

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 July 2022) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.241-822402.1525543973.1674849857-346854326.1661880588

¹ Annual physical for school-age is recommended but not required

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 while at child care or school (Include over-the-counter medications)

- | | <u>Name</u> | <u>Dosage</u> |
|--------------------------|----------------------|---------------|
| <input type="checkbox"/> | Fever/Pain reliever: | |
| <input type="checkbox"/> | Sunscreen: | |
| <input type="checkbox"/> | Cough medication: | |
| <input type="checkbox"/> | Other: | |

Prescribed medication should be listed with written instructions for use in child care. Medication forms available at <https://hhs.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 templates at <https://hhs.iowa.gov/hcci/products>)

Health Care Provider Comments:

May use stamp

Signature _____

Circle Provider Type: MD DO PA ARNP Chiropractor

Address: _____ Telephone: _____

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: _____

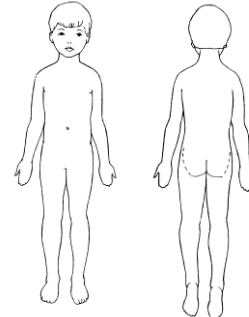
- Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.).

List allergies: _____

- Body Health** - My child has problems with skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars.

Draw below where these marks/scars are located.



- 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 <https://hhs.iowa.gov/hcci/products>

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

Parent/Guardian Signature **(required)** _____ Date: _____

² Please review the child care program's/school policies about the use of medication.