Child Name:

Infant, Toddler, Preschool Age – Child Health Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 - Child Information

Child's name		Child's	birthdate	Child Care	Facility							
Parent/Guardian name #1			Parent/Guar									
Child home address #1			-		Telephone # 1							
Child home address #2					Telephone #2							
Where parent/guardian # 1 works	Work addre	ss			Home phone # Work # Cellular # Home email Work email							
Where parent /guardian # 2 works		Home phone # Work # Cellular # Home email Work email										
the child care facility is unable to immed	diately make co	ontact w	ith the parent	t/guardian.	rson when parent or guardian cannot be							
Child's doctor's name		Doc	tor telephone a	#1	Hospital choice							
Doctor's address		Afte	r hours telepho	one#	Does child have health insurance? Yes, Company ID #							
Child's dentist's name (or family's dentist r	ame)	Den	tist Telephone		Does child have dental insurance? ☐Yes, Company ID#							
Dentist's Address		Afte	r hours teleph	one#	NO, we do not have health insurance.NO, we do not have dental insurance.							
Other health care specialist name		Tele	ephone #		☐ Please help us find health or dental							
Type of specialty					insurance.							

PARENT/GUARDIAN COMPLETE THIS PAGE	Child's Name:
Tell us about your child's health. Place an X in the box ⊠ if the sentence applies to your child. Check all that apply to your child. This will help your health care provider plan your child's physical exam.	Body Health - My child has problems with Skin, birthmarks, Mongolian spots, hair, fingernails or toenails. Map and describe color/shape of skin markings birthmarks, scars, moles
Growth ☐ I am concerned about my child's growth.	Situmatio, odars, moles
Appetite I am concerned about my child's eating/ feeding habits or appetite.	
Rest - I am concerned about the amount of sleep my child needs.	
my office fields.	☐ Eyes \ vision, glasses
Illness/Surgery/Injury - My child ☐ had a serious illness, injury, or surgery	☐ Ears \ hearing, hearing aides or device, earaches, tubes in ears
Please describe:	 ☐ Nose problems, nosebleeds, runny nose ☐ Mouth, teething, gums, tongue, sores in mouth or on lips, mouth-breathing, snoring
Physical Activity - My child	Frequent sore throats or tonsillitis
must restrict physical activity.	☐ Breathing problems, asthma, cough, croup☐ Heart, heart murmur
Please describe:	☐ Stomach aches, upset stomach, spitting-up☐ Using toilet, toilet training, urinating☐ Bones, muscles, movement, pain when
	moving, uses assistive equipment.
Development and Learning	☐ Nervous system, headaches, seizures, or
☐ I am concerned about my child's	nervous habits (like twitches)
behavior, development, or learning.	☐ Needs special equipment.
Please describe:	List equipment:
Allergies-My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.).	Medication - My child takes medication. (List the name of medication, time medication taken, and the reason
Please describe:	medication prescribed).
	,
Special Needs Care Plan – My child has a special needs care plan (IEP, IFSP, Asthma Action Plan, Food Allergy Action Plan, etc.). Please discuss with your health care provider.	
Parent/Guardian questions or comments for the he	ealth care provider:
8	

