IOWA SCHOOL-AGE CARE – HEALTH STATUS – PARENT STATEMENT

Parent/Guardian complete this page

Child's Name:_____

Date of child's last physical exam: _____
Date of last dental appointment: _____

Please use an X in the box next to statements that apply to your child.

I am concerned about

☐ My child's growth
☐ My child's eating habits
☐ My child's play activity with other children
☐ How my child is doing in 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:

☐ **Allergy** – My child has allergies (list all allergies: food, medicine, fabrics, inhalants, insects, animals, etc.):

Child has Epipen, inhaler, or other emergency medication.
☐ Yes ☐ No

☐ **Medication**[1] – My child takes medication.
Medications 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 o-site at the childcare facility.

Body Health – My child has problems with:

☐ Skin, hair, fingernails, or toenails.
☐ 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
☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Females – difficult monthly periods
☐ Other special needs.

If any of the above are checked please describe:

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:

☐ *By checking this box and typing your name in the signature field, you are stating that the information you've provided herein is true and correct to the best of your knowledge.*

Parent Signature: _____ Date: _____
(required)

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			

	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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