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 Grade ____ School Telephone #
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

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. ☐ YES ☐NO

During an emergency the child care provider is authorized to contact the following person when parent or guardian can not be reached.

Parent/Guardian Signature: _____ Date _____

Alternate emergency contact person's name: Relationship to child: Phone number:

Child's doctor's name	Doctor telephone #1	Hospital of choice
Doctor's address	After hours telephone #	Does your child have health insurance? ☐ YES ☐NO Company _____ **ID#**
Child's dentist's name	Dentist telephone #1	Does your child have dental insurance? ☐ YES ☐NO Company _____ **ID#**
Dentist's address	After hours telephone #	☐ **Please help us find health or dental insurance.** Call: 800-257-8563
Other medical or dental specialist name **Type of specialty**	Telephone #	Specialist address:
Mental Health care specialist	Telephone #	Specialist address:

Child Name:

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Parent/Guardian complete this page

Child name: _____

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.

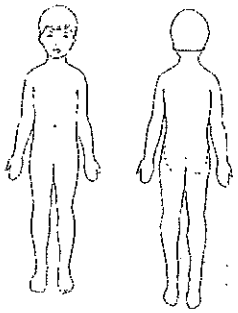
School and Learning - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

☐ **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

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:

☐ **Medication**[1] - 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.