

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

DOCTORS COMPLETE THIS PAGE¹

Child's Name: _____

Birthdate: _____ Age today: _____

Date of Exam: _____

Height or Length: _____

Weight _____

Head Circumference (for children under 2 yr.): _____

Body Mass Index (for children over 2 yr.): _____

Blood Pressure (start @ age 3 yr.): _____

Hgb. or Hct.: (start @ 1 yr.) _____

Blood Lead Level: (start @ 1 yr.) _____

Sensory Screening:

Vision Right eye _____ Left eye _____

Hearing Right ear _____ Left ear _____

Tympanometry (attach results)

Developmental Screening:

Personal-Social

Fine Motor-Adaptive

Language

Gross Motor

Developmental Referral Made Today: Yes No

Exam Results: (*n = normal limits*) otherwise describe

HEENT

Oral/Teeth

Date of Last Dental Exam: _____

Dental Referral Made Today: Yes No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Immunization: Doctor may attach a copy of Iowa Department of Public Health Immunization Certificate

DtaP/DTP/Td _____

Hepatitis B _____

HIB _____

Influenza _____

MMR _____

Pneumococcal _____

Polio _____

Varicella _____

Other _____

TB testing (for high risk child only)

Medication: Physician authorizes the child may receive the following medications while at child care: (include over-the-counter and prescribed)

Medication Name

Dosage

Diaper crème: _____

Pain reliever: _____

Sunscreen: _____

Cough medication _____

Other Medication should be listed with written instructions for use in child care.

Referrals made:

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

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 these restrictions:**

Doctor 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

Health Care Provider comments or instructions:

Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care

Health Provider's Guide	AGE ²											
	1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	24 mo	3 yr	4 yr	5 yr
History: Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Measurement: Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●			
Blood Pressure										●	●	●
Sensory Screen: Vision	S	S	S	S	S	S	S	S	S	O	O	O
Hearing	O	S	S	S	S	S	S	S	S	S	O	O
Developmental Screening	●	●	●	●	●	●	●	●	●	●	●	●
Complete Unclothed Physical Exam	●	●	●	●	●	●	●	●	●	●	●	●
Lab: Hereditary/Metabolic Screen	● ³											
Hematocrit or Hemoglobin					●	→	◆	→				→
Urinalysis												●
Lead Test						●		◆	● ⁴	◆	◆	◆
Cholesterol Screen									◆			→
TB test ⁵						◆						→
Immunizations: <i>per Iowa schedule</i> ⁶	●	●	●	●	●	●	●	●	●	●	●	●
Family Guidance: Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Tricycle-Helmet Counseling									●	●	●	●
Sleep Position Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●

Key: ● = to be performed
 ◆ = to be performed for at-risk children
 → = Range in which the task may be completed
 S = Subjective, by history
 O = Objective, by standard testing

² If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

³ All newborns should receive metabolic screening (e.g. Thyroid, hemoglobinopathies, PKU, galactosemia) during neonatal period.

⁴ Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk.

Lead program 1-800-242-2026.

⁵ TB testing for only at-risk children, Iowa TB program 1-800-383-3826. ⁶ Iowa Immunization program 1-800-831-6293.