Infant, Toddler, Preschool Age (including Kindergarten entry) **– Child Health Form**

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)

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