School-Age Child Health Form/Parent Statement of Health

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL[1]

Date of Exam: _____

Height: _____ Weight: _____

Body Mass Index: _____,

☐There are weight concerns

☐Referral made to _____

Blood Pressure: _____

Laboratory Screening:

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

Hgb. / Hct: _____

Urinalysis: _____

Sensory Screening

Vision Acuity: 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:

Developmental Surveillance:

Psychosocial/Behavioral Assessment: (Depression screening starting at age 12)

Allergies:

Environmental
Medication
Food
Insects
Other

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures March 2021) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

[1] Annual physical for school-age is recommended but not required for child care

Child Name: _____

Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed & signed

☐ TB testing completed (only for high-risk child)

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

Other Medication should be listed with written instructions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Additional Referrals made:

☐ _____

☐ _____

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)

☐ The child has a special needs care plan
Type of plan _____
(Please complete and give to parent for child care)

Health Care Provider Comments:

May use stamp

Signature _____

Circle the Provider Type: **MD DO PA ARNP**

Address: Telephone: