# School-Age Child Health Form/Parent Statement of Health

HEALTH PROFESSIONAL COMPLETE PAGE –
OR PROVIDE COPY OF WELL CHILD PHYSICAL

Date of Exam: _____

Height: _____ Weight: _____

Body Mass Index: _____,

☐There are weight concerns

☐Referral made to _____

Blood Pressure: _____

**Laboratory Screening:**

Blood Lead Level: Date_____ ☐ venous ☐ capillary (for child under age 6 yr.) Results _____

Hgb. / Hct: _____

Urinalysis: _____

**Sensory Screening**

Vision Acuity: Right eye _____ Left eye _____

Hearing: Right ear _____ Left ear _____

Tympanometry: Right ear _____ Left ear _____

**Exam Results** (*N = normal limits) otherwise describe*

**Skin**:

**HEENT**:

**Teeth/Oral health**:

Date of Dentist Exam: _____ or ☐ none to date.

Dental Referral Made Today ☐ Yes ☐ No

**Heart**:

**Lungs**:

**Stomach/Abdomen**:

**Genitalia**:

**Extremities, Joints, Muscles, Spine**:

**Neurological**:

**Psychosocial/Behavioral Assessment** (Depression screening starting at age 11)

**Allergies:**

| |
|---|
| **Environmental** |
| **Medication** |
| **Food** |
| **Insects** |
| **Other** |

American Academy of Pediatrics has recommendations for frequency of childhood preventative pediatric health care (Bright Futures March 2021) https://www.aap.org/en-us/Documents/periodicity_schedule.pdf

Child Name: _____

Date of Birth: _____ Age: _____

**Immunization and TB Testing:** (check as indicated)

☐ IDPH Certificate of Immunization reviewed/signed

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

**Health provider authorizes the child to receive the following medications while at child care or school**
(Including *over-the-counter* and *prescribed*)

Medication Name Dosage

☐Fever/Pain reliever:

☐Sunscreen:

☐Cough medication:

☐Other - list all

**Other Medication should be listed with written instructions for use in child care.** Medication forms available at www.idph.iowa.gov/hcci/products

**Additional Referrals made:**

☐ _____

☐ _____

**Health Provider Statement:**

☐The child may **fully participate** with ***NO*** health-related restrictions.

☐The child has the following **health-related restrictions** to participation: (please specify)

☐ The child has a special needs care plan
Type of plan _____
(Please complete and give to parent for child care)

**Health Care Provider Comments:**

May use stamp

**Signature** _____

Circle the Provider Type: **MD DO PA ARNP**

Address: Telephone:

# School-Age Child Health Form/Parent Statement of Health

Parent/Guardian complete this page

Child name: _____

Please use an **X** in the box ☐ for statements that apply to your child.

Date of child's last physical exam: _____
Date of last dental appointment: _____

**Growth**
☐ I am concerned about child's growth.

**Appetite**
☐ I am concerned about child's eating habits.

**Rest**
☐ My child needs to rest after school.

**Illness/Surgery/Injury**
☐ My child had a serious illness, surgery, or injury. Please describe:

**Physical Activity** - My child
☐ Must restrict physical activity or needs special equipment to be active. Please describe:

**Play with friends** - My child
☐ Plays well in groups with other children.
☐ Will play only with one or two other children.
☐ Prefers to play alone.
☐ Fights with other children.
☐ I am concerned about my child's play activity with other children. Please describe:

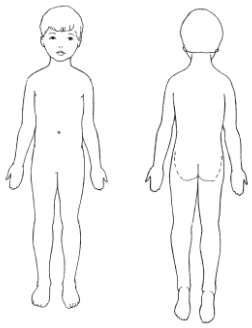
**School and Learning** - My child
☐ Is doing well at school.
☐ Is having difficulty in some classes.
☐ Does not want to go to school.
☐ Frequently misses or is late for school.
☐ I am concerned about how my child is doing in school. Please describe:

☐ **Allergy** - My child has allergies (Medicine, food, dust, mold, pollen, insects, animals, etc.). List allergies:

☐ **Special Needs Care Plan** –My child has a special need and needs a care plan for child care. Please discuss with your health care provider.

**Body Health** - My child has problems with

☐ Skin, hair, fingernails or toenails.
Describe skin marks, birthmarks, or scars. Show us where these skin marks are located using the drawing below.



