It is vital that each portion of the forms are completed in full, including names, addresses and phone numbers of each box listed as we are audited on these. Should the forms not be completed in full, they will be returned home to do so. THANK YOU!

Infant, Toddler, Preschool Age – Child Health Exam Form

PARENTS/GUARDIAN COMPLETE PAGES 1 and 2 – Child Information

Child's name	Child's birthdate	Name of center, provider, or preschool Turkey Valley Preschool 3219 State Highway 24 Telephone # 563-776-6011 Jackson Junction, IA 52171
Parent 1 name	Parent 2 name	
Child home address #1		Telephone # 1
Child home address #2		Telephone #2
Where parent # 1 works	Work address	Home phone # Work # Pager # Cellular # Home email Work email
Where parent # 2 works	Work address	Home phone # 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 parent/guardian. ☐ **YES** ☐ **NO**

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

Parent/Guardian Signature: ______________________________ Date ____________

Alternate emergency contact person's name: ____________________ Phone number:

Relationship to child: Cellular number:

Child's doctor's name	Doctor telephone # 1	Hospital choice
Doctor's address	After hours telephone #	Does child have health insurance? ☐Yes, Company ____________ ID #
Child's dentist's name	Dentist Telephone # 1	Does child have dental insurance? ☐Yes, Company ____________ ID#
Dentist's Address	After hours telephone #	☐ **NO, we do not have health insurance.** ☐ **NO, we do not have dental insurance.**
Other health care specialist name Type of specialty	Telephone #	☐ **Please help us find health or dental insurance.**

Child Name:

*! **Medical Staff: WE ARE AUDITED ON THIS FORM. PLEASE COMPLETE IN ITS ENTIRETY, EVEN IF JUST LISTING " NORMAL" "NOT DONE", "NONE", ETC... THANK YOU!** !*

Iowa Child Care Infant, Toddler, Preschool Age – Child Health Exam Form

HEALTH PROFESSIONAL COMPLETE THIS PAGE[1]

Child's Name: ______________________

Birthdate: **Age today:**

Date of Exam:__________

Height/Length:

Weight:

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 ______

Tympanometry (may attach results)

Developmental Screening[2]**:**

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

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

Heart

Lungs

Stomach/Abdomen

Genitalia

Extremities, Joints, Muscles, Spine

Skin, Lymph Nodes

Neurological

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[1] Iowa Child Care Regulations require an admission physical exam report within the previous year. Annually thereafter, a statement of health condition signed by an approved health care provider. The American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (RE9939, March 2000) www.aap.org

[2] Developmental screening procedures were expanded to include autism, developmental surveillance, and psychosocial/behavioral screening July 2009 by the Iowa EPSDT Medicaid program. Toll-free 800-383-3826.

Allergies

Environmental:
Medication:
Food:
Insects:
Other:

Medication: Please list any prescription medications that the student will need to take while at school or that the school would need to know about.

Also, please note if any restrictions on medications or any other pertinent information.

____

____

____

____

____

____

Referrals made:

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

☐ Other: ______________________

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***:

Signature ______________________

Circle the Provider Credential Type: MD DO PA ARNP