IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parents please complete pages 1 and 2.

Child's name	Child's birthdate	Name of school Grade School Telephone #

Parent #1 name	Parent #2 name

Child home address #1	Telephone # 1
Child home address #2	Telephone # 2

Where parent #1 works	Work address	Telephone # Work # Pager # Cellular # Home email Work email
Where parent #2 works	Work address	Telephone # Work # Pager # Cellular # Home email Work email

Child Name:

In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parents/guardian. And, during an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.

Parent/Guardian Signature: _____ Date _____

Alternate emergency contact person's name: Relationship to child: Phone number:

Child's doctor's name	Doctor telephone #1	Hospital of choice
Doctor's address	After hours telephone #	Does your child have health insurance? ☐ Yes, Company _____ **ID#**
Child's dentist's name	Dentist telephone #1	Does your child have dental insurance? ☐ Yes, Company _____ **ID#**
Dentist's address	After hours telephone #	☐ **We do not have health insurance.** ☐ **We do not have dental insurance.** ☐ **Help us find insurance.**
Other medical or dental specialist name **Type of specialty**	Telephone #	Specialist address:
Mental Health care specialist	Telephone #	Specialist address:

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Parents complete this page

Please use a checkmark in the box ☐ to all the sentences that apply to your child.

Date of child's last physical exam: _____

Growth
☐ I am concerned about my child's growth.

Appetite
☐ I am concerned about my child's eating habits.

Rest - My child
☐ May need to rest or sleep 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.

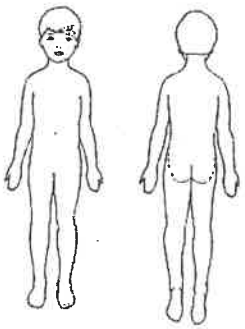
School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

☐ **Allergy** - My child has allergies (list any allergies to food, medicine, fabric, inhalants, insects, animals, etc.):

Child has Epipen, inhaler, or other emergency medication.
☐ Yes ☐ No

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, 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 moving
☐ Mobility, uses assistive equipment _____
☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Female monthly periods
☐ Other special needs. Please describe:

☐ **Medication**[1] - My child takes medication.
Medication Name Time Given Reason for giving medication

Note to parents: **Certificate of Immunization**
School-owned and operated child care programs located on school property may file/store your child's Certificate of Immunization in the school office or in the school nurse's office. All other school-age child care programs must keep the Certificate of Immunization on-site at the child care facility not off-site.

Parent Signature: (required)

[1] Please review the child care program policies about the use of medication while your child is at the program.

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Doctors complete the **Physical Exam Form***

Date of Physical Exam:

Height: _____ Weight: _____

Body Mass Index: _____,

☐ There are weight concerns and

☐ Referral made to _____

Blood Pressure:

Laboratory Screening:

Blood Lead Level: _____ ☐ venous ☐ capillary (for child under age 6 yr)

Hgb. / Hct:

Urinalysis:

TB testing (high risk child only)

Sensory Screening

Vision: 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 Exam by Dentist: _____ or ☐ None to date.
Dental Referral Made Today ☐ Yes ☐ No

Heart:

Lungs:

Stomach/Abdomen:

Genitalia:

Extremities, Joints, Muscles, Spine:

Neurological:

Other Notes:

Child Birthdate: **Age:**

Vaccines given Today:
Vaccines entered into IRIS database. ☐ Yes ☐ No

DtaP/DTP/Td
HEP B
HIB
Influenza
MMR
Pneumococcal
Polio
Varicella
Other

Referrals made Today:

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

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
Pain reliever:	
Sunscreen:	
Cough medication:	

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)

Signature _____
Provider Type (circle) MD DO PA ARNP

Address: May use stamp

Telephone:

* Iowa Child Care regulations require an annual parent statement about the child's health. Parents obtaining a physical exam are asked to have their family doctor or clinic use this form.

January 2008

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parents: A physical exam for school-age children enrolled in child care is not required every year. However, school-age children need to continue to receive health care to prevent illness and to identify potential health problems. The following guide will help you and your child prepare for a thorough physical exam with your family doctor. If you do not have a family doctor, please call the Healthy Families Line (**1-800-369-2229**) to locate a health care provider near you.

Iowa Recommendations for Preventive Health Care – School-Age Youth

Health Provider Guide		5 yr.	6yr.	8 yr.	10 yr.	12 yr.	14 yr.	16 yr.
History:	Initial and Interval	●	●	●	●	●	●	●
Measurement:	Height/ Weight and Body Mass Index	●	●	●	●	●	●	●
	Blood Pressure	●	●	●	●	●	●	●
Nutrition: Assessment/ education for food intake and physical activity		●	●	●	●	●	●	●
Development/School Achievement:	Screening or questionnaire	●	●	●	●	●	●	●
Mental Health / Mood:	Screening questionnaire	●	●	●	●	●	●	●
Sensory Screen: (This screening may be completed at school or in child care)	Vision	I	I	I	●	I	I	●
	Hearing	I	●	●	●	I	●	●
Oral Health assessment: dental history, recent concerns, pain or injury, visual inspection or oral cavity		●	●	●	●	●	●	●
	Dental exam	Dentist exam or refer to dentist every 6 months						
PHYSICAL EXAM		●	●	●	●	●	●	●
Lab tests:	Hematocrit or Hemoglobin and (hemoglobinopathy for adolescents at risk)	●				◄	●	►
	Urinalysis	●				◄	●	►
	Lead Test[2]	●						
	Cholesterol Screen	◆						
	STD Screen and Genital or Pelvic Exam[3]						◆	►
	TB test[4]	◆	►	►	►	►	►	►
Immunizations:	*per Iowa schedule*[5]	●	●	●	●	●	●	●
Family Guidance:	Injury Prevention	●	●	●	●	●	●	●
	Seat Belt Use	●	●	●	●	●	●	●
	Bike Helmet Use	●	●	●	●	●	●	●
	Violence Prevention[6]	●	●	●	●	●	●	●
	Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●
	STD and Pregnancy Prevention for males and females[7]	●	●	●	●	●	●	●

Key: ● To be performed I = Interview parent or child ◆ =Done for at risk children
►Arrow indicates range which item may be completed

[2] Lead testing Iowa Lead Testing program 1-800-242-2026.
[3] Sexually active youth should be screened.
[4] TB testing for at-risk children Iowa TB program 1-800-383-3826.
[5] Immunization per schedule Iowa Immunization 1-800-831-6293.
[6] All families to receive domestic and youth violence prevention. CALL TEENLINE 1-800-443-8336 (operates 24/7).
[7] All youth to have access to STD and pregnancy prevention services. CALL TEENLINE 1-800-443-8336.