

## Infant, Toddler, Preschool Age – Child Health Form

**HEALTH PROFESSIONAL COMPLETE THIS PAGE**

**Child's Name:** \_\_\_\_\_

**Birthdate:** \_\_\_\_\_ **Age today:** \_\_\_\_\_

**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:**

**Vision 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

Health Care Provider comments:

**Allergies**

Environmental:
Medication:
Food:
Insects:
Other:

**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.

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
<input type="checkbox"/> Diaper crème:	
<input type="checkbox"/> Fever or Pain reliever:	
<input type="checkbox"/> Sunscreen:	
<input type="checkbox"/> Other	

Other Medication should be listed with written instructions for use in child care. Medication forms available at [www.idph.iowa.gov/hcci/products](http://www.idph.iowa.gov/hcci/products)

**Referrals made:**

- Referred to **hawk-i** today 1-800-257-8563
- Other: \_\_\_\_\_

**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 attach)

May use stamp

**Signature** \_\_\_\_\_  
**Circle the Provider Credential Type:** MD DO PA ARNP  
 Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

<sup>1</sup> Iowa Child Care Regulations require an admission physical exam report within the previous year and annually. 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](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)