

School-Age Child Health Form/Parent Statement of Health

HEALTH PROFESSIONAL COMPLETE PAGE
OR PROVIDE COPY OF WELL CHILD PHYSICAL¹

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*)

<u>Medication Name</u>	<u>Dosage</u>
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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: _____

School-Age Child Health Form/Parent Statement of Health

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

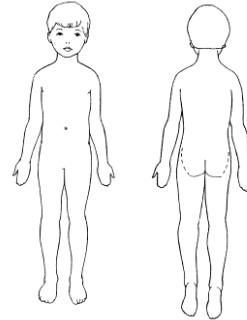
- Is doing well at school.
- Is having difficulty in some classes.
- Does not want to go to school.
- Frequently misses or is late for school.
- I am concerned about how my child is doing in school. Please describe:

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:

Medication² - 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.