STATE OF IOWA DEPARTMENT OF
Health and Human
SERVICES

Infant, Toddler, Preschool Age (including Kindergarten entry)
Child Health Form

HEALTH PROFESSIONAL COMPLETE PAGE

OR PROVIDE COPY OF WELL CHILD PHYSICAL (ANNUALLY)

Date of Exam: _____

Height/Length: _____ Weight: _____

BMI – starting at age 24 mo.: _____

Head Circumference @ age 2 yr. and under: _____

Blood Pressure-start @ age 3 yr.: _____

Hgb or Hct @ 12 mo.: _____

Lead Risk Assessment: _____

Blood Lead Level @ 1 yr. & 2 yr.: date_____ results_____

Sensory Screening:

Vison Assessment: _____

Vision Acuity: Right eye _____ Left eye _____

Hearing Assessment: Right ear _____ Left ear _____

Tympanometry (may attach results)

Developmental Screening/Surveillance:
(n = normal limits) otherwise describe
Developmental screening results:

Autism screening results:

Psychosocial/behavioral results

Developmental Referral Made Today: ☐Yes ☐ No

Exam Results: *(n = normal limits) otherwise describe*

HEENT

Oral/Teeth Date of Dental exam _____

Oral Health/Dental Referral Made Today: ☐Yes ☐ No

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Child Name: _____
Date of Birth: _____ **Age:** _____

Immunization and TB Testing: (check as indicated)

☐ IDPH Certificate of Immunization reviewed and signed

☐ TB testing completed (only for high-risk child)

Health provider authorizes the child may receive the following at child care: (include *over-the-counter medications)*

	Name	Dosage
☐ Diaper cream/ointment:		
☐ Fever or Pain reliever:		
☐ Sunscreen:		
☐ Other		

Prescribed Medication should be listed with written instructions for use in child care. Medication forms available at https://hhs.iowa.gov/hcci/products

Additional Referrals made:

☐ _____
☐ _____

Health Provider Assessment Statement:

☐ The child may participate in developmentally appropriate early care/learning with ***NO*** health-related restrictions.

☐ The child may participate in developmentally appropriate early care/learning ***with restrictions*** (see comments).

☐ The child has a special needs care plan
Type of plan _____
(Please complete and give to parent for child care templates at https://hhs.iowa.gov/hcci/products)

Comments:

May use stamp

Signature _____
Circle Provider Type: MD DO PA ARNP Chiropractor

Address: Telephone:

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures July 2022) https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf?_ga=2.153767288.1525543973.1674849857-346854326.1661880588