☐ Eyes/vision, glasses or contact lenses
☐ Ears/hearing, hearing assistive aides or device, earache, tubes in ears
☐ Nose problems, nosebleeds
☐ Mouth, teeth, gums, tongue, sores in mouth or on lips, breaths through mouth
☐ Frequent sore throats or tonsillitis
☐ Breathing problems, asthma, cough
☐ Heart problems or heart murmur
☐ Stomach aches or upset stomach
☐ Trouble using toilet or wetting accidents
☐ Hard stools, constipation, diarrhea, watery stools
☐ Bones, muscles, movement, pain when moving
☐ Mobility, child uses assistive equipment
☐ Nervous system, headaches, seizures, or nervous habits (like twitches or tics)
☐ Females – difficult monthly periods
☐ Other special needs. Please describe:

☐ **Medication**[1] - My child takes medication.

| Medication Name | Time Given | Reason for giving medication |
|---|---|---|

**Child has Epipen, inhaler, or other emergency medication.**
☐ Yes ☐ No

**Parent/Guardian Signature:** _____ **Date:** _____

[1] Parents: Please review the child care program's policies about the use of medication at child care.

# Recommendations for Preventive Pediatric Health Care – School-Age Child

**Bright Futures/American Academy of Pediatrics**

Each child and family is unique; therefore, these Recommendations for Preventive Pediatric Health Care are designed for the care of children who are receiving competent parenting, have no manifestations of any important health problems, and are growing and developing in satisfactory fashion. Additional visits may become necessary if circumstances suggest variations from normal. Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

These guidelines represent a consensus by the American Academy of Pediatrics (AAP) and Bright Futures. The AAP continues to emphasize the great importance of continuity of care in comprehensive health supervision and the need to avoid fragmentation of care. Refer to the specific guidance by age as listed in Bright Futures guidelines (Hagan JF, Shaw JS, Duncan PM, eds. Bright Futures Guidelines for Health Supervision of Infants, Children and Adolescents. 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008).

The recommendations in this statement do not indicate an exclusive course of treatment or standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

| | MIDDLE CHILDHOOD | | | | | | ADOLESCENCE | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **AGE**[1] | 5 y | 6 y | 7 y | 8 y | 9 y | 10 y | 11 y | 12 y | 13 y | 14 y | 15 y | 16 y | 17 y | 18 y | 19 y | 20 y | 21 y |
| **HISTORY:** Initial/Interval | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **MEASUREMENTS:** Length/Height and Weight | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Head Circumference | | | | | | | | | | | | | | | | | |
| Weight for Length | | | | | | | | | | | | | | | | | |
| Body Mass Index[5] | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Blood Pressure[6] | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **SENSORY SCREENING:** Vision[7] | ● | ● | ✱ | ● | ✱ | ● | ✱ | ● | ✱ | ✱ | ● | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ |
| Hearing | ● | ● | ✱ | ● | ✱ | ● | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ |
| **DEVELOPMENTAL/BEHAVIORAL ASSESSMENT:** | | | | | | | | | | | | | | | | | |
| Developmental Screening[9] | | | | | | | | | | | | | | | | | |
| Autism Screening[10] | | | | | | | | | | | | | | | | | |
| Developmental Surveillance | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Psychosocial/Behavioral Assessment | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Alcohol and Drug Use Assessment[11] | | | | | | | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ |
| Depression Screening[12] | | | | | | | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **PHYSICAL EXAMINATION**[13] | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| **PROCEDURES**[14]**:** Newborn Blood Screening[15] | | | | | | | | | | | | | | | | | |
| Critical Congenital Heart Defect Screening[16] | | | | | | | | | | | | | | | | | |
| Immunization[17] | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |
| Hematocrit or Hemoglobin[18] | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ |
| Lead Screening[19] | ✱ | ✱ | | | | | | | | | | | | | | | |
| Tuberculosis Testing[21] | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ |
| Dyslipidemia Screening[22] | | ✱ | | ✱ | ←——— | ● | ———→ | ✱ | ✱ | ✱ | ✱ | ✱ | ✱ | ←——— | ——— | ● | ———→ |
| STI/HIV Screening[23] | | | | | | | ✱ | ✱ | ✱ | ✱ | ✱ | ←——— | ● | ———→ | ✱ | ✱ | ✱ |
| Cervical Dysplasia Screening[24] | | | | | | | | | | | | | | | | | ● |
| **ORAL HEALTH**[25] | | ● | | | | | | | | | | | | | | | |
| Fluoride Varnish[26] | ———→ | | | | | | | | | | | | | | | | |
| **ANTICIPATORY GUIDANCE** | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● | ● |

KEY: ● = to be performed ● or ✱ = risk assessment to be performed with appropriate action to follow, if positive ←——● ——→ = range during which a service may be provided

See pages 131 and 132 for footnotes.