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