

# 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**<sup>1</sup> – 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 on-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](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: \_\_\_\_\_

(required)

Date: \_\_\_\_\_

<sup>1</sup> Parents: Please review the child care program's policies about the use of medication at child care.