use stamp

Signature _____

Circle the Provider Type: **MD DO PA ARNP**

Address: Telephone:

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PARENT/GUARDIAN (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** _____

Please use an **X** in the box ☐ for statements that apply to your child.

Date of child's last physical exam: _____
Date of last dental appointment: _____

☐ **Growth** - I am concerned about child's growth.

☐ **Appetite** - I am concerned about 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:

Play with friends - My child
☐ Plays well in groups with other children.
☐ Will play only with one or two other children.
☐ Prefers to play alone.
☐ Fights with other children.
☐ I am concerned about my child's play activity with other children. Please describe:

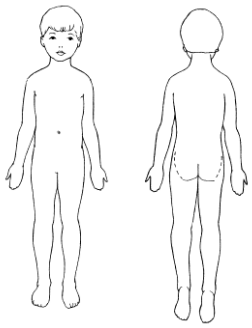
School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

☐ **Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.). List allergies:

☐ **Special Needs Care Plan** - My child has a special need and a care plan for child care. Please discuss with your health care provider.

☐ **Body Health** - My child has problems with skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



☐ Eyes/vision, glasses or contact lenses
☐ Ears/hearing, hearing assistive aides or device, earache, tubes in ears
☐ Nose problems, nosebleeds
☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
☐ Breathing problems, asthma, cough
☐ Heart problems or heart murmur
☐ Stomach aches or upset stomach
☐ Trouble using toilet or accidents
☐ Hard stools, constipation, diarrhea, watery stools
☐ Bones, muscles, movement, pain when moving
☐ Mobility, child uses assistive equipment
☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Females – difficult monthly periods
☐ Other special needs. Please describe:

☐ **Medication**[2] - My child takes medication.
Medication Name Time Given Reason for giving medication

☐ **Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at www.idph.iowa.gov/hcci/products

Parent/Guardian Signature (required)**:** _____ **Date:** _____

[2] Please review the child care program's policies about the use of medication at child care.