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

***Health Professional's*** **Physical Exam Findings***

**Date of Physical Exam:**

Height:_____ Weight:_____

Body Mass Index: _____,

☐ There are weight concerns and

☐ Referral made to _____

Blood Pressure:

**Laboratory Screening:**

Blood Lead Level: _____ ☐ venous ☐ capillary (for child under age 6 yr)

Hgb. / Hct:

Urinalysis:

TB testing (high risk child only)

**Sensory Screening**

Vision: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry: Right ear _____ Left ear _____

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

**Skin:**

**HEENT:**

**Teeth/Oral health:**

Date of Dentist Exam: _____ or ☐ None to date.
Dental Referral Made Today ☐ Yes ☐ No

**Heart:**

**Lungs:**

**Stomach/Abdomen:**

**Genitalia:**

**Extremities, Joints, Muscles, Spine:**

**Neurological:**

**Other Notes:**

**Child Name:** _____
Birthdate: Age:

**Vaccines given Today:**
Vaccines entered into IRIS database. ☐ Yes ☐ No

DtaP/DTP/Td
HEP B
HIB
Influenza
MMR
Pneumococcal
Polio
Varicella
Other

**Referrals made today:**

☐ Referred to ***hawk-i*** today 1-800-257-8563

**Health provider authorizes the child to receive the following medications while at child care or school**
(Including *over-the-counter* and *prescribed*)

| Medication Name | Dosage |
|---|---|
| ☐Fever/Pain reliever: | |
| ☐Sunscreen: | |
| ☐Cough medication: | |
| ☐Other - list all | |

**Health Provider Statement:**

☐The child may **fully participate** with ***NO*** health-related restrictions.

☐The child has the following **health-related restrictions** to participation: (please specify)

Signature _____
Provider Type (circle) MD DO PA ARNP
Address: May use stamp Telephone:

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



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