Infant, Toddler, Preschool – Child Health Exam Form

**DOCTORS COMPLETE THIS PAGE**

Child’s Name: ________________________________

Birth date: __________________ Age today: ________

Date of Exam: ________________

Height/Length: _____________________________

Weight: _____________________________

Head Circumference (for children age 2 yr and under)

Blood Pressure (start @ age 3 yr):

Hgb or Hct (anytime between 6-9 mo):

Blood Lead Level (start @ 12 mo):

**Sensory Screening:**

Vision: Right eye ________  Left eye ____________

Hearing: Right ear ________  Left ear ____________

Date of newborn hearing test: ________________

Tympanometry (may attach results)

**Developmental Screening:**

- Autism screening results:
- Psychosocial/behavioral results:
- Gross Motor:
- Personal/Social:
- Fine Motor-Adaptive:
  - Language:
- Developmental Referral Made Today:
  - No  Yes

**Referrals made:**

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

**Allergies:** (food, medicine, fabric, inhalants, insects, animals, etc.).

Please describe:

**Immunization:** Attach a copy of Iowa Department of Public Health Immunization Certificate

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

- HEENT:
- Oral/Teeth:
- Oral Health/Dental Referral Made Today:
  - No  Yes
  - Date of last dental screening: ______________
- Heart:
- Lungs:
- Stomach/Abdomen:
- Genitalia:
- Extremities, Joints, Muscles, Spine:
- Skin, Lymph Nodes:
- Neurological:

**Medication:** list all medications the child is currently taking. Please note this is not appropriate authorization for center to administer the medication.

**Disability:**

Does the child have a disability?  No  Yes

If yes, describe the major life activity or functions affected by the disability (see link for definitions of disability http://www.eeoc.gov/laws/statutes/adaaa_info.cfm)

If yes, explain why the disability restricts the child’s daily activity:

If no, identify the medical condition that does not rise to the level of a disability:

**Health Provider Assessment Statement:**

- The child may participate in developmentally appropriate child care/preschool with NO health-related restrictions.
- The child may participate in developmentally appropriate child care/preschool with the following restrictions:

Doctors Signature _______________________

Circle the Provider Credential Type: MD DO PA ARNP
Iowa Department of Public Health
Certificate of Immunization

Name Last: ______________________ First: ______________________ Middle: ______________________ Date of Birth: ______________________
Parent/Guardian: ______________________ Address: _________________________________________________________________ Phone: (____)_______________

I certify that the above named applicant has a record of age-appropriate immunizations that meet the requirement for licensed child care or school enrollment.
Signature: __________________________________________________________________ Date: ______________________

Physician, Physician Assistant, Nurse, or Certified Medical Assistant

A representative of the local Board of Health or Iowa Department of Public Health may review this certificate for survey purposes.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Date Given</th>
<th>Doctor / Clinic / Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis DTaP/DTP/DT/ Td/Tdap</td>
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<tr>
<td>Polio IPV/OPV</td>
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<tr>
<td>Measles, Mumps, Rubella MMR</td>
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<tr>
<td>Haemophilus influenzae type b Hib</td>
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<td></td>
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<tr>
<td>Hepatitis B</td>
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<td></td>
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</tbody>
</table>

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<tbody>
<tr>
<td>Varicella Chicken Pox</td>
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<tr>
<td>If patient has a history of natural disease write “Immune to Varicella”</td>
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<tr>
<td>Pneumococcal PCV/PPV</td>
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<tr>
<td>Meningococcal MCV4/MPSV4</td>
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<td>Hepatitis A</td>
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<td>Rotavirus</td>
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<tr>
<td>Human Papilloma Virus HPV</td>
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<tr>
<td>Other</td>
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</tbody>
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April 2012