Infant, Toddler, Preschool Age - Child Health Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE	Allergies										
Child's Name:	Environmental:										
Birthdate: Age today:	Medication:										
Date of Exam:	Food:										
Height/Length: Weight:	Insects: Other:										
	Othor.										
BMI- starting at age 24 mo.	Immunization: Please attach:										
Head Circumference- age 2 yr. and under:	☐ Iowa Department of Public Health Certificate of Immunization										
Blood Pressure-start @ age 3 yr:	☐ Iowa Department of Public Health										
Hgb or Hct- @ 12 mo:	Certificate of Immunization Exemption Medical Iowa Department of Public Health										
Lead Risk Assessment:	Certificate of Immunization Exemption Religious.										
Blood Lead Level: date results	☐ TB testing completed (only for high-risk child)										
Sensory Screening:	Medication: Health professional authorizes the child may										
Vison Assessment:	receive the following medications while at the child care facility: (include over-the-counter and prescribed)										
Vision Acuity: Right eye Left eye											
Hearing Assessment: Right ear Left ear	Medication Name <u>Dosage</u> ☐ Diaper crème:										
Tympanometry (may attach results)	Fever or Pain reliever:										
Developmental Screening/Surveillance: (n = normal limits) otherwise describe Developmental screening results:	☐ Sunscreen:☐ Other Other Medication should be listed with written instructions for use										
Autism screening results:	in child care. Medication forms available at										
Psychosocial/behavioral results	www.idph.iowa.gov/hcci/products										
Developmental Referral Made Today: Yes No	Referrals made:										
Exam Results: (n = normal limits) otherwise describe	☐ Referred to <i>hawk-i</i> today 1-800-257-8563☐ Other:										
HEENT											
Oral/Teeth	Health Provider Assessment Statement:										
Date of Dental exam	The child may participate in developmentally appropriate early early learning with NO health related										
Oral Health/Dental Referral Made Today: ☐Yes ☐ No	propriate early care/learning with NO health-related restrictions.										
Heart	_										
Lungs											
Stomach/Abdomen	comments).										
Genitalia											
Extremities, Joints, Muscles, Spine	The child has a special needs care plan Type of plan										
Skin, Lymph Nodes	(please attach)										
Neurological	May use stamp										
Health Care Provider comments:	Signature Circle the Provider Credential Type: MD DO PA ARNP Address: Telephone:										

¹ Iowa Child Care Regulations require an admission physical exam report within the previous year and annually.

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



become necessary if circumstances suggest variations from normal.

Recommendations for Preventive Pediatric Health Care

Bright Futures/American Academy of Pediatrics

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care.

Refer to the specific guidance by age as listed in Bright Futures guidelines (Hagan JF, Shaw JS. Duncan PM, eds. Bright Futures Guidelines for Health Supervision of Infants, Children and

Bright Futures.

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be

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AGE	Prenatal ²	Newborn ³	3-5 d	⁴ By 1 m	10 2 m	9 4 m	6 mg	9 mo	12 mo	15 mo	18 mo	24 mo	30 mo	3 y	4 y	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 у	14 y	15 y	16 У	A SUPPLY OF	16 у	10 y	20 y	1000
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1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are

designed for the care of children who are receiving competent parenting, have no manifestations of any

important health problems, and are growing and developing in satisfactory fashion. Additional visits may

Developmental psychosocial, and chronic disease issues for children and adolescents may require

- should be brought up to date at the earliest possible time.

 A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, perlinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding, per the 2009 AAP statement. The Prenatal Visit* (http://endiatrics.eapeublications.org/content/12/4/4/1227.full).
- Every infant should have a newborn evaluation after birth, and breastfeeding should be encouraged (and instruction and support should be offered).
 Every infant should have an evaluation within 3 to 5 days of birth and within 48 to 72 hours after discharge from the hospital to include evaluation for
- 48 hours of discharge, per the 2010 AAP statement "Hospital Stay for Healthy Term Newborns"
- (http://ipedianics.aappt.biinations.org/content/125/24/05.full),
 Screen, per the 2007 AAP statement "Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report" (http://pediatrica.aaopublicationa.crg/content/120/Supplement_4/S164_full). Blood pressure measurement in Infants and children with specific risk conditions should be performed at visits before age 3 years.
- A visual acuity screen is recommended at ages 4 and 5 years, as well as in cooperative 3 year olds. Instrument based screening may be used to assess risk at ages 12 and 24 months, in addition to the well visits at 3 through 5 years of age. See 2016 AAP statement, "visual System Assessment in Infants, Children, and Young Adults by Pediatricians" (https://pediatricians.ang/content/137/1/1.51) and "Procedures for Evaluation of the
- Visual System by Pediatricians (http://incediatrics.aapta/bleations.craicontent/137/1/1.52).

 8. All newborns should be screened, per the AAP statement "Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs* (http://pediatrics.aappublications.org/content/120/4/598.full).
- neror virtual or Cognition (Indicated Section Control of Control Office Control of Contr
- (http://pediatrics.aappublications.org/content/120/5/1183.full).

- 11. A recommended screening tool is available at http://www.exasar-beston.org/CRAFFT/findex.phn.

 22. Recommended screening using the Patient Health Questionnaire (PHQ)-2 or other tools available in the GLAD-PC toolkit and at <a href="http://www.nap.org/en-es/advocaty-and-script/viaga-bentif-http://www.nap.org/en-es/advocaty-advocaty-and-script/viaga-bentif-http://www.nap.org/en-es/advocaty-advo 2011 AAP statement "Use of Chaperones During the Physical Examination of the Pediatric Patient" (http://inediatrics.aarnublications.org/content/127/5/991 full).
- These may be modified, depending on entry point into schedule and individual need.
- 15. The Recommended Uniform Newborn Screening Panel
- The Neconstitution of the control of us uthesca edustres games-rus/flearhtsdieorders.pdf), establish the criteria for and coverage of newborn screening procedures and programs. Follow-up must be provided, as appropriate, by the pediatrician.

- Every visit should be an opportunity to update and complete a child's immunatizations.

 See you will should be an opportunity to update and complete a child's immunatizations.

 See 2010 AP statement plagnosis and Preventi
- Interpretation and the Comment of the Control of th
- Perform risk assessments or screenings as appropriate, based on universal screening requirements for patients with Medicaid or in high prevalence

- 21. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of AAP Red Books Report of the Committee on Infectious Diseases. Testing should be performed on recognition on high-risk factors of high-risk factors.

 22. See AAP-endorsed 2011 guidelines from the National Heart Blood and Lung Institute, "Integrated Guidelines for Cardiovascular Health and
- Risk Reduction in Children and Adolescents" (http://www.nbibl.nih.gov/oude/liens/cvd_pediandex.htm).

 3. Adolescents should be screened for sexually transmitted infections (STB) per recommendations in the current edition of the AAP Red Book:
- Report of the Committee on Infectious Diseases. Additionally, all adolescents should be screened for HIV according to the AAP statement (http://ipediatrics.eappublications.org/content/128/5/1023.full) once between the ages of 16 and 18, making every effort to preserve confidentiality of the adolescent. Those at increased risk of HIV infection, including those who are sexually active, participate in injection drug use, or are being tested for other STIs, should be tested for HIV and reassessed annually.
- See USPSTF recommendations (http://www.usprarentiveservicestaskforce.org/uspst/fuspsaerv.htm). Indications for pelvic examinations prior to age 21 are noted in the 2010 AAP statement "Gynocologic Examination for Adolescents in the Pediatric Office Sotting"
- (http://pediarrics.aappublications.org/content/126/3/593.full).

 25. Assess if the child has a dental home, If no dental home is identified, perform a risk assessment
- (http://www2.aap.org/oralhea/th/docs/RiskAssessmentTcol.pdf) and refer to a dental home. If primary water source is deficient in fluoride, consider oral fluoride supplementation. Recommend brushing with fluoride toothpaste in the proper dosage for age. See 2009 AAP statement "Oral Health Risk Assessment Timing and Establishment of the Dental Home" (http://pediatrics.asppublications.org/content/111/6/1113/ull). 2014 clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://portistrics.aspotablications.ore/content/134/3/92R), and 2014 AAP statement "Maintaining and Improving the Oral Health of Young Children" (http://nedlatrics.sappublications.org/content/134/6/1224.full).*

 26. See USPSTF recommendations (http://www.uspreventiveservicestaskforce.org/uspst/fuspstdncth.htm). Once teeth are present, fluoride
- varish may be applied to all children every 3-5 months in the primary care or dental office, Indications for fluoride use pessell, indicate the primary care or dental office, Indications for fluoride use pessell, indicate the primary care or dental office, Indications for fluoride use pessell, indicate the primary care or dental office, Indications of fluoride use pessell in the 2014 AAP clinical report "Fluoride Use in Caries Prevention in the Primary Care Setting" (http://inactiatrics.asconstilications.org/content/13//3/026).