IOWA SCHOOL-AGE CARE- HEALTH STATUS- PARENT STATEMENT
Health Professional's Physical Exam Findings

Child's Name_____
DOB_____**Age**_____
Date of Physical Exam:_____
Height_____Weight_____
Body Mass Index_____
There are weight concerns ___Yes OR ____No
Referral made to_____
Blood Pressure_____/_____
Laboratory Screening:
Blood Lead Level_____
- Venous
- Capillary(for child under age 6yr)

HGB/HCT_____
Urinalysis_____
TB testing (high risk child only)
Sensory Screening
Vision: Right Eye_____Left Eye_____
Hearing: Right Ear_____Left Ear_____
Tympanometry: Right Ear_____Left Ear_____
Exam Results (N=Normal limits) otherwise describe
Skin_____
EENT_____
Teeth/Oral Health_____
Date of Dentist Exam_____
___None to date
Referral made today: ___Yes OR ___No
Where to_____
Heart_____
Lungs_____
Stomach/Abdomen_____
Genitalia_____
Extremities/Joints/Muscles/Spine_____
Urological_____
ER Notes_____

Vaccines given today

Vaccines entered into IRIS database ___**Yes** ____**No**

Dtap/DTP/Td
HEP B
HIB
Influenza
MMR
Pnemococcal
Polio
Varicella
Other

Referrals made today:_____

____Referred to Hawk-I today 1-800-257-8563

Health provider authorizes the child to receive the following medications while at Child Care or School (including *over-the-counter* & *prescribed*)

Medication Name & Dosage

___Fever/Pain Reliever:
___Sunscreen:
___Cough Medicine:
___Other-List ALL

Health Provider Statement:

___This child may ***fully participate*** with ***NO*** health related restrictions
___The child has the following ***health-related restrictions*** to participation (Please specify)

Child care regulations require an annual parent statement for the child's health. Parents obtaining a physical exam are asked to have their family doctor or clinic use this form.

Signature_____

Provider Type (circle) MD DO PA ARNP

Address_____

_____

Phone_____