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

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

During an emergency the child care provider is authorized to contact the following person when parent or guardian cannot be reached.

Parent/Guardian Signature: _____ **Date** _____

Alternate emergency contact person's name: _____ **Phone #** _____
Relationship to child: _____ **Cellular #** _____

Child's **Doctor's** name ☐ Child does not have doctor	Doctor telephone #1	**Hospital of choice** Phone #_____
Doctor's address	After hours telephone #	Does your child have health insurance? ☐ YES ☐NO Company _____ **ID#**
Child's **Dentist's** name ☐ Child does not have dentist	Dentist telephone #1	Does your child have dental insurance? ☐ YES ☐NO Company _____ **ID#**
Dentist's address	After hours telephone #	☐ **HELP us find a family doctor or dentist** ☐ **HELP us find health or dental insurance**
Other health care/mental health specialist name **Type of specialty**	Telephone #	

Child Name: _____

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Parent/Guardian complete this page

Child name: _____

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:

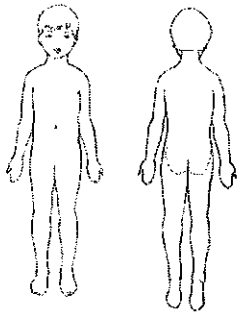
☐ **Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.). List allergies:

☐ **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.

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:

☐ **Medication**[1] - 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.

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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
☐Fever/Pain reliever:	
☐Sunscreen:	
☐Cough medication:	
☐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: _____ 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