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: 

**Space is available on back page for detailed comments or instructions pertaining to enrollment at child care or preschool.**

**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](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