

Infant, Toddler, Preschool Age – Child Health Exam Form

CHILD INFORMATION

Parents complete this page.

Child's name	Child's birthdate	Name of center, provider, or preschool
		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	Home phone # Work # Pager # Cellular # Home email Work email
Where parent # 2 works	Work address	Home phone # 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. 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 choice
Doctor's address	After hours telephone #	Does your child have health insurance? <input type="checkbox"/> Yes, Company _____ ID #
Child's dentist's name	Dentist Telephone # 1	Does your child have dental insurance? <input type="checkbox"/> Yes, Company _____ ID#
Dentist's Address	After hours telephone #	<input type="checkbox"/> NO, we do not have health insurance. <input type="checkbox"/> NO, we do not have dental insurance.
Other health care specialist name	Telephone #	<input checked="" type="checkbox"/> Please help us find health or dental insurance.
Type of specialty		

Child Name: _____

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Parents complete this page.

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.

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

has had a serious illness, surgery, or injury. *Please describe.*

Physical Activity - My child

must restrict physical activity. *Please describe.*

Development and Learning

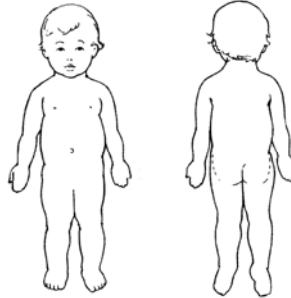
I am concerned about my child's behavior, development, or learning. *Please describe:*

Medication - My child takes medication. List meds taken at home, preschool, or in child care. List the name, time medication taken, and the reason medication prescribed.

Body Health - My child has problems with

Skin, birthmarks, Mongolian spots, hair, fingernails or toenails.

Map and describe any skin markings



Eyes \ vision, glasses

Ears \ hearing, hearing aides or device, ear-aches, 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, colic, spitting up

Using toilet, toilet training, urinating

Bones, muscles, movement, pain with moving

Mobility, uses assistive equipment

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

Needs special equipment. *Please describe:*

Allergy - My child has allergies (food, medicine, fabric, inhalants, insects, animals, etc.). *Please describe.*

Parent or child care provider questions or concerns to ask health care provider:

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Health provider complete this page¹

Date of Exam:

Height or Length:

Weight

Head Circumference (for children **under** 2 yr.):

Body Mass Index (for children **over** 2 yr.):

Blood Pressure (start @ age 3 yr.):

Hgb. or Hct.: (start @ 1 yr.)

Blood Lead Level: (start @ 1 yr.)

Exam Results (*n = normal limits*) otherwise describe

HEENT

Teeth

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Sensory and Developmental Screening

Vision Right eye _____ Left eye _____

Hearing Right ear _____ Left ear _____

Tympanometry (attach results)

Developmental Screening results:

Personal-Social

Fine Motor-Adaptive

Language

Gross Motor

Developmental Referral Made Today: Yes No

Birthdate:

Age today:

Date of Last **Dental** Exam:

Dental Referral Made Today: Yes No

Vaccines given today:

DtaP/DTP/Td

HEP B

HIB

Influenza

MMR

Pneumococcal

Polio

Varicella

Other

TB testing (for high risk child only)

Referrals made today:

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

Physician authorizes the child may receive the following medications while at child care: (include over-the-counter and prescribed):

Medication Name

Dosage

Diaper crème:

Pain reliever:

Sunscreen:

Cough medication

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

