

School-Age Child Health Form/Parent Statement of Health

Parent/Guardian please complete pages 1 and 2.

Child's name		Child's birthdate	Name of school
			Grade ____ School 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	Telephone # Work # Cellular # Home email Work email	
Where parent/guardian #2 works	Work address	Telephone # Work # Cellular # Home email Work email	
<p>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. YES NO</p> <p>During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.</p> <p>Parent/Guardian Signature: _____ Date _____</p> <p>Alternate emergency contact person's name: _____ Phone # _____</p> <p>Relationship to child: _____ Cellular # _____</p>			
Child's Doctor's name	Doctor telephone #1	Hospital of choice	
<input type="checkbox"/> Child does not have doctor		Phone # _____	
Doctor's address	After hours telephone #	Does your child have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Company _____ ID#	
Child's Dentist's name	Dentist telephone #1	Does your child have dental insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO Company _____ ID#	
Dentist's address	After hours telephone #	<input type="checkbox"/> HELP us find a family doctor or dentist <input type="checkbox"/> HELP us find health or dental insurance	
Other health care/mental health specialist name	Telephone #		
Type of specialty			

Child Name: _____

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Parent/Guardian complete this page

Please use an **X** in the box to 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.

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:

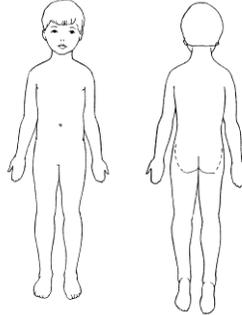
Special Needs Care Plan - My child has a special needs care plan (IEP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.

Child name: _____

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

Frequent sore throats or tonsillitis

Breathing problems, asthma, cough

Heart problems or heart murmur

Stomach aches or upset stomach

Trouble using toilet or wetting 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:

Medication¹ - My child takes medication.

Medication Name	Time Given	Reason for giving medication

Child has Epipen, inhaler, or other emergency medication.

Yes No

Parent Signature:
(required)

Date:

¹ Parents: Please review the child care program's policies about the use of medication at child care.
HCCI July 2016

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HEALTH PROFESSIONAL COMPLETE PAGE

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: _____

TB testing (high risk child only) _____

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:

Psychosocial/Behavioral Assessment (Depression screening starting at age 11)

Allergies

Environmental
Medication
Food
Insects
Other

Health Care Provider Comments:

Child Name: _____

Date of Birth: _____ Age: _____

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

Health provider authorizes the child to receive the following medications while at child care or school
(Including *over-the-counter* and *prescribed*)

Medication Name	Dosage
<input type="checkbox"/> Fever/Pain reliever:	
<input type="checkbox"/> Sunscreen:	
<input type="checkbox"/> Cough medication:	
<input type="checkbox"/> 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

Referrals made:

Referred to hawk-i today 1-800-257-8563

Other: _____

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 attach)

Signature _____
Provider Type (circle) MD DO PA ARNP

Address: *May use stamp* Telephone: _____

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

