IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

***Health Professional's* Physical Exam Findings** *

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 Dentist Exam: __________ or ☐ None to date.
Dental Referral Made Today ☐ Yes ☐ No

Heart:

Lungs:

Stomach/Abdomen:

Genitalia:

Extremities, Joints, Muscles, Spine:

Neurological:

Other Notes:

Child Name: ______________________________
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
☐Fever/Pain reliever:	
☐Sunscreen:	
☐Cough medication:	
☐Other - list all	

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.

July 2009