

IOWA SCHOOL-AGE CARE - HEALTH STATUS - PARENT STATEMENT

Parent/Guardian please complete pages 1 and 2.

Child's name		Child's birthdate	Name of school
Parent #1 name		Parent #2 name	
Child home address #1		Telephone # 1	
Child home address #2		Telephone # 2	
Where parent #1 works	Work address	Telephone #	Work #
			Pager #
			Cellular #
			Home email
			Work email
Where parent #2 works	Work address	Telephone #	Work #
			Pager #
			Cellular #
			Home email
			Work email
<p>In the event of an emergency, the child care provider is authorized to obtain EMERGENCY MEDICAL or DENTAL CARE even if the child care center is unable to immediately make contact with the parents/guardian. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.</p> <p>Parent/Guardian Signature: _____ Date _____</p> <p>Alternate emergency contact person's name: _____ Relationship to child: _____ Phone number: _____</p>			
Child's doctor's name	Doctor telephone #1	Hospital of choice	
Doctor's address	After hours telephone #	Does your child have health insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		Company _____	
		ID# _____	
Child's dentist's name	Dentist telephone #1	Does your child have dental insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Dentist's address	After hours telephone #	Company _____	
		ID# _____	
		<input type="checkbox"/> Please help us find health or dental insurance.	
		Call: 800-257-8563	
Other medical or dental specialist name	Telephone #	Specialist address:	
Type of specialty			
Mental Health care specialist	Telephone #	Specialist address:	

Child Name:

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Parent/Guardian complete this page

Please use a **X** in the box to 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.

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 (list all allergies: food, medicine, fabric, inhalants, insects, animals, etc.):

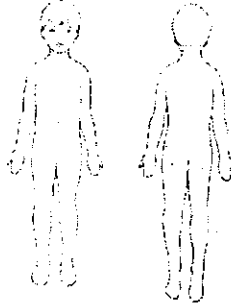
Child has Epipen, inhaler, or other emergency medication.
 Yes No

Child name: _____

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
 - Frequent sore throats or tonsillitis
 - Breathing problems, asthma, cough
 - Heart problems or heart murmur
 - Stomach aches or upset stomach
 - Trouble using toilet or wetting accidents
 - Hard stools, constipation, diarrhea, watery stools
 - Bones, muscles, movement, pain when moving
 - Mobility, child uses assistive equipment
- Please describe

- Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
- Females – difficult monthly periods
- Other special needs. Please describe:

Medication¹ - My child takes medication.

Medication Name	Time Given	Reason for giving medication

Note to parents: Certificate of Immunization

School-owned and operated child care programs located on school property may file/store your child's Certificate of Immunization in the school office or in the school nurse's office. All other school-age child care programs must keep the Certificate of Immunization on-site at the child care facility.

Parent Signature:
(required)

Date:

¹ Parents: Please review the child care program's policies about the use of medication at child care.

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Health Professional's Physical Exam Findings

Date of Physical Exam: _____

Height: _____ Weight: _____

Body Mass Index: _____

There are weight concerns and

Referral made to _____

Blood Pressure: _____

Laboratory Screening:

Blood Lead Level: _____ venous capillary (for child under age 6 yr)

Hgb. / Hct: _____

Urinalysis: _____

TB testing (high risk child only) _____

Sensory Screening

Vision: 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: _____

Other Notes: _____

Child Name: _____

Birthdate: _____ Age: _____

Vaccines given Today:

Vaccines entered into IRIS database. Yes No

DtaP/DTP/Td

HEP B

HIB

Influenza

MMR

Pneumococcal

Polio

Varicella

Other _____

Referrals made today:

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

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 _____

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) _____

Signature _____

Provider Type (circle) MD DO PA ARNP

Address: _____ Telephone: _____

* Iowa Child Care regulations require an annual parent statement about the child's health. Parents obtaining a physical exam are asked to have their family doctor or clinic use this form.