

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

HEALTH PROFESSIONAL COMPLETE THIS PAGE¹

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 Screening²:

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.

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.

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 preschool: (include over-the-counter and prescribed)

Medication Name	Dosage
<input type="checkbox"/> Cough medication	
<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.

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: _____