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

HEALTH PROFESSIONAL COMPLETE THIS PAGE

Child’s Name: __________________________

Birthdate: __________________ Age today: ____________

Date of Exam: ____________

Height/Length: __________________

Weight: __________________

Head Circumference—(for children age 2 yr and under):

Blood Pressure—(at age 3 yr):

Hgb or Hct—(anytime between 6-9 mo):

Blood Lead Level—(at 12 mo):

Sensory Screening:

Vision: Right eye ______ Left eye _______

Hearing: Right ear ______ Left ear _______

Tympanometry (may attach results)

Developmental Screening:

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

Allergies

Environmental:

Medication:

Food:

Insects:

Other:

Immunization: May attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td

MMR

Hepatitis B

Pneumococcal

HIB

Varicella

Polio

Other

Influenza

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

☐ 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

☐ Other: ____________________________

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 ____________________________

1 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

2 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.