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

**HEALTH PROFESSIONAL COMPLETE THIS PAGE**[1]

**Child's Name:**_____

**Birthdate:** **Age today:**

**Date of Exam:**_____

Height/Length:

Weight:

Head Circumference-for children age 2 yr and under:

Blood Pressure-start @ age 3 yr:

Hgb or Hct-anytime between 6-9 mo:

Blood Lead Level-start @ 12 mo:

## Sensory Screening:

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry (may attach results)

## Developmental Screening[2]:

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

**Space is available on back page for detailed comments or instructions pertaining to enrollment at child care or preschool.**

## 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 pre-school: (include over-the-counter and prescribed)*

Medication Name Dosage

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.