

School-Age Child – Parent Statement of Health

PARENT/GUARDIAN (Please complete pages 1 and 2.)

Child's name	Child's birthdate	Name of school: _____ Grade: _____ School telephone #: _____
Parent/Guardian name #1		Parent/Guardian name #2
Child home address #1		Telephone # 1
Child home address #2		Telephone #2
Where parent/Guardian # 1 works	Work address	Telephone # Work # Cellular # Home email Work email
Where parent/Guardian # 2 works	Work address	Telephone # Work # 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 facility is unable to immediately make contact with the parent/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 cannot be reached.</p> <p>Parent/Guardian signature: _____ Date: _____</p> <p>Alternate emergency contact person's name: _____ Phone #: _____</p> <p>Relationship to child: _____ Cellular #: _____</p>		
Child's doctor's name	Doctor telephone # 1	Hospital of choice: _____ _____ Phone #: _____
<input type="checkbox"/> Child does not have doctor		
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 Company: _____ ID #: _____
<input type="checkbox"/> Child does not have dentist		
Dentist's address	After hours telephone #	<input type="checkbox"/> HELP us find a family doctor or dentist. <input type="checkbox"/> HELP us find health or dental insurance.
Other health care/mental health specialist name	Telephone #	
Type of specialty		

Child Name:

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PARENT/GUARDIAN Complete this page.

Child's name: _____

Please use an **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 my child's growth.
- Appetite.** I am concerned about my 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:

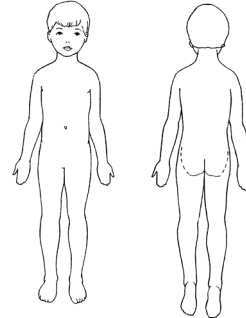
- Allergy.** My child has allergies. (Medicine, food, dust, mold, pollen, insects, animals, etc.)

List allergies:

- Special Needs Care Plan.** My child has a special needs care plan. (IEP, Asthma Action Plan, Food Allergy Action Plan, etc.) Please discuss with your health care provider.

- 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 aids or device, earache, tubes in ears
- Nose problems, nosebleeds
- Mouth, teeth, gums, tongue, sores in mouth or on lips, breathes 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
- Nervous system, headaches, seizures or nervous habits (like twitches or tics)
- Females – difficult monthly periods**

Please describe:

- Medication.** My child takes medication. **Parents:** Please review the child care program's policies about the use of medication at child care.

<u>Medication Name</u>	<u>Time Given</u>	<u>Reason for Giving Medication</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

- Yes No **Child has EpiPen, inhaler or other emergency medication.**

Parent signature (required)

Date

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Health professional complete this 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 years)

Results: _____

Hgb or 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's name: _____

Date of birth: _____ Age: _____

Immunizations 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

Medication

Health provider authorizes the child to receive the following medications while at child care or school. (Include over-the-counter and prescribed.)

Medication Name	Dosage
<input type="checkbox"/> Fever/pain reliever	_____
<input type="checkbox"/> Sunscreen	_____
<input type="checkbox"/> Cough medication	_____
<input type="checkbox"/> 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 Assessment 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: _____
May use stamp.

Check the provider type:

MD DO PA ARNP

Address: _____

Telephone: _____

Recommendations for Preventive Pediatric Health Care – School-Age Child

Bright Futures/American Academy of Pediatrics

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 become necessary if circumstances suggest variations from normal. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

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 Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

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 appropriate.

	MIDDLE CHILDHOOD										ADOLESCENCE									
	5 y	6 y	7 y	8 y	9 y	10 y	11 y	12 y	13 y	14 y	15 y	16 y	17 y	18 y	19 y	20 y	21 y			
HISTORY:																				
Initial/Interval	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
MEASUREMENTS:																				
Length/Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Head Circumference																				
Weight for Length																				
Body Mass Index ⁵	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Blood Pressure ⁶	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
SENSORY SCREENING:																				
Vision ⁷	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Hearing	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:																				
Developmental Screening ⁹																				
Autism Screening ¹⁰																				
Developmental Surveillance	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Psychosocial/Behavioral Assessment	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Alcohol and Drug Use Assessment ¹¹																				
Depression Screening ¹²																				
PHYSICAL EXAMINATION¹³	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
PROCEDURES¹⁴:																				
Newborn Blood Screening ¹⁵																				
Critical Congenital Heart Defect Screening ¹⁶																				
Immunization ¹⁷	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Hematocrit or Hemoglobin ¹⁸	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Lead Screening ¹⁹	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Tuberculosis Testing ²¹	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
Dyslipidemia Screening ²²	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
STI/HIV Screening ²³																				
Cervical Dysplasia Screening ²⁴	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		
ORAL HEALTH²⁵																				
Fluoride Varnish ²⁶	→																			
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●		

KEY: ● = to be performed ● or * = risk assessment to be performed with appropriate action to follow, if positive ◀ → = range during which a service may be provided

See pages 131 and 132 for footnotes.