Infant, Toddler, Preschool Age – Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE –
OR PROVIDE COPY OF WELL CHILD PHYSICAL

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:

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

PARENT/GUARDIAN COMPLETE THIS PAGE

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

Growth

☐ I am concerned about my child's growth.

Appetite

☐ I am concerned about my child's eating/ feeding habits or appetite.

Rest -

☐ I am concerned about the amount of sleep my child needs.

Illness/Surgery/Injury - My child

☐ had a serious illness, injury, or surgery.

Please describe:

Physical Activity - My child

☐ must restrict physical activity.

Please describe:

Development and Learning

☐ I am concerned about my child's behavior, development, or learning.

Please describe:

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

Please describe:

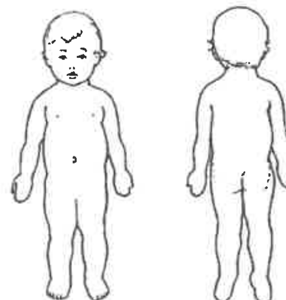
☐ **Special Needs Care Plan** – My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

Child's Name: ______________________

Body Health - My child has problems with

☐ Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings birthmarks, scars, moles



☐ Eyes \ vision, glasses

☐ Ears \ hearing, hearing aids or device, earaches, tubes in ears

☐ Nose problems, nosebleeds, runny nose

☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring

☐ Frequent sore throats or tonsillitis

☐ Breathing problems, asthma, cough, croup

☐ Heart, heart murmur

☐ Stomach aches, upset stomach, spitting-up

☐ Using toilet, toilet training, urinating

☐ Bones, muscles, movement, pain when moving, uses assistive equipment.

☐ Nervous system, headaches, seizures, or nervous habits (like twitches)

☐ Needs special equipment.

List equipment:

☐ **Medication** - My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed).

Parent/Guardian questions or comments for the health care provider:

Parent/Guardian Signature Date: