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 instructions 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 restrictions** 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