

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

### PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name	Child's birthdate	Child Care Facility _____ Telephone # _____
Parent/Guardian name #1	Parent/Guardian name #2	
Child home address #1	Telephone # 1	
Child home address #2	Telephone #2	
Where parent/guardian # 1 works	Work address	Home phone # Work # Cellular # Home email Work email
Where parent /guardian # 2 works	Work address	Home phone # Work # 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 facility 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 cannot be reached.</b>                  Parent/Guardian Signature: _____ Date _____                  Alternate emergency contact person's name: _____ Phone # _____                  Relationship to child: _____ Cellular # _____</p>		
Child's doctor's name	Doctor telephone # 1	Hospital choice  <b>Phone #</b> _____
Doctor's address	After hours telephone #	Does child have health insurance? <input type="checkbox"/> Yes, Company _____ <b>ID #</b>
Child's dentist's name (or family's dentist 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>
Other health care specialist name	Telephone #	<input type="checkbox"/> <b>Please help us find health or dental insurance.</b>
Type of specialty		

Child 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.).

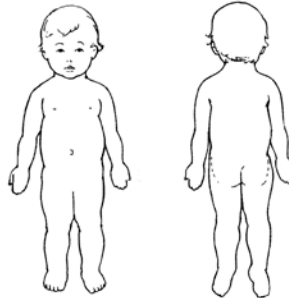
Please describe:

**Special Needs Care Plan** – My child has a special needs care plan (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.). **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 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, 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:

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### 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:

Vision 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
<input type="checkbox"/> Diaper crème:	
<input type="checkbox"/> Fever or Pain reliever:	
<input type="checkbox"/> Sunscreen:	
<input type="checkbox"/> Other	



Other Medication should be listed with written instructions for use in child care. Medication forms available at [www.idph.iowa.gov/hcci/products](http://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: \_\_\_\_\_

<sup>1</sup> 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](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)

