Infant, Toddler, Preschool – Child Health Exam Form

DOCTORS COMPLETE THIS PAGE

Child's Name:

Birth date: 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 _____
Date of newborn hearing test:_____

Tympanometry (may attach results)

Developmental Screening:

- Autism screening results:
- Psychosocial/behavioral results:
- Gross Motor:
- Personal/Social:
- Fine Motor-Adaptive:
  Language:
- Developmental Referral Made Today:
  ❑ No ❑ Yes

Referrals made:
___Referred to hawk-i today 1-800-257-8563

Allergies: (food, medicine, fabric, inhalants, insects, animals, etc.).
Please describe:

Immunization: Attach a copy of Iowa Department of Public Health Immunization Certificate

Exam Results: (n = normal limits) otherwise describe

- HEENT:
- Oral/Teeth:
- Oral Health/Dental Referral Made Today:
  ❑ No ❑ Yes
  Date of last dental screening: _____
- 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.

Medication: list all medications the child is currently taking. Please note this is **not** appropriate authorization for center to administer the medication.

Disability:
Does the child have a disability? ❑ No ❑ Yes

If yes, describe the major life activity or functions affected by the disability (see link for definitions of disability http://www.eeoc.gov/laws/statutes/adaaa_info.cfm)

If yes, explain why the disability restricts the child's daily activity:

If no, identify the medical condition that does not rise to the level of a disability:

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:

Doctors Signature_____
Circle the Provider Credential Type: MD DO PA ARNP

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			

	Vaccine	Date Given	Doctor / Clinic / Source
Varicella Chicken Pox If patient has a history of natural disease write "Immune to Varicella"			
Pneumococcal PCV/PPV			
Meningococcal MCV4/MPSV4			
Hepatitis A			
Rotavirus			
Human Papilloma Virus HPV			
Other			

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