IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parent/Guardian 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

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. ☐ YES ☐NO

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 ☐NO Company _____ **ID#**
Child's dentist's name	Dentist telephone #1	Does your child have dental insurance? ☐ YES ☐NO Company _____ **ID#**
Dentist's address	After hours telephone #	☐ **Please help us find health or dental insurance.** Call: 800-257-8563
Other medical or dental specialist name **Type of specialty**	Telephone #	Specialist address:
Mental Health care specialist	Telephone #	Specialist address:

Child Name:

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parent/Guardian complete this page

Child name: _____

Please use a **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 child's growth.

Appetite
☐ I am concerned about 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.

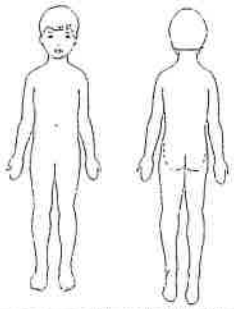
School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

☐ **Allergy** - My child has allergies (list all allergies: 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 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
Please describe

☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Females – difficult 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.

Parent Signature: (required) **Date:**

[1] Parents: Please review the child care program's policies about the use of medication at child care.

Iowa Department of Public Health
Certificate of Immunization

Name Last: _____ First: _____ Middle: _____ Date of Birth: _____

Parent/Guardian: _____ Address: _____ Phone: (____) _____

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.

Signature: _____ Date: _____
Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

	Vaccine	Date Given	Doctor / Clinic / Source
Diphtheria, Tetanus, Pertussis *DTaP/DTP/DT/ Td/Tdap*			
Polio *IPV/OPV*			
Measles, Mumps, Rubella *MMR*			
***Haemophilus influenzae* type b** *Hib*			
Hepatitis B			
Varicella Chicken Pox If applicant has a history of natural disease write "Immune to Varicella"			
Pneumococcal *PCV/PPV*			

	Vaccine	Date Given	Doctor / Clinic / Source
Meningococcal *MCV4/MPSV4*			
Hepatitis A			
Rotavirus			
Human Papilloma Virus *HPV*			
Other			

Licensed Child Care Requirements

4 through 5 months
1 dose Diphtheria/Tetanus/Pertussis
1 dose Polio
1 dose Hib
1 dose Pneumococcal

6 through 11 months
2 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib
2 doses Pneumococcal

12 through 18 months
3 doses Diphtheria/Tetanus/Pertussis
2 doses Polio
2 doses Hib or 1 dose received at ≥ 15 months of age.
3 doses Pneumococcal if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

19 through 23 months
4 doses Diphtheria/Tetanus/Pertussis
3 doses Polio
3 doses Hib with the final dose in the series ≥ 12 months of age, or 1 dose received ≥ 15 months of age.
1 dose Measles/Rubella ≥ 12 months of age.
1 dose Varicella ≥ 12 months of age if born on or after September 15, 1997, or a reliable history of natural disease.
4 doses Pneumococcal; or 3 doses if received 1 or 2 doses < 12 months of age; or 2 doses if received 1 dose ≥ 12 months of age or has not received this vaccine before.

24 months and older
Same requirements as the 19-23 months except 4 doses Pneumococcal if received 3 doses < 12 months of age; or 3 doses if received 2 doses < 12 months of age; or 2 doses if received 1 dose < 12 months of age or received 1 dose between 12 and 23 months of age; or 1 dose if no doses had been received prior to 24 months of age.

Elementary/Secondary School Requirements

4 years of age and older
5 doses Diphtheria/Tetanus/Pertussis with at least 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 4 doses, with 1 dose received ≥ 4 years of age if born after September 15, 2000, but before September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2000.
4 doses Polio with 1 dose received ≥ 4 years of age if born on or after September 15, 2003; or 3 doses, with 1 dose received ≥ 4 years of age if born on or before September 15, 2003.
2 doses Measles/Rubella; the first dose shall have been received ≥ 12 months of age; the second dose shall have been received ≥ 28 days after the first.
3 doses Hepatitis B if born on or after July 1, 1994.
2 doses Varicella ≥ 12 months of age if born on or after September 15, 2003; or 1 dose received ≥ 12 months of age if born on or after September 15, 1997, but before September 15, 2003, unless the applicant has a reliable history of natural disease.

Rev. 12/2008

Infant, Toddler, Preschool Age – Child Health Form

PARENTS/GUARDIAN (Complete pages 1 and 2 – Child Information)

Child's name	Child's birthdate	Child Care Facility: 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	Home phone # Work # Cellular # Home email Work email
Where parent/Guardian # 2 works	Work address	Home phone # 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	Doctor telephone # 1	Hospital choice: **Phone #:**
Doctor's address	After hours telephone #	Does child have health insurance? ☐ Yes, Company: **ID #:**
Child's dentist's name (or family's dentist name)	Dentist telephone # 1	Does child have dental insurance? ☐ Yes, Company: **ID #:**
Dentist's address	After hours telephone #	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.** ☐ **Please help us find health or dental insurance.**
Other health care specialist name Type of specialty	Telephone #	

Child Name:

Infant, Toddler, Preschool Age – Child Health Form

PARENTS/GUARDIAN **Complete this page.** **Child's name:**_____

Tell us about your child's health. Place an **X** in the box ☒ if the sentence applies to your child. Check *all* that apply to your child. This will help your health care provider plan your child's physical exam.

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

☐ **Appetite.** I am concerned about my child's eating/ feeding habits or appetite.

☐ **Rest.** I am concerned about the amount of sleep my child needs.

☐ **Illness/Surgery/Injury.** My child had a serious illness, injury or surgery.

Please describe:

☐ **Physical Activity.** My child must restrict physical activity.

Please describe:

☐ **Development and Learning.** I am concerned about my child's behavior, development or learning.

Please describe:

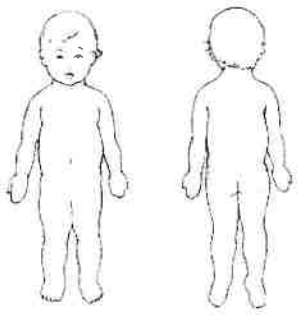
☐ **Allergies.** My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.)

Please describe:

☐ **Special Needs Care Plan.** My child has a special needs care plan. (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.) **Please discuss with your health care provider.**

☐ **Body Health.** My child has problems with skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe color/shape of skin markings, birthmarks, scars, moles



☐ Eyes\vision, glasses

☐ Ears\hearing, hearing aids or device, earaches, tubes in ears

☐ Nose problems, nosebleeds, runny nose

☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring

☐ Frequent sore throats or tonsillitis

☐ Breathing problems, asthma, cough, croup

☐ Heart, heart murmur

☐ Stomach aches, upset stomach, spitting-up

☐ Using toilet, toilet training, urinating

☐ Bones, muscles, movement, pain when moving, uses assistive equipment

☐ Nervous system, headaches, seizures or nervous habits (like twitches)

☐ Needs special equipment

List equipment:

☐ **Medication.** My child takes medication. (List the name of medication, time medication taken, and the reason medication prescribed.)

Parent/Guardian questions or comments for the health care provider:

HEALTH PROFESSIONAL COMPLETE THIS PAGE[1]

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 Screening[2]:

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
☐ Cough medication	
☐ Diaper crème:	
☐ Fever or Pain reliever:	
☐ Sunscreen:	
☐ 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:

Health Care Provider comments or instructions: **Child's name:** _____

Iowa Health Care Provider -- Guide to Iowa Recommendations for Preventive Pediatric Health Care[3]

Health Provider's Guide		AGE[4]											
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr
History:	Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●
Physical Exam		●	●	●	●	●	●	●	●	●	●	●	●
Measurement:	Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●
	Head Circumference	●	●	●	●	●	●	●	●	●			
	Blood Pressure	Risk Assessment									●	●	●
Nutrition	Assess/Educate	●	●	●	●	●	●	●	●	●	●	●	●
Oral Health Assessment[5]		●	●	●	●	●	●	●	●	●	●	●	●
Development and Behavioral Assessment		●	●	●	●	●	●	●	●	●	●	●	●
	Developmental Screening					●			●		●		
	Autism Screening								●	●			
	Developmental Surveillance	●	●	●	●		●	●		●		●	●
	Psychosocial/behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●
Sensory Screen:	Vision	S	S	S	S	S	S	S	S	S	O	O	O
	Hearing[6]	S	S	S	S	S	S	S	S	S	S	O	O
Immunizations:	*per Iowa schedule*[7]	●	●	●	●	●	●	●	●	●	●	●	●
Lab:	Hemaglobinopathy/Metabolic Screen	●[8]											
	Hematocrit or Hemoglobin					●→		◆ →					
	Urinalysis												●
	Lead Test						●		◆	●[9]	◆	◆	◆
	Cholesterol Screen									◆ →			
	TB test[10]						◆	→					
Family Guidance:	Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Car Seat Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Tricycle Helmet Counseling									●	●	●	●
	Sleep Position Counseling	●	●	●	●	●	●						
	Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●
	Violence Prevention	●	●	●	●	●	●	●	●	●	●	●	●
	Child Development Guidance	●	●	●	●	●	●	●	●	●	●	●	●
		1 mo	2 mo	4 mo	6 mo	9 mo	12 mo	15 mo	18 mo	2 yr	3 yr	4 yr	5 yr

Key: ● = to be performed
◆ = to be performed for high-risk children
→ = Range in which the task may be completed

S = Subjective, by history
O = Objective, by standard testing

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[3] The periodicity schedule was revised July 2009 by the Iowa Medicaid EPSDT program. http://www.idph.state.ia.us/hpcdp/epsdt_care_for_kids.asp

[4] 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.

[5] Oral Health Assessment consists of dental history; recent concerns, pain or injury; visual inspection of hard and soft tissues of oral cavity; and dental referral based on risk assessment. http://www.idph.state.ia.us/hpcdp/oral_health.asp or toll-free: 866-528-4020.

[6] Infants born in Iowa should have record of results from newborn hearing screening. http://www.idph.state.ia.us/iaehdi/default.asp or toll-free 800-383-3826.

[7] Iowa Immunization program 1-800-831-6293.

[8] All newborns should receive metabolic screening during neonatal period. www.idph.state.ia.us/genetics

[9] Lead testing should be done at 12 & 24 months. Testing may be done at additional times for children determined at risk.
Lead program 1-800-972-2026.

[10] TB testing for only at-risk children, Iowa TB program 1-800-383-3826.