School-Age Child Health Form/Parent Statement of Health

HEALTH PROFESSIONAL COMPLETE PAGE

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: _______________

TB testing (high risk child only) ______________

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:

Psychosocial/Behavioral Assessment (Depression screening starting at age 11)

Allergies

Environmental
Medication
Food
Insects
Other

: **Health Care Provider Comments:**

Child Name: ________________________________

Date of Birth: ______________ Age: ________

Immunization: Please attach:

☐ Iowa Department of Public Health Certificate of Immunization

☐ Iowa Department of Public Health Certificate of Immunization Exemption Medical

☐ Iowa Department of Public Health Certificate of Immunization Exemption Religious

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 in-structions for use in child care. Medication forms available at www.idph.iowa.gov/hcci/products

Referrals made:

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

☐ Other: ______________________________

Health Provider Statement:

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

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

☐ The child has a special needs care plan Type of plan ____________________________
(please attach)

Signature ___________________________________
Provider Type (circle) MD DO PA ARNP

Address: May use stamp Telephone:

The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures 2015) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf