School-Age Child – 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's 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 my child's growth.

☐ **Appetite**. I am concerned about my 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:

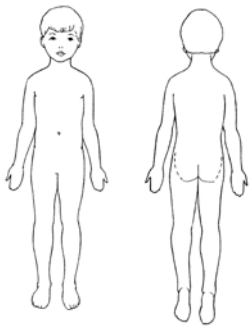
☐ **Allergy**. My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.)

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 aids or device, earache, tubes in ears
☐ Nose problems, nosebleeds
☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breathes 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**. My child takes medication. **Parents**: Please review the child care program's policies about the use of medication at child care.

Medication Name	Time Given	Reason for Giving Medication

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

Parent signature (required)	Date

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Health professional complete this 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 years)

Results:_____

Hgb or 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's name:_____

Date of birth:_____ **Age:**_____

Immunizations 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

Medication

Health provider authorizes the child to receive the following medications while at child care or school. (Include 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 Assessment 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:_____

May use stamp.

Check the provider type:

☐ 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

Recommendations for Preventive Pediatric Health Care – School-Age Child

Bright Futures/American Academy of Pediatrics

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. Developmental, p children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of ca the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in Bright Futures guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures Guidelines and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be

		MIDDLE CHILDHOOD						ADOLESCEN					
	AGE[1]	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y
HISTORY:	Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS:	Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●
	Head Circumference												
	Weight for Length												
	Body Mass Index[5]	●	●	●	●	●	●	●	●	●	●	●	●
	Blood Pressure[6]	●	●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING:	Vision[7]	●	●	✱	●	✱	●	✱	●	✱	✱	●	✱
	Hearing	●	●	✱	●	✱	●	✱	✱	✱	✱	✱	✱
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:													
	Developmental Screening[9]												
	Autism Screening[10]												
	Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●
	Psychosocial/Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
	Alcohol and Drug Use Assessment[11]							✱	✱	✱	✱	✱	✱
	Depression Screening[12]							●	●	●	●	●	●
	PHYSICAL EXAMINATION[13]	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES[14]**:**	Newborn Blood Screening[15]												
	Critical Congenital Heart Defect Screening[16]												
	Immunization[17]	●	●	●	●	●	●	●	●	●	●	●	●
	Hematocrit or Hemoglobin[18]	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱
	Lead Screening[19]	✱	✱										
	Tuberculosis Testing[21]	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱	✱
	Dyslipidemia Screening[22]		✱		✱	←———	●	——→	✱	✱	✱	✱	✱
	STI/HIV Screening[23]							✱	✱	✱	✱	✱	←——
	Cervical Dysplasia Screening[24]												
	ORAL HEALTH[25]		●										
	Fluoride Varnish[26]	——→											
	ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●

KEY: ● = to be performed ● or ✱ = risk assessment to be performed with appropriate action to follow, if positive ←——● ——→ = range during whic

See pages 131 and 132 for footnotes.