

# IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

## CHILD and FAMILY INFORMATION

Parents please complete this page.

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
<p><b>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.</b></p>		
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? <input type="checkbox"/> Yes, Company _____ <b>ID#</b>
Child's dentist's name	Dentist telephone #1	Does your child have dental insurance? <input type="checkbox"/> Yes, Company _____ <b>ID#</b>
Dentist's address	After hours telephone #	<input type="checkbox"/> We do not have <u>health</u> insurance. <input type="checkbox"/> We do not have <u>dental</u> insurance. <input type="checkbox"/> Help us find health or dental insurance.
Other medical or dental specialist name	Telephone #	Specialist address:
<b>Type of specialty</b>		
Mental health care specialist	Telephone #	Specialist address:

Child Name: \_\_\_\_\_

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**Parents please 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.

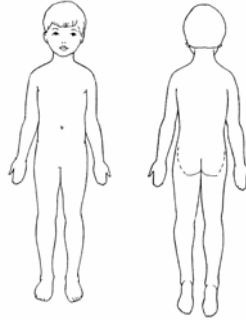
**School and Learning - My child**

- 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 the following allergies** (list any allergies to food, medicine, fabric, inhalants, insects, animals, etc.):

**Body Health - My child has problems with**

Skin, hair, fingernails or toenails  
Map and describe any skin markings or birthmarks.



- 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, heart murmur
- Stomach aches or upset stomach
- Using toilet, night time wetting
- 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<sup>1</sup> - My child takes medication.**

<u>Medication Name</u>	<u>Time Given</u>	<u>Reason for giving medication</u>

**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 in an administrative office off site.

**Parent Signature (required):** \_\_\_\_\_

<sup>1</sup> Please refer to your child care program's policies regarding the giving of medication while your child is at the program.

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## School-Age Care Physical Exam Form <sup>\*</sup>

Health Care Provider completes this page.

**Date of Physical Exam:**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Body Mass Index: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_  
 Hgb. or Hct.: \_\_\_\_\_  
 Blood Lead Level: \_\_\_\_\_  
 Urinalysis: \_\_\_\_\_

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

HEENT:  
 Teeth:  
 Heart:  
 Lungs:  
 Stomach/Abdomen:  
 Genitalia: \_\_\_\_\_ Tanner stage: \_\_\_\_\_  
 Extremities, Joints, Muscles, Spine:  
 Skin, Lymph Nodes:  
 Neurological:

**Sensory Screening**

Vision Right eye \_\_\_\_\_ Left eye \_\_\_\_\_  
 Hearing Right ear \_\_\_\_\_ Left ear \_\_\_\_\_  
 Tympanometry (attach results)  
 Referral Made Today  Yes  No

Date of Last **Dental** Exam:

Dental Referral Made Today  Yes  No

**Birthdate:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**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):

<u>Medication Name</u>	<u>Dosage</u>
Pain reliever:	
Sunscreen:	
Cough medication	

Physician signature needed on next page.

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

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## Health Provider Assessment Statement:

- The child may participate in school-age child care with **NO** health-related restrictions.
- The child may participate in school-age child care **with these restrictions:** (please specify)

Health Provider

Signature \_\_\_\_\_ (may use stamp)

Provider's Type (circle) MD DO PA ARNP

Health Care Provider Address:

Health Care Provider Telephone:

**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 well child 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 or clinic. If you do not have a family doctor or clinic, please call the toll free 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	AGE <sup>2</sup>												
	5 yr.	6yr.	7 yr.	8 yr.	9 yr.	10 yr.	11 yr.	12 yr.	13 yr.	14 yr.	15 yr.	16 yr.	
<b>History:</b> Initial and Interval	●	●	●	●	●	●	●	●	●	●	●	●	●
<b>Measurement:</b> Height/ Weight	●	●	●	●	●	●	●	●	●	●	●	●	●
Body Mass Index	●	●	●	●	●	●	●	●	●	●	●	●	●
Blood Pressure	●	●	●	●	●	●	●	●	●	●	●	●	●
<b>Sensory Screen:</b> Vision	●	●	●	●	●	●	I	●	I	I	●	●	●
Hearing	●	●	●	●	●	●	I	●	I	I	●	●	●
<b>Developmental/Behavior/School:</b> Screening	●	●	●	●	●	●	●	●	●	●	●	●	●
<b>PHYSICAL EXAM</b> recommended but not required for school-age child to maintain enrollment in child care	●	●	●	●	●	●	●	●	●	●	●	●	●
<b>Lab tests:</b> Hematocrit or Hemoglobin	●						●						→
Urinalysis	●						●	●	●	●	●	●	●
Lead Test <sup>3</sup>	◆	◆											
Cholesterol Screen	◆												→
STD Screen <sup>4</sup>	◆												→
Genital or Pelvic Exam <sup>5</sup>	◆												→
TB test <sup>6</sup>	◆												→
<b>Immunizations:</b> per Iowa schedule <sup>7</sup>	●	●	●	●	●	●	●	●	●	●	●	●	●
<b>Family Guidance:</b> Injury Prevention	●	●	●	●	●	●	●	●	●	●	●	●	●
Seat Belt Use	●	●	●	●	●	●	●	●	●	●	●	●	●
Bike Helmet Use	●	●	●	●	●	●	●	●	●	●	●	●	●
Violence Prevention <sup>8</sup>	●	●	●	●	●	●	●	●	●	●	●	●	●
Nutrition & Physical Activity Counseling	●	●	●	●	●	●	●	●	●	●	●	●	●
Pregnancy Prevention <sup>9</sup>	◆												→

Key: ● to be performed I = Interview parent or child ◆ = to be performed for at risk children  
 → An arrow indicates the range in age in which a test/exam may be completed

<sup>2</sup> 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.

<sup>3</sup> Lead testing Iowa Lead Testing program 1-800-242-2026.

<sup>4</sup> Sexually active youth should be screened.

<sup>5</sup> Sexually active youth should be screened.

<sup>6</sup> TB testing for at-risk children Iowa TB program 1-800-383-3826.

<sup>7</sup> Immunization per schedule Iowa Immunization 1-800-831-6293.

<sup>8</sup> All families to receive domestic and youth violence prevention. CALL TEENLINE 1-800-443-8336 (operates 24/7).

<sup>9</sup> All sexually active youth should have access to pregnancy prevention services. CALL TEENLINE 1-800-443-8336.

### Additional Parent or Physician Notes: