

## School-Age Child Health Form/Parent Statement of Health

**PARENT/GUARDIAN** (COMPLETE THIS PAGE ANNUALLY) **Child's Name:** \_\_\_\_\_

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

Date of child's last physical exam: \_\_\_\_\_

Date of last dental appointment: \_\_\_\_\_

**Growth** - I am concerned about child's growth.

**Appetite** - I am concerned about child's eating habits.

**Rest** - My child needs to rest after 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:

**Play with friends** - My child

- Plays well in groups with other children.
- Will play only with one or two other children.
- Prefers to play alone.
- Fights with other children.
- I am concerned about my child's play activity with other children. Please describe:

**School and Learning** - My child

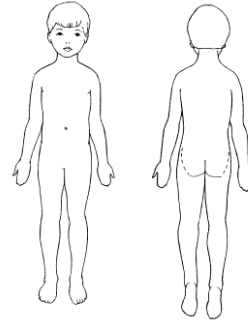
- Is doing well at school.
- Is having difficulty in some classes.
- Does not want to go to school.
- Frequently misses or is late for school.
- I am concerned about how my child is doing in school. Please describe:

**Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.). List allergies:

**Special Needs Care Plan** - My child has a special need and a care plan for child care. Please discuss with your health care provider.

**Body Health** - My child has problems with skin, hair, fingernails or toenails.

Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



- 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
- Breathing problems, asthma, cough
- Heart problems or heart murmur
- Stomach aches or upset stomach
- Trouble using toilet or 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. Please describe:

**Medication<sup>2</sup>** - My child takes medication.

Medication Name      Time Given      Reason for giving medication

**Child has Emergency Medication** - Epipen, Respiratory Inhaler, Nebulizer, etc. (Please complete care/action plan) templates at [www.idph.iowa.gov/hcci/products](http://www.idph.iowa.gov/hcci/products)

**Parent/Guardian Signature** (required): \_\_\_\_\_ **Date:** \_\_\_\_\_

<sup>2</sup> Please review the child care program's policies about the use of medication at child care.