Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE –
OR PROVIDE COPY OF WELL CHILD PHYSICAL

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

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____

Date of Birth: _____ Age: _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

☐ 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

Additional Referrals made:

☐ _____
☐ _____

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 complete and give to parent for child care)

Comments:

May use stamp

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

Address: Telephone:

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

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

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 health care provider 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.

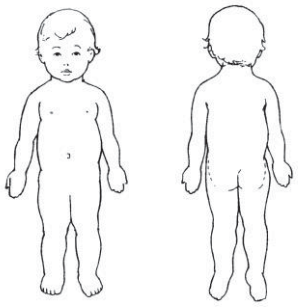
Please describe:

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

Please describe:

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

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 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, spitting-up
☐ Using toilet, toilet training, urinating
☐ Bones, muscles, movement, pain when moving, uses assistive equipment.
☐ Nervous system, headaches, seizures, or nervous habits (like twitches)
☐ Needs special equipment.

List equipment:

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

Parent/Guardian questions or comments for the health care provider:

Parent/Guardian Signature Date: